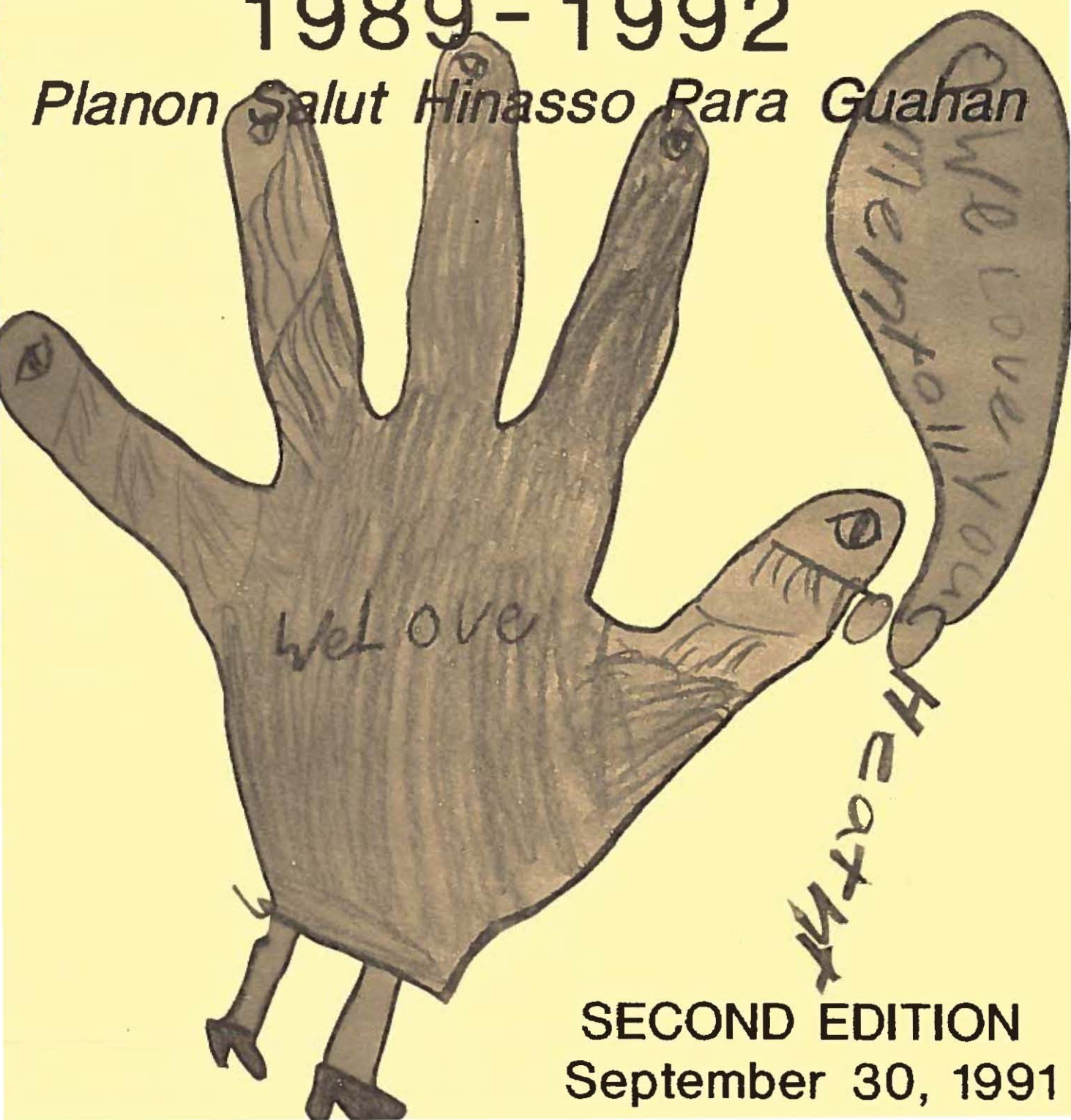


GUAM MENTAL HEALTH PLAN

1989 - 1992

Planon Salud Hinasso Para Guahan



SECOND EDITION
September 30, 1991

GUAM MENTAL HEALTH PLAN

1989 - 1992

September 30, 1991

**Guam Mental Health
Planning Council**

**P.O. Box 9400
Tamuning, Guam 96931**

**Cover illustration by child-consumer
of mental health services.**

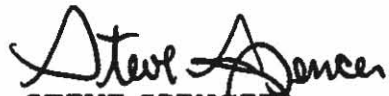
F O R E W O R D

Hafa Adai!

The Guam Mental Health Planning Council is proud to present the second edition of the **Guam Mental Health Plan, 1989 - 1992**. The plan's ultimate mission is to establish a comprehensive community-based system of care for the seriously mentally ill and emotionally disturbed populations and substance abusers of Guam. We hope this plan will continue to serve as a guide for a better way of life for those in need.

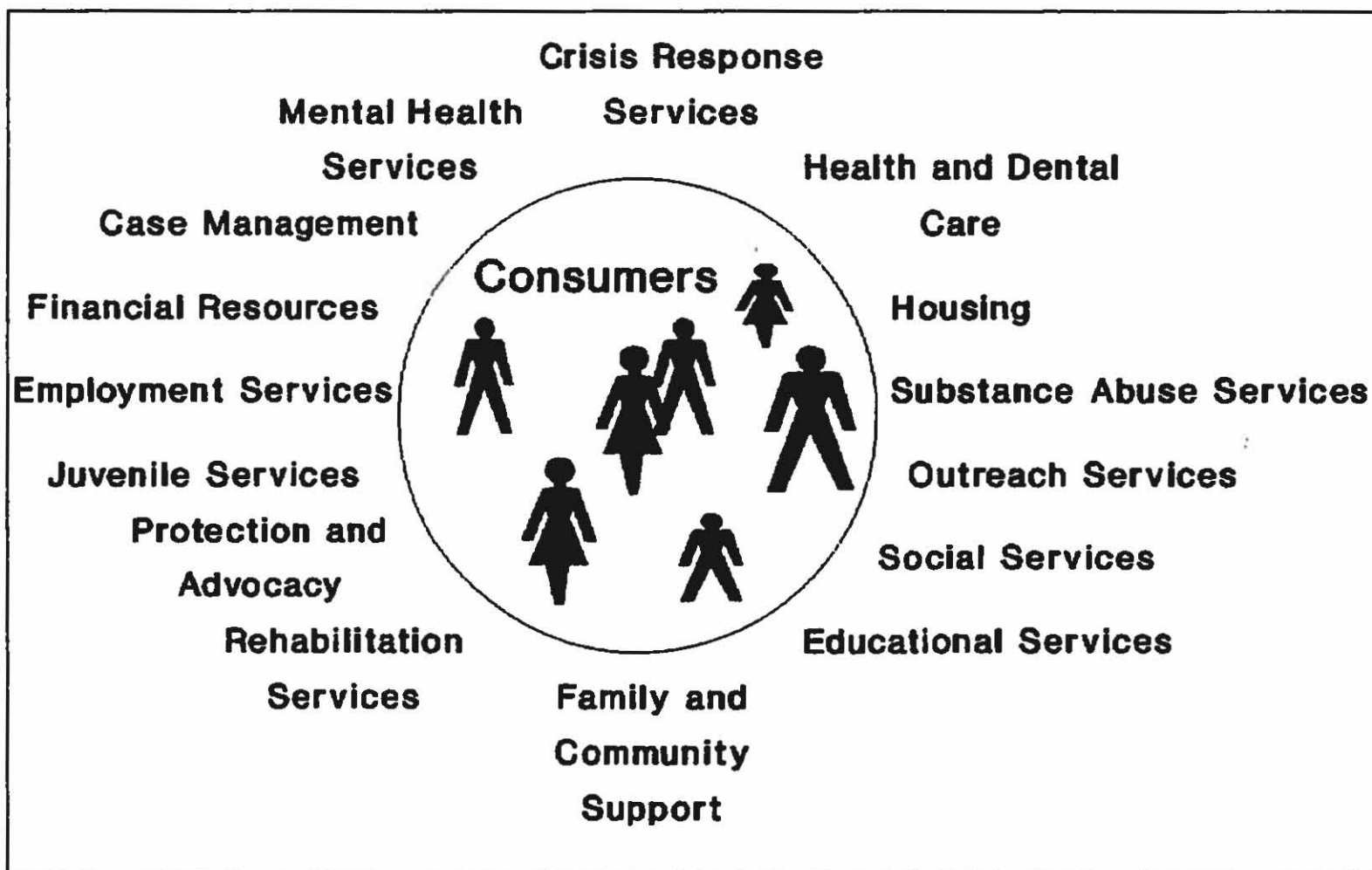
Si Yu'os Ma'asi.

Sincerely,


STEVE SPENCER
Chairperson,
Guam Mental Health
Planning Council

GUAM MENTAL HEALTH PLAN, 1989 - 1992

A Community-Based System of Care



Guam Mental Health Planning Council:

Steve Spencer, Chairperson of the Council

Ruth Hall, Vice-Chairperson of the Council, and Chairperson, Committee for Mentally Ill Adult Population

**Christie Anderson, Co-Chairperson,
Committee for the Prevention and Treatment of Alcohol and Other Drug Abuse**

**Diann B. Aninao, Chairperson,
Committee for Seriously Emotionally Disturbed Children and Adolescents**

**Sr. Mary Joanne Getz, Chairperson,
Committee for the Homeless Mentally Ill Population**

**William Melendez, Jr., Co-Chairperson,
Committee for the Prevention and Treatment of Alcohol and Other Drug Abuse**

**John Weisenberger, Co-Chairperson,
Committee for Mentally Ill Adult Population**

**Rosanne Ada
Judge Benjamin J. Cruz
Julita Lifoifoi
Vicente Morta
Jose C. Taitano
Fred Ungacta**

Advisor to the Council:

Marilyn L. Wingfield, Director (DMHSA)

The Planning Team:

**Simeon M. Palomo, Planner II (DMHSA)
Dr. Randall Workman, Technical Consultant (UOG)
Dr. Ulla-Katrina Craig, Technical Consultant (UOG) - 1st Edition**

Committee for Seriously Mentally Ill Adult Population:

**Ruth Hall
Fred F. Ungacta
John Weisenberger
Dr. Randall Workman**

Committee for Children and Adolescents with Serious Emotional Disturbances:

**Diann B. Aninao
Dr. Kirk Bellis
Judge B.J. Cruz
Gordon Ibanez
Bev Miller
Steve Spencer
Dan Sommerfleck
Ed Taitano
Dr. Randall Workman
Michael Wylie**

Committee for Mentally Ill Homeless Population:

Wayne Antkowiak
Evelyn O. Cruz
Vicky Ll. Duenas
Sister Mary Joanne Getz
Tita Matanane
Richard Punzalan
Lola Rojas
Josephine Rosario
John Weisenberger
Dr. Randall Workman

Committee for the Prevention and Treatment of Alcohol and Other Drug Dependencies:

Luisa Ada
Louis Agbulos, Jr.
David Aflague
Christie Anderson
Jesus Angoco
Gloria Arriola-Artero
Rodney Barker
Barbara S.N. Benavente
Tina Blas
Robert Borger
Tess Borja
Karen Carpenter
Joseph Claveria
Sister Mary John Cristobal
Kathryn Davis-Finch
Lola Eclavea
Tomas M. Fejeran
Aida Fernandez
Judy P. Fernandez
Richard Hartendorp
Faye Kaible
Christine Lanada
Robert Legaspi
Larry K. Gilliam
Dr. Archana Leon Guerrero
Claudette McGhee
William Melendez, Jr.
Michelle L. Monts
Daniel J. Mulhauser
Del Northway
Leilani Nishimura
Linda Ortiz
Jaime L. Petenia
Genevieve L.G. Perez
Clifford Porter
Athena Ramos
Alan Sapalaran
Art San Agustin
Jeff Shafer
Luckie San Nicolas
Andi Santos
Robert Santos
John Taitano, M.D.
Enrique F. Torres
Carlyn Torres-Castro
Ann Workman

Participating Community and Government Agencies:

Advocacy and Protection Office
Bureau of Planning
Catholic Social Services
Dededo Drug Free Association
Department of Education
Department of Vocational Rehabilitation
Department of Youth Affairs
Department of Mental Health and Substance Abuse
Department of Public Health and Social Services
Diagnostic and Treatment Services, Family Court of Guam
Guam Housing and Urban Renewal Development (GHURA)
Guam Legal Services Corporation
Guma' Mami, Incorporated;
Social Actions, Andersen Air Force Base
University of Guam: Community Development Institute, Cooperative Extension and
Counseling Departments
Western Pacific Association of the Disabled (WPAD)

GUAM MENTAL HEALTH PLAN, 1989 - 1992

TABLE OF CONTENTS

	Page
Executive Summary	1-4
Chapter I: Introduction and Planning Process	
A. Purpose of the Guam Mental Health Plan	5
B. Establishment of the Guam Mental Health Planning Council	5-6
C. Planning Activities	6
D. Planning Methodology	6-8
E. Underlying Assumptions and Values for the Planning Process	8
F. Synthesis of Meeting Input	8
G. Limitations and Restraints to Planning Activities	8
Chapter II: Background Information	
A. Geography and Climate	9
B. Historical Background of the Territory	9-12
C. Unique Characteristics of the Territory	12-13
D. Demographic Information	13-18
E. Changes in Culture, Traditions and Values	18
Chapter III: Guam's Mental Health System	
A. "Mental Health"	19-20
B. Mental Health Services	20-21
C. Facility, Programs and Services	21-23
D. System Concerns and Problems	23-29
E. System Goals and Objectives	29-30
Chapter IV: Seriously Mentally Ill Adults	
A. Adults with a Serious Mental Illness	31
B. Definition	31-32
C. General Description	32
D. Number of Seriously Mentally Ill Adults	32-43
E. Needs Assessment	43
F. Vision of an Ideal System	44-45
G. Guam's Services for Seriously Mentally Ill Adults	45-47

I.	GOALS, OBJECTIVES AND STRATEGIES	52-55
----	----------------------------------	-------

Chapter V: Seriously Emotionally Disturbed Children and Adolescents

A.	Definition	56
B.	General Description	57
C.	Number of Seriously Emotionally Disturbed Children and Adolescents	57
D.	Needs Assessment	57-58
E.	Vision of an Ideal System	58-59
F.	Guam Services for Seriously Emotionally Disturbed Children and Adolescents	59-62
G.	Analysis and Discussion	62-64
H.	GOALS, OBJECTIVES AND STRATEGIES	64-71

Chapter VI: Mentally Ill Homeless

A.	Guam's Mentally Ill Homeless	73-74
B.	Definition	74
C.	General Description	75
D.	Number of Mentally Ill Homeless	75-76
E.	Needs Assessment	76
F.	Vision of an Ideal System	76
G.	Guam's Services for the Mentally Ill Homeless	76
H.	Analysis and Description	76-78
I.	GOALS, OBJECTIVES AND STRATEGIES	79-81
J.	Financial Sources	81

Chapter VII: Prevention and Treatment of Alcohol and Other Drug Dependencies

A.	Alcohol and Drug Abuse	82-84
B.	Definitions	84-85
C.	Number of Persons with an Alcohol and/or Drug Dependency	85-86
D.	Vision of an Ideal System	86-89
E.	Guam's Alcohol and Drug-Related Services	89-92
F.	Analysis and Description	92-94
G.	GOALS, OBJECTIVES AND STRATEGIES	94-101

Appendices

EXECUTIVE SUMMARY
FOR
GUAM MENTAL HEALTH PLAN, 1989 - 1992
SECOND EDITION

This is the *second* mental health plan presented to the National Institute of Mental Health (NIMH) for the territory of Guam.

The Guam Mental Health Plan addresses the twelve requirements of Public Laws 99-660 and 101-639 as described below:

1. ESTABLISHING AND IMPLEMENTING AN ORGANIZED COMMUNITY-BASED SYSTEM OF CARE FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS AND CHILDREN WITH SERIOUS EMOTIONAL AND MENTAL DISORDERS.

The plan's ultimate mission is to create a system of care that functions throughout the community, rather than institutionalize all services within the Department of Mental Health and Substance Abuse. The implementation of the Goals and Objectives identified for the various populations, Seriously Mentally Ill Adults, Seriously Emotionally Disturbed Children and Adolescents, Mentally Ill Homeless, and Substance Abusers will pave the way for a community-based system of care.

2. SPECIFYING QUANTITATIVE TARGETS TO BE ACHIEVED IN THE IMPLEMENTATION OF SUCH SYSTEM, INCLUDING NUMBERS OF INDIVIDUALS WITH SERIOUS MENTAL ILLNESS RESIDING IN THE AREAS TO BE SERVED UNDER THE SYSTEM.

Target populations and *numbers to be served* have been identified for goals and objectives of the plan.

3. DESCRIBING SERVICES, AVAILABLE TREATMENT OPTIONS, AND AVAILABLE RESOURCES (INCLUDING FEDERAL, STATE, AND LOCAL PUBLIC SERVICES AND RESOURCES, AND TO THE EXTENT PRACTICABLE, PRIVATE SERVICES AND RESOURCES) TO BE PROVIDED FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS TO ENABLE THEM TO GAIN ACCESS TO SERVICES, INCLUDING TREATMENT, PREVENTION AND REHABILITATION SERVICES.

Guam Public Law 17-21 mandates that mental health care services are to be provided to all of Guam's inhabitants. Similar laws assure access to education, vocational rehabilitation services from the Department of Education and the Department of Vocational Rehabilitation. Consequently, there are no apparent financial access barriers. However, geographic, temporal and socio-demographic access barriers exist, as well as barriers arising from the cultural differences in values and perceptions of mental health care of Guam's different ethnic groups. The plan has attempted to address the above concerns.

4. DESCRIBING HEALTH AND MENTAL HEALTH SERVICES, REHABILITATION SERVICES, EMPLOYMENT SERVICES, HOUSING SERVICES, EDUCATIONAL SERVICES, MEDICAL AND DENTAL CARE, AND OTHER SUPPORT SERVICES TO BE PROVIDED TO INDIVIDUALS AND CHILDREN WITH SERIOUS EMOTIONAL AND MENTAL DISORDERS WITH FEDERAL, STATE AND LOCAL PUBLIC AND PRIVATE RESOURCES TO ENABLE SUCH INDIVIDUALS TO FUNCTION OUTSIDE OF INPATIENT OR RESIDENTIAL INSTITUTIONS TO THE MAXIMUM EXTENT OF THEIR CAPABILITIES, INCLUDING SERVICES TO BE PROVIDED UNDER THE

EDUCATION OF THE HANDICAPPED ACT.

Guam has an array of services to provide for the basic needs of all inhabitants, including the mentally ill. There is a general shortage of government-sponsored housing though, and there are long waiting lists for occupancy. Nominal preference for housing is given to the mentally ill. There is also a lack of residential treatment facilities for children and adults with severe/chronic mental illness or emotional disturbances but the plan addresses these needs and efforts are being made to achieve such goals.

5. DESCRIBING FINANCIAL RESOURCES AND STAFFING NECESSARY TO IMPLEMENT THE REQUIREMENTS OF THE PLAN.

Funding and staffing for the implementation of Goals and Objectives have been largely identified, depending on the status of the goal and objective.

6. PROVIDING ACTIVITIES (PROGRAMS) TO REDUCE THE RATE OF HOSPITALIZATION OF INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

This requirement is not completely applicable to the island's situation, as there are insufficient inpatient facilities for the mentally ill. Planning includes additional inpatient beds in the new mental health and substance abuse facility and community-based care services. The new Case Management Unit, the new Adult Residential Treatment facility (Guma IFIL), the proposed in-home services for emotionally disturbed children, group homes for mentally ill adults, a children's residential treatment center, and other goals of the plan are expected to decrease the cyclic re-admissions for inpatient care.

7. PROVIDING CASE MANAGEMENT SERVICES FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS WHO RECEIVE SUBSTANTIAL AMOUNTS OF PUBLIC FUNDS OR SERVICES; THE TERM "INDIVIDUAL WITH SERIOUS MENTAL ILLNESS" TO BE DEFINED UNDER STATE LAWS AND REGULATIONS.

The recent reorganization of the Department of Mental Health and Substance Abuse established a designated unit of Case Management. Case management is not a new function for DMHSA: The former Outpatient and Aftercare units had provided case management to their clients prior to the reorganization. The new case management unit is centralized and will provide services for all mental health patients diagnosed with severe or chronic illness or serious emotional disturbances. Public Laws 99-660 and 101-639 requirements of providing case management to mentally ill individuals who receive substantial amounts of public funds has been preceded by Guam's P.L. 17-21, which also mandates services to all mentally ill persons, regardless of their economic status.

8. PROVIDING FOR THE IMPLEMENTATION OF THE CASE MANAGEMENT REQUIREMENTS IN THE PRECEDING PARAGRAPH IN A MANNER WHICH PHASES IN THE BEGINNING OF FISCAL YEAR 1989 AND PROVIDES FOR THE SUBSTANTIAL COMPLETION OF THE PHASING IN OF THE PROVISION OF SUCH SERVICES BY THE END OF FISCAL YEAR 1992.

As new programs are being implemented through 1992, via the Guam Mental Health Plan, case management services will be needed.

9. PROVIDING FOR THE ESTABLISHMENT OF AND IMPLEMENTATION OF A PROGRAM OF OUTREACH TO, AND SERVICES FOR, INDIVIDUALS WITH SERIOUS MENTAL ILLNESS WHO ARE HOMELESS.

Goals such as the implemented Drop-In Center for Guam's homeless mentally ill persons are creating outreach services for the mentally ill populations. It must be noted that the Guam Mental Health Planning Council voted to include mentally retarded persons as a target population under the homeless section. Other goals (Goal 4 of the adult section, Goals 1, 5 & 11 of the children's section, and Goals 1 & 4 of the Drug and Alcohol section) will further enhance outreach services throughout the island.

10. DESCRIBING A SYSTEM OF INTEGRATED SOCIAL, EDUCATIONAL, JUVENILE, SUBSTANCE ABUSE SERVICES WHICH TOGETHER WITH HEALTH AND MENTAL HEALTH SERVICES, SHOULD BE PROVIDED IN ORDER FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL AND MENTAL DISORDERS TO RECEIVE CARE APPROPRIATE FOR THEIR MULTIPLE NEEDS, INCLUDING SERVICES TO BE PROVIDED BY LOCAL SCHOOL SYSTEMS UNDER THE EDUCATION OF THE HANDICAPPED ACT.

The newly included section, *The Prevention and Treatment of Alcohol and Other Drug Dependencies*, addresses substance abuse services for children and adolescents. Other services, social, educational, juvenile, health and mental health, are discussed in the children's section.

11. CONSULTING WITH REPRESENTATIVES OF EMPLOYEES OF STATE INSTITUTIONS AND PUBLIC AND PRIVATE NURSING HOMES WHO CARE FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

Guam has only one long-term care facility, the St. Dominic's Senior Care Home, which provides intermediate care to individuals aged 60 or older. Consultation with this provider of long-term care services centered on the mental health needs of the patients.

12. UTILIZING THE STATE MENTAL HEALTH PLANNING COUNCIL, OR ESTABLISHING A NEW COUNCIL TO REVISE, REVIEW, MONITOR, AND EVALUATE ALL ASPECTS OF THE DEVELOPMENT AND IMPLEMENTATION OF THE STATE PLAN, WITH A FORMAL TRANSMISSION OF COMMENTS TO THE GOVERNOR AND TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; COUNCIL MUST SERVE AS AN ADVOCATE, INCLUDE CONSUMERS AND FAMILY MEMBERS, AND HAVE NOT MORE THAN 50% OF MEMBERSHIP BE STATE EMPLOYEES AND MENTAL HEALTH PROVIDERS.

The Governor of Guam established in May 1989 the Guam Mental Health Planning Council through Executive Order No. 89-11. Council members are either consumers and/or family members, advocates, or providers of generic human services and mental health care services. Council input to the plan was comprehensive, for each section of the plan was supervised by a council member and members provided valuable assistance in the creation and continuing implementation of the plan. The public, government providers and advocates also provided valuable input into the Plan.

It must be noted that two review criteria for Mental Health Plans under P.L. 99-660 may not be relevant to Guam: planning for populations in rural areas and for minority groups. Guam's population has been classified as mixed rural/urban, and the majority of Guam's population is, in fact, classified as a "minority", i.e., "Pacific Islander", by the U.S. Census Bureau. The Guam Mental Health Plan makes provisions for mental health and needed support services for all the inhabitants of Guam, regardless of their residence or ethnic identification.

Because the council considered substance abuse influential with all three populations, the council included a chapter on the prevention and treatment of alcohol and drug dependency. Two representatives from the substance abuse field were added to the council in 1990.

Chapter 1

Introduction & Planning Process

CHAPTER I

INTRODUCTION AND PLANNING PROCESS

Public Law 99-660, Title V, the "State Mental Health Services Act of 1986," requires states and territories to develop and implement plans for a comprehensive community-based system of mental health services that target the priority populations of adults with serious and persistent mental illness, children and adolescents with serious emotional disturbances or mental illness, and the mentally ill homeless. Such plans must meet twelve criteria which cover a wide range of issues. They deal with mission, purpose, action, quantification of needs and services, as well as input from providers of generic health and social services, long-term care services, and mandatory consultation with a mental health planning council.

A. Purpose of the Guam Mental Health Plan

The Plan is intended to fulfill the following functions:

1. Inform the reader about Guam's unique geographic and population features;
2. Document Guam's existing mental health services;
3. Identify and define the three mandated priority populations;
4. Establish a vision of an ideal mental health system for the Island of Guam;
5. Serve as a 3-year policy statement and framework which will direct decision making, future activities and budget allocation of mental health services, and
6. Meet the requirements of federal Public Laws 99-660 and 101-639.

B. Establishment of the Guam Mental Health Planning Council

In order to comply with Public Law 99-660, the Governor of Guam, Joseph F. Ada, established the Guam Mental Health Planning Council (GMHPC) through Executive Order 89-11, in May 1989.

Members of the GMHPC were recruited by Guam's Department of Mental Health and Substance Abuse (DMHSA). The composition of the GMHPC adheres to the federal guidelines: a representative match of primary consumers or family members/caregivers of consumers, and advocates and providers of mental health and generic health and social services. Under P.L. 99-660 at least half (50%) of the council members must not be employees of the Government of Guam. Fourteen council members were sworn in by the Governor on May 18, 1989. Three members of the original council resigned and two were replaced during fiscal year 1990 by other appropriate members of the community. Thirteen members comprise the present council.

The council viewed it necessary to include an additional section addressing the prevention and treatment of alcohol and other drugs in the plan's second submittal since they hold influence with the other three populations mandated by P.L. 99-660.

Below is the make-up of the 1990 - 1991 council:

Five (5) Consumers or parents/family members of consumers.

Two (2) Consumer Advocates, representing:
Marianas Association for Retarded Persons;
Guam Interagency Coordinating Council for Special Children.

Three (3) Representatives of Government of Guam Agencies:
Department of Public Health & Social Services -
Child Protective Services;
Superior Court of Guam--Family Court;
Department of Education--Special Education Division;

One (1) Representative from Catholic Social Service--
"Alee" Shelter for Women and Children.

Two (2) Representatives from the Substance Abuse field.

C. Planning Activities

The Guam Mental Health Planning Council initiated a large portion of the write-up of the second submission, as each committee addressed the various target populations and was headed by a council member. In addition to the valuable input by the council members, the Director of DMHSA served as an advisor to the council, one DMHSA Planner II was assigned to do the researching and editing of the plan and facilitate meetings for the council and the children's committee, and a technical consultant was hired for the period of July - September 1990 to facilitate meetings and workshops for the mentally ill adults and homeless committees and to manage and edit their sections of the plan. Implementation efforts are jointly coordinated by the council, the DMHSA Director and Planner II.

Below are the four committees:

- a. Committee for Mentally Ill Adult Population;
- b. Committee for Mentally Ill Homeless Population;
- c. Committee for Children and Adolescents with Emotional Disturbances; and
- d. Committee for the Prevention and Treatment of Alcohol and Other Drug Dependencies.

D. Planning Methodology

A strategic planning approach was employed. It was explained to council and committee members that planning identifies ways and means to achieve the desired goals but is not an end in itself.

Meetings addressed the following agenda:

1. Identify the target (priority) population under discussion.
2. Establish a definition of that population suitable for Guam.
3. Look at the existing programs and services for this target population and the organizational purpose of the agencies and departments providing these services.

4. Identify data sources for these programs and services.
5. Evaluate existing services.
6. Envision an ideal delivery of services system which should minimally include:
 - * Prevention Activities
 - * Outreach
 - * Crisis Response
 - * Case Management Services
 - * Treatment at an Appropriate Level
 - * Life and Social Support
 - * Rehabilitation/Education
 - * Protection and Advocacy
 - * Institutional/Residential/Natural Settings for Treatment.
7. Identify the gaps between the existing services ("what is") and the desired ideal system ("what should be").
8. Look at realistic and appropriate ways to fill these gaps. Identify:
 - a) What is necessary - facilities, services, manpower,
 - b) Who will/should provide these services,
 - c) How long will it take to implement such services,
 - d) If such services are already mandated by existing local or federal law,
 - e) Whether new legislation is required to implement the services; if so, who should promulgate it,
 - f) How the services would be financed.

The participants were aware that P.L. 99-660, and most recently P.L. 101-639, required planning activities leading to the implementation of a community-based system of care for seriously mentally ill adults and emotionally disturbed children, the purpose of which is to decrease inpatient admissions. Furthermore, it was clear that case management is to be provided to members of the target population who receive substantial amounts of public funds.

The "community-wide system" of care has been explained to mean "the spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of the severely emotionally disturbed and seriously mentally ill persons of all ages on the island of Guam."

At the beginning of the planning process it was recognized that Guam's Mental Health Plan will differ from that of other jurisdictions in three important areas:

1. Because Guam has never had a designated mental health facility, and because the present facility (described in Chapter III) is inadequate, planning for a comprehensive mental health care system must envision an increase of appropriate and separate inpatient beds for children and adults, segregated from forensic clients and alcohol/drug patients, while still identifying a means for decreasing inpatient days. Consequently, planning efforts addressed the question of how to expand and improve comprehensive community-wide services in addition to providing sufficient and appropriate inpatient facilities to meet local needs.
2. DMHSA is the only provider of care for seriously emotionally disturbed children and adolescents as well as seriously mentally ill adults on island. Since local law mandates that services be provided to everyone, regardless of income, planning for community-based services, including

- case management, must take into account the total mentally ill population, and not only those who receive substantial amounts of public funds.
3. By virtue of Guam's population composition (see Chapter II), the majority of the mental health care consumers belong to a minority, i.e., Pacific Islanders or Chamorros, as identified by the U.S. Census Bureau. Consequently there is no discussion of "services for minority populations" in this Plan, as all ethnic groups on island have equal access to the system.

E. Underlying Assumptions and Values for the Planning Process

Planning activities were conducted on the assumption that people with mental health problems have the same basic needs as any other person, and that people with mental health problems, regardless of the severity, have the right to live in fully integrated communities. These assumptions gave rise to the following values:

1. Care for the mentally ill should be provided in the least restrictive manner and appropriate to the age and condition of the client;
2. The client and his family (or significant other) should be regarded as a treatment unit.
3. Treatment should enhance a client's self-sufficiency, dignity, and participation in treatment planning, and
4. Greater emphasis must be put on rehabilitation and community integration.

F. Synthesis of Meeting Input

The proceedings of the meetings were recorded. The Planner II and consultant prepared a synthesis of all discussions and presented this to the council members during the meetings. Council members assessed the stated needs, goals, objectives, and activities for providing services for the target populations, as presented in Chapters IV, V and VI and VII. These chapters also address barriers to the utilization of mental health care services.

G. Limitations and Restraints to Planning Activities

A major constraint for the various planning components was the unavailability of reliable data. This is detailed in Chapter III under Service System Problems.

Chapter 2

Background Information

CHAPTER II

BACKGROUND INFORMATION

A. Geography and Climate

Guam, situated in the Western Pacific, is the United States' western-most territory. It lies 5,800 miles from the U.S. mainland and 3,300 miles west of Hawaii, its closest U.S. neighbor. While being remote from the U.S., Guam is close to the Pacific Rim countries. Tokyo, Taipei, Manila and Hong Kong are all within 2-3 hours flight distance, while flying to Hawaii takes 7 hours and to the U.S. west coast 12 hours (See Figure 1).

Guam is the southernmost of the Marianas Islands and lines up along the 145th meridian east of Greenwich at 13 degrees north latitude. The island was formed by volcanic action, coral growth and uplift of submarine mountain ranges. It is 32 miles long, 4 to 8 miles wide and encompasses 212 square miles (See Figure 2).

The northern third of Guam is a broad limestone plateau with steep coastal cliffs and no surface rivers. Most of this area is occupied by military installations. The central part of the island lies northeast of a fault line that crosses the middle of the island from the villages of Agana to Yona. Central Guam consists of coastal low lands and high limestone terraces; it is the most urbanized and heavily populated area. The southern area of Guam is distinguished by a line of extinct volcanic peaks. A mixed terrain slopes eastward from the peaks, with several rivers flowing through eroded valleys to the coast. This is the most rural area and represents the most culturally conservative part of Guam's population.

The climate is tropical, with high humidity and an average annual temperature of 82 degrees Fahrenheit with a range of 74-96 degrees. The early months of the year, the "dry" season, are cooler due to prevailing trade winds from the east and northeast. The late months are dominated by monsoon winds from the south and southwest, bringing in the warmer and wetter "rainy" season. Guam receives 90 inches of rainfall annually, 75% of which occurs during the wet season. Typhoons are a recurrent feature each year. Two super typhoons, Karen in 1962 and Pamela in 1976, destroyed millions of dollars worth of property, but warning systems and island-wide typhoon shelters prevented loss of lives or serious personal injuries.

B. Historical Background of the Territory

The first settlers in the Marianas Islands were the Chamorros, related by linguistic and archaeological evidence to people in the Philippines, Malaysia and Indonesia. Their arrival has been tentatively dated at 1500 to 2000 B.C. It was achieved in outrigger sailing canoes and marked by the importation of a neolithic technology and food plants such as taro, coconut, yam and breadfruit. When first seen by the sea-faring Europeans, the Chamorros were living in villages along the coast, dependent on fishing and farming. With the landing of Magellan in 1521 in the southern village of Umatac, the Spanish period (1521-1898) began. Serious attempts at colonization were made in 1668, which led to open warfare between the native Chamorros and the Spaniards. By the end of the 17th century, the Chamorros had been reduced by war, disease, and famine to some 3,000 survivors, one-tenth their number before European contact. Over the next two centuries there was a progressive hybridization of the Chamorro race and

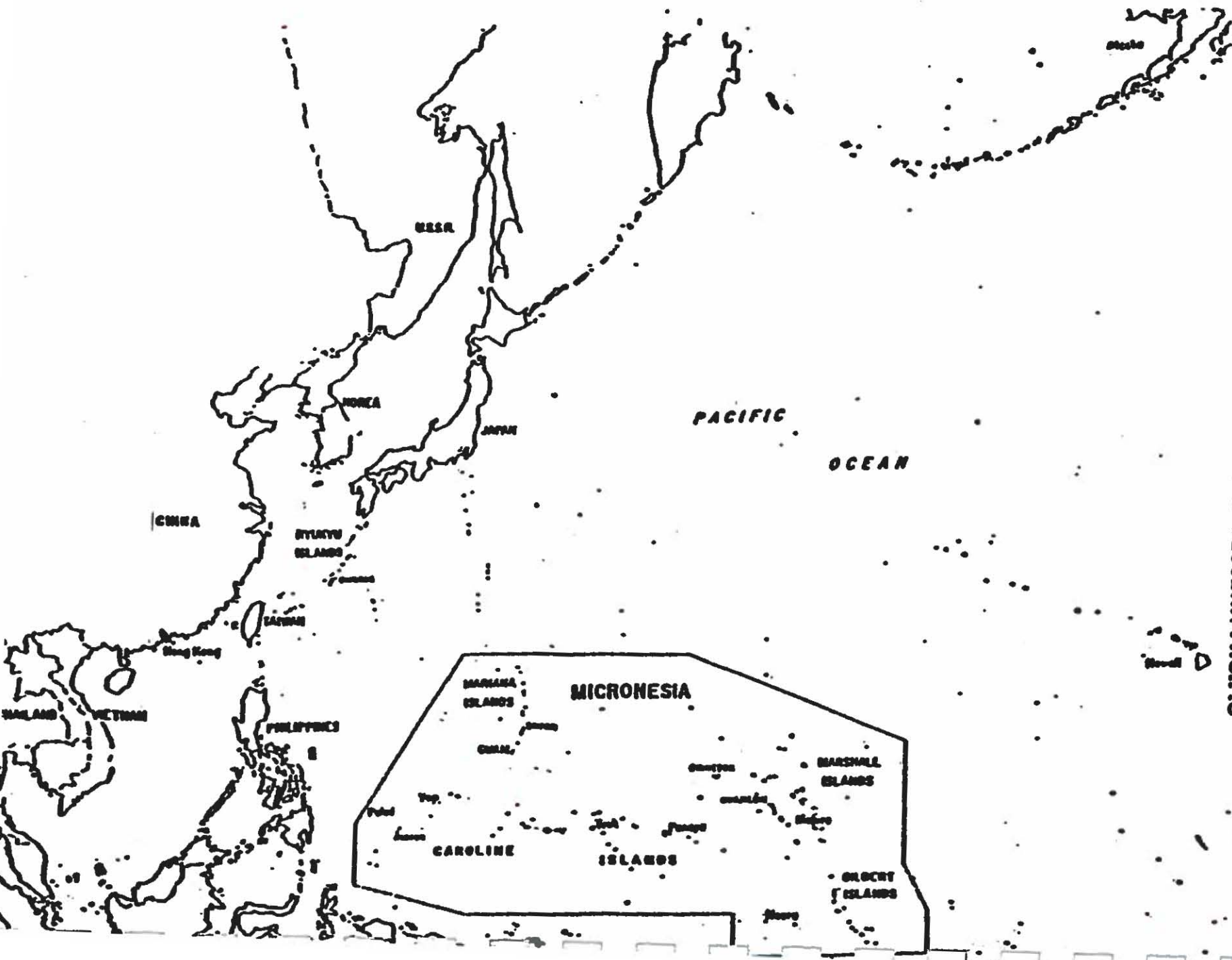
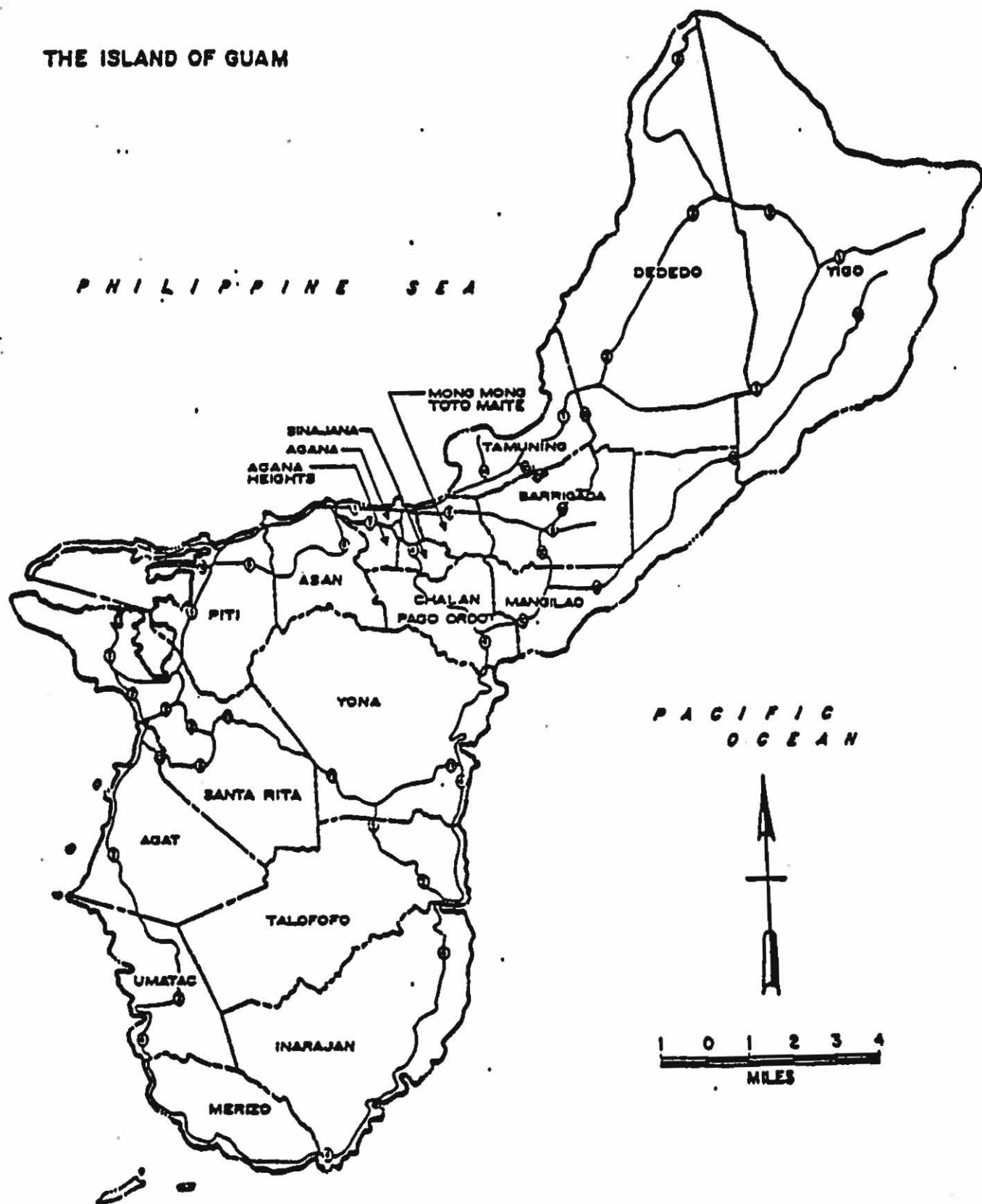


FIGURE 1
GUAM IN THE WESTERN PACIFIC

FIGURE 2

THE ISLAND OF GUAM



VILLAGE BOUNDARIES

culture, as Spanish, Mexican, and Filipino forces acted on the Chamorro's native habitat. The major legacy of the Spanish is the importation of Catholicism to Guam. The precepts of the Church are now integral parts of Guam's culture.

During the Spanish-American War, the U.S. occupied Guam and retained it when the Spanish sued for peace. The U.S. Navy Department was given the responsibility for maintaining Guam as a naval station, a fueling stop for warships travelling between Hawaii and the Philippines. This started the American pre-war period: 1898-1941. At the beginning of that period nearly 10,000 indigenous people lived on Guam: About half of them resided in Agana, the seat of government, and the rest in 14 villages throughout the island.

On December 8, 1941, Japanese aircraft bombed and strafed Guam as a prelude to the Japanese Occupation (1941-1944). The Chamorro way of life was greatly curtailed and many island inhabitants were killed during these years of hardship under Japanese rule. U.S. military forces re-occupied the island in July 1944, in a battle that ended with additional loss of Guamanian lives and property. The U.S. Naval Government was re-established in 1946 and functioned much as it had before the war. The island was rebuilt and the economy expanded with the high demand for goods and services by the civilian and military population.

In 1950 the U.S. Congress passed the Organic Act of Guam, which established Guam as an *Unincorporated Territory* and changed the status of Guamanians from U.S. nationals to citizens of the U.S. Responsibility for the island's administration was shifted from the U.S. Navy to the Department of the Interior. An elected twenty-one man legislature was balanced by a governor appointed by the U.S. President. Congress authorized Guamanians to elect their own governor in 1970, and a non-voting delegate to the U.S. Congress in 1972. Negotiations for a new political status with the U.S. are underway to replace the Organic Act and to put Guam on a new footing. Whether the final outcome will be the desired Commonwealth or another political arrangement, it is expected to be much more satisfactory than the present territorial status with its many limitations.

C. Unique Characteristics of the Territory

The planning for and provision of mental health care services on Guam are affected by several factors not commonly found in communities of comparable size in the contiguous United States. Some of these factors are presented below to provide a better understanding of the problems in the island's mental health care delivery system.

1. While Guam has established modern communication and transportation links, the island is relatively isolated from the U.S. mainland because of the high costs involved in overcoming distance. Mail services are often slow and not always reliable. They affect communication between government agencies and funding sources and cause delays in receiving needed administrative information or announcements of available funds. Often such announcements reach Guam after the submission due date. Some improvements can be expected through FAX communication, but the costs for this, as for long-distance calls, are still prohibitive for most budgets.
2. Isolation causes problems for mental health professionals in two ways: it limits the availability of training programs for new mental health workers and it hampers the continuing education programs necessary for existing workers to keep abreast of the latest professional developments in order to obtain specialty certification (such as geropsychiatric technicians or

alcohol and drug therapists). The island's small population base and its financial inability to support specialized mental health care training programs (beyond the bachelor's level in nursing, social work and psychology) or specialized services components limit the population's access to some much needed treatment which is available only in distant major population centers. An example of this is the complete lack of treatment for autism. For this reason the purchase of specialized mental health care services off-island may not be a reality for Guam's near future.

3. Guam's political status prevents the island from participating fully in some health and social service-related federal programs. Congressional unwillingness to extend the Supplemental Security Income (SSI) program to Guam's citizens and the unique, and arbitrarily set, fixed ceiling on the federal share of Medicaid are examples of the disadvantages of Guam's status. Medicaid and SSI are the principle sources for financing institutional long-term care for the aged and for residential housing for the seriously mentally ill and mentally retarded. In the absence of such funds, members of these vulnerable populations are frequently and inappropriately placed in the Inpatient Unit of the Department of Mental Health and Substance Abuse or the Intermediate Care Facility at Guam Memorial Hospital. Even worse, some of them are left at risk in the community and to their own devices to join the increasing number of homeless people on Guam.

D. Demographic Information

Sound mental health planning must be based on a careful analysis of need, services and resources, and must include a thorough understanding of the population. In fact, meaningful planning for any of the human services is population-based and integrates the demographic characteristics of a community in the planning process.

When discussing Guam's inhabitants, a distinction between total and civilian population must be made. The total population includes a contingent of approximately 25,000 military personnel: active duty Navy, Air Force, and Marine Corps servicemen, dependents, and support personnel. This military population fluctuates with the homeporting and deployment of large Navy ships and variations in specific military activities. Local and temporary alien residents comprise the civilian population.

As the Department of Mental Health and Substance Abuse provides mental health care to both the civilian and the military populations, demographic information is provided for both populations. The latest available statistics are used. However, estimates and projections for 1980 and onward are based on the official 1980 census information. These estimates and projections are only approximate and need to be substantiated by the 1990 Census information.

1. Ethnic Distribution

Over the last 80 years, Guam's population has experienced rapid growth and a considerable shift in ethnic composition. The greatest changes occurred immediately after the last world war when the population more than doubled with a large influx of Caucasian military personnel and Filipino contract workers. (See Table 1 and Figure 3).

2. Population Distribution

Besides the shift in ethnic composition, Guam has also experienced a

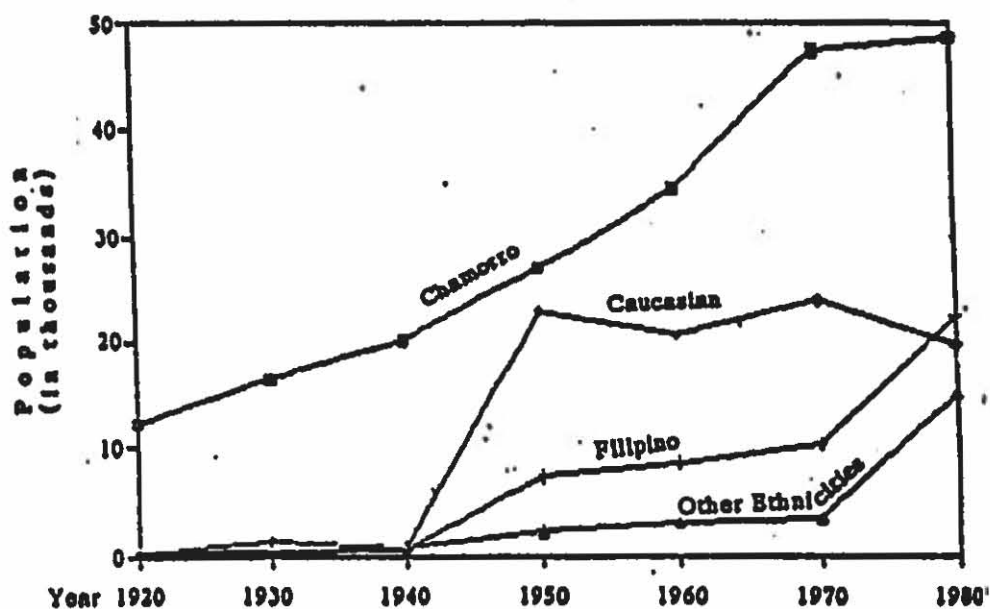
Table 1.
Ethnic Composition of Total Population
Guam: 1920 - 1980

Year	Total Population	Chamorro (And Part Chamorro, 1980)	%	Filipino	%	Caucasian	%	Other	%
1920	13,275	12,216	92.0	396	2.1	280	2.1	383	2.9
1930	18,509	16,402	88.6	365	2.0	1,205	6.5	537	2.9
1940	22,290	20,177	90.5	569	2.6	785	3.5	759	3.4
1950	59,498	27,124	45.6	7,258	12.2	22,920	38.5	2,196	3.7
1960	67,044	34,762	51.8	8,580	12.8	20,724	30.9	2,979	4.4
1970*	84,996	47,472	55.9	10,172	12.0	23,934	28.2	3,418	4.0
1980	105,979	48,675	45.9	22,447	21.18	19,751	18.6	15,106	14.3

*Ethnicity based on country of origin.

Source: Tung (1981) Table 7 Revised.

Figure 3.
POPULATION GROWTH BY ETHNICITY
GUAM: 1920 - 1980



Source: Guam Health Planning and Development Agency.

Table 2.
Total Population by Region
Guam: 1960 - 1985

Region	1960	%		1970	%		1985	%
North	12,808	19.1	59.23	22,322	26.3	70.47	41,578	34.12
North-Central	26,903	40.1		37,571	44.2		49,138	40.33
South-Central	23,461	35.0	40.77	20,864	24.5	29.53	26,288	21.58
South	3,872	5.8		4,239	5.0		4,840	3.97
TOTAL	67,044	100.0		84,996	100.0		121,844	100.00

Source: U.S. Bureau of the Census, General Population Characteristics:
Guam 1960, 1970, and 1980.

Regional Definitions (by village):

North	=	Yigo, Dededo
North-Central	=	Agana, Agana Heights, Chalan Pago-Ordor, Mangilao Mongmong-Toto-Maite, Barrigada, Sinajana, Tamuning
South-Central	=	Agat, Asan, Piti, Santa Rita, Talofofo, Yona
South	=	Inarajan, Merizo, Umatac

Table 3.
Civilian Population by Resident Status
Guam: 1960 - 1984

Year	Local Residents		Stateside Hired*		Temporary Aliens		Total Civilian Population	
	#	%	#	%	#	%	#	%
1980	82,121	93.9	1,300	1.4	4,000	4.6	87,421	100
1981	85,813	96.3	1,362	1.5	1,900	2.2	89,075	100
1982	87,637	96.6	1,154	1.2	1,970	2.2	90,761	100
1983	89,443	96.7	1,106	1.2	1,930	2.1	92,479	100
1984	91,323	96.9	966	1.0	1,940	2.1	94,229	100

*Department of Defense employees and their dependents.

Source: Department of Commerce, Government of Guam;
Commander Naval Force, Marianas Islands.

major change in population distribution. Until the outbreak of World War II, residency of the indigenous population, which subsisted on farming and fishing, was dictated by the topography of the islands, i.e., they lived close to the arable land and the fresh water sources in the central and southern regions as well as in the coastal low lands and accessible shoreline areas. After the war and due to the expansion of Guam's commercial economy, people tended to gravitate toward the north-central and northern areas of the island to be close to the places of employment, education and the amenities of urbanization. This trend was evident in 1985, when 74.5% of the total population resided in the north-central and northern regions of the island as can be seen from the information presented in Table 2.

3. Guam's Transient Population

The nature of Guam's population composition makes it necessary to consider the transient population since a growing tourism industry, a fluctuating temporary alien work force and a large military presence impact the local mental health care system to varying degrees. Guam's service industry has rapidly expanded due to efforts by many in making the island a major tourist destination, particularly for people from Japan, the Pacific Rim countries, the U.S. mainland, and Australia. The number of visitors has more than doubled from 291,133 in 1980 to approximately 600,000 in 1988.

The presence of so many tourists has created new employment opportunities, bringing immigrants from other island nations (e.g., the Federated States of Micronesia [FSM] and the Commonwealth of the Northern Mariana Islands [CNMI]) to Guam in the hope of making a new and more prosperous life for themselves. However, the expectations and hopes often remain unfulfilled, leading to stress and frustration.

Guam has a fluctuating number of temporary alien workers subsidized by the island's construction industry. There were several thousand such workers in the community in 1988. Mental health concerns of this particular population include the abuse of alcohol and other drugs and mental illness caused by the stress of separation from family and friends, while trying to adjust to an "alien community". (See Table 3).

The military population ranged from 20,266 in 1980 to 23,600 in 1985, an increase of 16.5% over 1980. These numbers are expected to increase considerably, as can be seen in Table 4. This large military contingent impacts on Guam's mental health care system because DMHSA is the only provider on island capable of rendering psychiatric care to military personnel and their dependents.

4. Civilian Population Growth

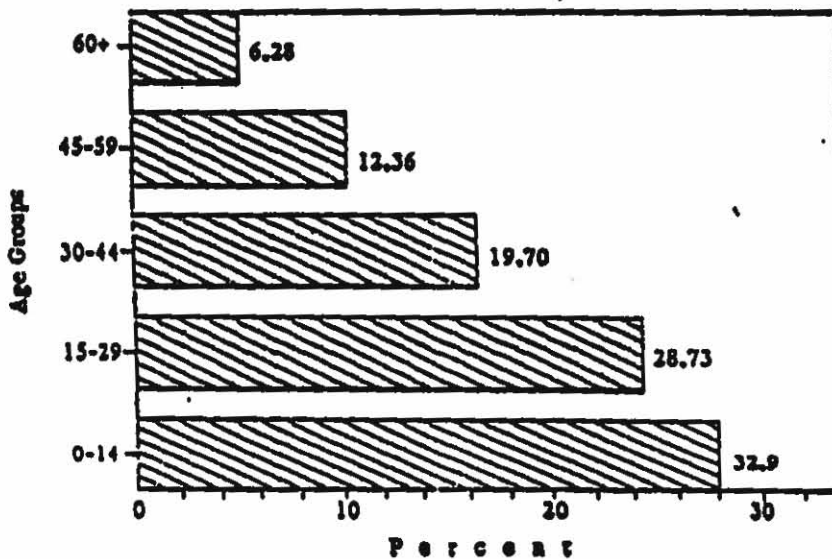
Even though DMHSA serves the total island population, the civilian population must be the determining factor in planning efforts for community-based services, particularly for seriously mentally ill children, adolescents and adults. Population growth and age distribution are especially important. Between the years 1970-1980, Guam's civilian population increased from 64,680 to 87,421 at an annual rate of 3.01 per cent. This significant growth is attributed to natural increase and immigration. As can be seen in Table 5, though, there was a decline in the annual rate for the years 1980-1985, down to 1.87 percentage points. An annual growth rate of 2.14 per cent had originally been projected for the years 1985-1990, but now this figure is expected to be considerably higher due to the economic boom currently experienced on island and the free entrance to Guam allowed by the Compacts of Self-Determination for selected Micronesian island nationals who come here for educational and financial opportunities.

Table 4.
Projection for Total, Civilian,
and Military Populations
Guam: 1980 - 1990

Year	Total Population	Civilian Population		Military Population	
		#	%	#	%
1980	105,979	87,421	82.5	18,558	17.5
1981	109,581	89,075	81.3	20,506	18.7
1982	108,874	90,761	83.4	18,113	16.6
1983	112,285	92,479	82.4	19,806	17.6
1984	118,344	94,229	79.6	25,115	20.4
1985	121,844	96,011	78.8	25,833	21.2
1986	123,794	98,089	79.2	25,705	20.8
1987	126,547	100,212	79.2	26,335	20.8
1988	129,362	102,381	79.2	26,981	20.8
1989	132,240	104,597	79.1	27,643	20.9
1990	138,606	106,858	77.1	31,748	22.9

Source: Guam Health Planning and Development Agency.

Figure 4.
CIVILIAN POPULATION BY AGE
GUAM: 1985



Source: Guam Health Planning and Development Agency.

Table 5.
Projected Increase of Civilian
Senior Population 55 Years and Older
Guam: 1985 - 2000

Year	Total Senior Population 55+	Increase In Senior Population From 1985	Increase As Percent of 1985 Seniors
1985	9,677	2,546	26.08
1990	12,223	3,897	40.27
1995	13,574	5,102	52.73
2000	14,779		

Source: Guam Health Planning and Development Agency.

5. Age Distribution

Figure 4 shows that Guam has a very young population; the median age calculated from the 1980 Census for the total population was 22.2 years. In 1985, more than half, 53.5 per cent, of all civilian inhabitants were under the age of 25, and one-third, 32.8 per cent, were children below age 15. Since birth rates have declined over the last decade (from 34.8/1,000 in 1974 to 24.6/1,000 in 1984), the proportion of the population aged 20 and below is likely to decline in the future. However, over the next few decades there will still be a considerable demand for mental health services for children, adolescents and young adults.

The demand for senior mental health services will steadily increase in the near future. Whereas in 1980 only 2,983, or 3.4 per cent, of Guam's civilian population was aged 65 or older, the proportion of elderly increased to 3.6 per cent, or 3,423, in 1985. These figures are expected to rise further to 5,219, or 4.9 per cent, in 1990. The sharp increase in actual numbers (rather than percentages) of elderly makes it necessary to investigate the available health and support services for them. In addition to the physical and mental infirmities attributed to old age, Guam's inhabitants have a higher incidence and prevalence rate than the national average of neurological diseases, often manifested as dementia, necessitating care from mental health professionals.

E. Changes in Culture, Traditions and Values

The people of Guam have witnessed significant changes in their culture and traditions over the last few centuries. However, this was a gradual process and cannot be compared with their "Americanization," which took place at break-neck pace during the last 45 years. The Chamorro way of life was propelled from an agrarian, extended-family system to a job and possession-oriented society of individualistic values. Agriculture declined to the point that the island now imports nearly all of its food and other goods at exorbitant prices.

This transition to modern society, which took Western Civilization hundreds of years, was accomplished within a 45 year period during which Guam also experienced two major demographic changes: an extraordinary jump in Guam's civilian population and a relative decrease in the Chamorro population. While Chamorros continue to be the largest ethnic group, immigration has greatly increased Guam's cultural heterogeneity and, with this, social tension. In view of the population shifts, Chamorros have reason to fear that they might become a minority in their own land, as has been experienced by the Hawaiians. Added to this is the uncertain political status of Guam. The transition period is not yet over. The patient acceptance of U.S. influence, which has often involved major policies made by people in Washington with no awareness by Guam and its people, is coming to an end. While the people of Guam are acutely aware of the economic implications of independence from the U.S. political sphere, sentiments are high for considering alternatives to American domination if an equal political status, first class citizenship and respect cannot be gained. The pride and basic unity of the Chamorro people are still strong and are expected to remain as the dominating values.

This underlying pride and political tension, combined with the stresses of cultural transition, have a significant impact on Guam's mental health status. Problems such as high rates of alcohol and other drug use, a large number of violent crimes, homicide and suicide, might be at least partially explained by these factors. While closely correlated to incidence and prevalence of mental health problems, social stress is and will be high on Guam in the foreseeable future.

Chapter 3

Guam's Mental Health System

CHAPTER III

GUAM'S MENTAL HEALTH SYSTEM

A. "Mental Health"

There is neither a precise nor a scientific definition of mental health and the exact incidence of mental illness is unknown. Consequently, mental health is considered to exist when no mental illness is diagnosed.

Traditionally, a diagnosis of mental illness followed the medical model and was classified into organic and functional disorders. At present, this no longer holds true. Most organic dysfunctions are now more appropriately called mental retardation, an area of specialization apart from the mental health system. Other organic disorders due to physical, chemical or biological causes are more often treated within the traditional medical care systems. The broad class of functional disorders indicative of mental illness includes psychosis, character and personality disorders, psychosomatic illness and trait and behavior disorders.

Mental health has been described as the ability to resist stress, to be autonomous (i.e., to make independent decisions), and to adapt satisfactorily to changing life circumstances. Specialists in the field of mental health suggest that indicators of positive mental health should be sought in the attitudes of an individual towards himself. Mental health professionals see the essence of mental health as an on-going process variously called self-actualization, self-realization, growth, or becoming self-sufficient. Mastery of the environment is considered yet another criterion of mental health. Such mastery includes efficiency in meeting situational requirements and problem-solving, adequacy in inter-personal relationships, and the capacity for adaptation and adjustment.

Mental illness is seen as having complex causes. Biological causes, chemical imbalances, life stresses, the quality of the total environment and the interaction of family and community are equally important in understanding and treating mental illness. The increasing evidence correlating socio-economic status to the incidence and type of mental illness must also be taken into consideration.

Rapid changes in a society, as experienced on Guam, create stresses in both individuals and the community for which neither are prepared. It is important to recognize that a community's mental health is predicated on the quality of community life and the interaction of people and social institutions.

If a community appears disharmonious, violent, and non-supportive, people often adopt deviant means to survive in it. Guam's growing incidence of alcohol and other drug abuse, violent crimes against persons, homicide and suicide, child abuse and neglect, as well as the increasing number of homeless people, must be seen both as manifestations of individual and societal dysfunction and as extreme means of coping with the frustrations produced by this dysfunction.

Despite the differences in their nature, the problems discussed above have many common elements. They represent extreme means of coping with situations over which a person has lost normal control and are reflective of impaired mental health of the individual and the community. It must therefore be recognized that mental health services have to be geared to the individual and to the community. Promoting independence in individuals, increasing their ability to cope, and enabling them to realize their goals are means of improving and strengthening a community's mental health. This, however, can only be

accomplished through a supportive, emotional, social, and economic climate within the community which provides the framework for a comprehensive system of mental health care.

B. Mental Health Services

A community's mental health services system should encompass a continuum from the most restrictive (inpatient) setting to independent living, with therapy and all necessary support services available to those in need. The necessary manpower includes psychiatrists, psychologists, nurses, social workers, psychiatric aides and community workers.

Guam has a paucity of mental health care providers. Only in the past two years has there been a privately practicing psychiatrist on island. There are three psychologists in private practice, but not all of them hold degrees in clinical psychology. In addition, professionals trained in the various fields of psychology or social work also provide therapy and counseling to Guam's population. While most mental health needs of the active duty military personnel are met through the military's medical care system (at the Navy Regional Medical Center or the Anderson Air Force Base Family Clinic), the military, including the local U.S. Veteran's Affairs Administration, contracts with the local providers through the CHAMPUS reimbursement plan and also refers dependents to the Department of Mental Health and Substance Abuse for psychiatric evaluation and treatment.

The Department of Mental Health and Substance Abuse (DMHSA) is the sole public agency available and authorized to provide inpatient and outpatient mental health services to the people of the Territory of Guam. The Department was created by Public Law 17-21 in October 1983 through a merger of the former Mental Health and Substance Abuse Agency and the Community Mental Health Center. DMHSA was charged with the following mission:

"To provide comprehensive inpatient and community-based outpatient mental health, alcohol and drug programs and services for the people of Guam, and to continually strive to improve, enhance, and to promote the physical and mental well-being of the people of Guam who experience the life-disrupting effects of mental illness, alcoholism, and drug abuse, as well as those who are at risk of suffering those effects and need such assistance; and to provide such assistance in an efficient, effective manner in order to minimize community disruption and strengthen the quality of personal, family and community life."

The same Public Law gives also a definition by which:

"Mental Illness means those diseases and conditions which the manifestation of which seem mostly to affect a person's behavior, feelings, thinking and perception and view of the world around him to the extent that his mental health is substantially impaired, including the mentally retarded."

Section 85105A of Public Law 17-21 established the powers vested in DMHSA as well as the duties to be performed:

1. The Department, adhering to federal regulations, local physical needs, feasibility and appropriateness, shall provide mental health, alcohol and drug abuse treatment services. Such services shall include:
 - a. 24 hour crisis intervention services to include as needed a mobile crisis team and hotline;
 - b. Partial hospitalization and aftercare services to include transitional homes for the mentally ill;

- c. Outpatient services to include as needed team services for children, elderly, and adults;
 - d. Individual, group and family counseling services;
 - e. Inpatient services to include but not limited to acute psychiatric and alcohol and drug detoxification services. The Department may contract in writing for the provision of inpatient services with any qualified providers. The Department shall be responsible for insuring that the medical care standards and quality controls for inpatient services provided above are met.
2. The Department shall provide mental health, alcohol and drug abuse prevention programs and services...."

In 1985, DMHSA adopted the following philosophy:

"The Department's philosophy is to provide the means to effect positive change for the individual, the family, and the community. This philosophy recognizes that in the continuum of health, optimum "wellness" is achieved by enhancing one's psycho-socio-economic and physical state of being."

The above mission statement, definition of mental illness, delineation of powers and duties, and philosophy are the principal tenets under which DMHSA fulfills its mandate to the people of Guam. These tenets were also used as guidelines for the planning process to ensure that the definitions for the three priority population groups and planned new programs and services would not be in conflict with the local enabling law and DMHSA's philosophy and mission.

C. Facility, Programs and Services

DMHSA is a Government of Guam line agency, administered by an appointed Director and Deputy Director, with the assistance of an appointed Advisory Council. The department is located in the old Guam Memorial Hospital in Tamuning. It occupies the F-Wing and F-Wing Annex, where the inpatient ward is located. In general, the facility is dilapidated, and there are continuous problems with the electrical and water systems. Fortunately a new facility, expected to be completed during the summer of 1993, will resolve these problems.

DMHSA underwent a reorganization, as mentioned in the 1989 plan, to make its services and programs more efficient and effective. The various service divisions are discussed as follows:

1. Division of Medical Services

a. Inpatient Services

This division is charged with providing inpatient medical and psychiatric services to both children and adults suffering from acute psychiatric disorders and distress that require hospitalization. Since DMHSA is Guam's only mental health facility, public or private, the 17 beds of the Inpatient Unit are utilized for a patient mix of acute and chronically mentally ill, voluntary and adjudicated admissions, alcohol and drug-related patients and court-ordered cases for psychiatric evaluation and treatment. The inappropriateness of this situation has been recognized by Guam's decision makers, and renovation of the existing facility and the completion of the new facility will resolve this problem.

Programs at the inpatient unit include, but are not limited to: milieu

therapy, individual, family, and group psycho-therapy, chemotherapy, participation in occupational and spiritual activities, and coordination with the newly established Case Management Services for follow-up upon discharge where social services referrals are indicated.

b. Medication Clinic

Psychotropic medication prescriptions are individualized to each client's need and are continuously evaluated under the direction of the medical director, staff psychiatrists and a psychiatric nurse.

c. Emergency Services and Consultation Liaison

DMHSA is mandated to provide 24-hour emergency care, including weekends and holidays. Clinical staff (psychiatrists, psychologist and a psychiatric nurse) are available on the premises or are on call at all times for DMHSA and the Guam Memorial Hospital Emergency Room. Services consist of immediate screening, assessment and intervention or treatment for persons who either call or walk in to the department or are referred from GMH or other sources.

Two psychiatrists, one psychologist, one psychiatric nurse specialist and psychiatric social workers provide consultation, as requested by a physician, at the emergency room and the various wards of the Guam Memorial Hospital. In addition, the psychiatric medical and other staff function as consultants to Guam's Judicial System (Criminal and Family Court, Juvenile Hall and Department of Correction), the Department of Education and its Division of Special Education, the military system, and private health and mental health care providers.

2. Division of Clinical Services:

a. Intake

Intake activities consist of screening, assessment, and evaluation in crisis situations (call-ins, walk-ins or admittance to the GMH ER) or by appointment and referral to appropriate treatment.

b. Counseling Services

These services provide therapeutic and supportive counseling to individuals, families and groups.

c. Drug & Alcohol Services

Individuals experiencing problems with alcohol and/or other drug abuse are provided services such as screening and assessment; alcohol detoxification on a limited out-patient basis; supportive chemotherapy; individual, family and couple therapy and counseling; alcohol and drug education; alcohol rehabilitation, and referral to Alcohol Anonymous, Narcotics Anonymous, etc.

d. Case Management Services

Included in these services are client identification and outreach; assessment and service planning; linkage and/or consultation with requisite services; monitoring of service delivery; and client advocacy. Individual workers or teams in this service maintain a long-term supportive relationship with a client which is continuous through all levels of care.

e. Prevention and Training

Prevention activities are targeted to specific audiences as well as the community-at-large. They are focused on activities which empower individuals or build their self-esteem, thereby minimizing the likelihood that the development of problems related to dysfunctional life situations or substance abuse will develop.

DMHSA staff are given training and continuing education opportunities on a regular basis. Experts in the various disciplines of mental health and substance abuse from the local system or from off-island institutions are requested to present workshops and seminars, often in conjunction with personnel from the education, health and social welfare systems.

Training by DMHSA staff is provided to community groups, staff of the Department of Education, the Department of Youth Affairs' Juvenile Hall, and to civic and other organizations upon request.

f. Residential and Day Treatment

At present, DMHSA operates limited residential treatment programs for children and adolescents - Guma Man Hoben I & II. This is a transitional residential program designed to serve clients from the ages of 9 to 17 who are seriously emotionally disturbed or mentally ill. A continuum of services is offered under this program, including therapy, the fostering of psycho-social skills, education, and recreational and spiritual opportunities. Length of stay at Guma Man Hoben cannot exceed 24 months.

Day treatment provides structured therapeutic activities for mentally ill adults three days (MWF) per week. These activities include, but are not limited to, social rehabilitation, life-skills training, educational development, prevocational training, referral for job placement, and recreational opportunities. The remaining days (TTH) are used to provide more individual services to patients and their families, such as medical, psychological and social evaluation, psychotherapy, chemotherapy, and, if necessary, crisis intervention.

An adult residential treatment facility opened in March 22, 1990, known as Guma IFIL (Institute for Independent Living) for adults with a serious mental illness.

3. Division of Support Services

This division operates the following units:

Research, Planning and Development
Personnel, Central Files and Medical Records
Financial Management, and
Facility Operations

The above listed services and programs will be described in greater detail in the chapters focused on the priority populations.

D. System Concerns and Problems

1. Facility and Housing Needs

The most pressing problem of the past several years has been the lack of an appropriate mental health facility. Unlike most communities on the mainland, Guam has never had a mental health facility built specifically for the population

in need. Since 1970, when mental health services were formalized on Guam, mental health treatment has been delivered from three separate locations in the old Guam Memorial Hospital - areas that were abandoned by the hospital due to structural inadequacies of the building. This has hampered the delivery of services and contributed to the negative image of DMHSA and the delivery of mental health services.

The existing building of DMHSA and its inpatient unit is sub-standard. Fortunately the new facility will again resolve this problem.

The facility will include inpatient facilities for children, adults, and an alcohol rehabilitation treatment unit (12 beds, expandable to 16). In addition, there will be office spaces for case management, day treatment, counseling, prevention, medical clinic, psychiatric services and administrative.

Besides the new mental health and substance abuse facility, Guam also needs residential treatment facilities. Unlike the mainland, Guam is not faced with the problem of reducing inpatient days and moving mentally ill patients from institutions back into communities. Rather, the emphasis here is to find appropriate housing for all levels of care.

Guam is experiencing an economic "boom" period, which has brought many new residents to the island. Housing is becoming scarce and real estate values are skyrocketing. It becomes more and more difficult for people with low or even median incomes to secure rental housing. For the mentally ill populations, it is almost impossible. There is low-cost and Section 8 housing, under the HUD program, administered by the Guam Housing and Urban Renewal Agency (GHURA), but the waiting lists are long, and mentally ill persons get no preferential treatment. This situation has led to homelessness and inappropriate inpatient admissions.

In November 1989, DMHSA negotiated with DOA for a block of apartments adjacent to DMHSA to establish an Adult Residential Program. This program was implemented as Guma IFIL in March 22, 1990. It is more fully described in the following chapters, as is the need for open and closed group homes.

2. Manpower Needs and Problems

DMHSA has experienced a chronic manpower shortage at all levels since its inception. For many years there was no psychiatrist practicing on island even though Guam had been designated a psychiatric manpower shortage area and was eligible for assistance from the National Health Service Corps in bringing psychiatrists to Guam. At present there are four psychiatrists employed by the Department, two of them added during fiscal year 1990.

In addition there is a need for:

- * Clinical social workers,
- * Psychiatric nurses, certified,
- * Psychiatric technicians,
- * Substance abuse counselors, certified,
- * Occupational therapists specializing in working with the mentally ill,
- * Psychiatric vocational rehabilitation counselors,
- * Community aides, and
- * Administrative and management personnel for diverse functions.

Guam has a limited pool of trained personnel in all categories in the health and social services. As one service provider so aptly put it: "we steal from one another." There is continuous off-island recruitment for mental health professionals, but Guam's salaries are not competitive, and the island's government does not allow for sufficient relocation expenses. This results in

the retention of inadequately trained and sometimes incompetent personnel in the mental health care system.

Local practitioners must go off-island for graduate training. The drawback is that Guam may lose someone permanently because working conditions and earning potentials for professionals with graduate degrees are better off-island than on Guam.

After careful deliberation, several recommendations were made during the planning process. A priority for DMHSA is the preparation of a comprehensive Human Resources Plan (HRP) which will identify staffing and training needs for at least five years in the future, taking into account the additional inpatient beds in the new facility and the requirements of the proposed residential treatment facilities. A survey of present DMHSA staff is underway to identify training needs and preferences.

DMHSA has established on-going dialogue with the University of Guam, which offers B.A. degree programs in social work, nursing, psychology and sociology, and can consequently be considered as the major training institution contributing to the pool of mental health manpower. However, enrollment in these categories is not high enough as it should be to fill the island's need. This might be due to the fact that social work and nursing are not seen as "high status" occupations. A vigorous campaign to enhance the image of these professions is needed. Special scholarships need to be established as an incentive for these professions.

Through its Professional/Technical Awards program, UOG supports off-island graduate education in fields not taught on Guam. Students under this program agree to return and work on Guam for a set period of time. An alternative is currently implemented by the university: the bringing in of graduate programs in nursing and social work for the summer months. Several mainland universities have shown great interest in this proposal. This would allow local practitioners to continue working during most of the year, and would also prevent the long separation from families, which is inevitable when pursuing a graduate degree off-island.

DMHSA has recently written a grant proposal in conjunction with UOG to train pre-professional workers, such as community aides and psychiatric technicians, in the mental health field. This training activity will also function as a "ladder" program in which suitable candidates for the nursing and social work program will be identified and prepared for admission.

UOG and DMHSA provide for training and continuing education opportunities in which off-island experts in various field are invited to Guam to present intensive short-term lectures and seminars for professionals at all levels.

3. The Financing of Mental Health Care

Regarding finances, DMHSA is unique and not comparable to mental health systems on the U.S. mainland. While mainland mental health services are financed by a multiplicity of funding and payment mechanisms, DMHSA relies solely on local and federal funding. DMHSA receives neither Medicaid nor Medicare for treatment services, nor do patients receive SSI payments. There are no mechanisms in place at this time for self-payment by patients, reimbursement from HMO's, private insurance, or the military and Veteran's Affairs Administration.

Various causal factors for this predicament can be identified. A major one is 10 GCA (Government Code Annotated) Section 82408, the former Guam Public Law 7-101, Government Code Section 49225, which obligates the Government of Guam to pay for all expenses incurred for medical or hospital care of the mentally ill and for the transportation of mentally ill persons to hospitals off-island. In 1977, the Guam Legislature completely changed the statute governing the

administration of Guam Memorial Hospital and included a section allowing GMH to charge fees for services to the mentally ill: 10 GCA Section 80104(b) (former Public Law 14-29, Government Code Section 49003 (b)). Despite this apparent shift in priorities, the Legislature made no changes in the requirements of former Government Code Section 49225 (10 GCA Section 82408).

The situation changed yet again by virtue of the mandate in 10 GCA Section 86105 (Government Code 85105) that DMHSA establish a fee schedule based on a client's ability to pay. Because 10 GCA Section 82408 has never been repealed, an anomaly exists and there is still a general assumption that mental health services are "free". The 10 GCA Section 82408 obligation that Government of Guam provide cost-free care for the mentally ill is the reason that major island health insurers provide no coverage for mental illness inpatient care and only for a limited number of outpatient care sessions.

The lack of a fee schedule has also prevented reimbursement through CHAMPUS, the V.A. Administration, and Medicare. And as Guam receives only limited Medicaid funds, which are grossly insufficient for regular medical care, the care for mental illness remains a local responsibility.

The implementation of a fee schedule is seen as an administrative priority for the coming year. This will allow negotiations with the third party insurers on island to include full coverage for mental illness, as well as with CHAMPUS and the V.A. Administration, and will bring much-needed revenues to the Department. In the meantime, proposed local funding for FY 1992 and existing FY 1991 federal monies for mental health and drug and alcohol treatment and services are derived from the following sources:

Proposed:

Local General Funding (FY '92)	\$ 3,103,426.00
Therapeutic Foster Home (FY '92)	\$ 304,857.00
Adult Resid. Treatment Facility (FY '92)	\$ 233,848.00
Guma Manhoben II (FY '92)	\$ 398,941.00
D&A Resid. Treatment Facility (FY '92)	\$ 347,572.00
PATH Grant (FY '92)	\$ 50,000.00

Existing:

Federal Block Grant (FY '91)	\$ 647,000.00
NIMH Planning Grant (P.L. 99-660)	\$ 5,610.45
Training Grant (FY '90)	\$ 63,272.00
Homeless Grant (FY '91)	\$ 50,000.00

4. Management Information System

The lack of a fully functioning Management Information System has impacted the operations of DMHSA at various levels. The implementation of the fee schedule is contingent on an MIS and as is the accountability of services rendered to patients. Most particularly, planning activities rely on information generated by the MIS. The absence of such information was keenly felt during the planning process.

The need for a fully automated and integrated MIS has been recognized for the past decade, and feasibility studies have been performed by several task forces under various past directors of DMHSA. Inadequate financial support, limited time, and the absence of qualified staff have prevented the MIS from becoming a reality. However, a Mental Health Administrator has been hired in 1991 to lead the department's efforts in standardizing the data collection through state-of-the-art computer machinery.

This management information system will eventually establish a data base containing basic demographic information about Guam's population; the structure and organization of DMHSA and all mental-health related services and programs

in the community; administration and management information; fiscal information; and information about available human resources in the mental health system on Guam. Daily, weekly, and monthly data input will keep the data base up-to-date. This system will not only allow data processing and communication, but will count and measure program activities; identify variances from one month to another; produce relevant reports; project the need for services, manpower and facilities; and support planning, implementation and evaluation activities.

An important aspect of planning for the mental health of a population is the conduct of needs assessments, which are concerned with the needs of population groups, regardless of whether or not they present themselves for mental health services. Needs assessments are usually performed for a geographically defined population, and involves the identification of the population's needs for services that treat existing disorders and/or prevent the development of disorders. They also involve gauging the magnitude of the identified needs since, in an environment of insufficient resources for services, needs have to be prioritized and addressed in the order of their importance. There are four major approaches to needs assessments: epidemiological surveys, inference based on utilization data, key informant surveys, and social area analysis. All of these approaches rely on data from the MIS.

Epidemiological surveys employ standardized procedures for identifying the true prevalence of the disorder (mental illness) under study. They need to be conducted on a large scale and cover a significant number of residents to allow statistical inferences from the surveyed sample to the total population. Such surveys are extensive, and therefore, expensive projects, and need expert manpower for data gathering and analysis.

Rates of utilization provide a good indicator of the need for services and expected demand on the service system. The great advantage of this method of needs assessments is that the necessary data is available from existing, on-going data systems and does not involve special data gathering efforts or techniques.

Key informant surveys elicit information on perceived prevalence, need for and prioritization of services from key community residents, health and social services providers, police and judicial systems, school personnel, and on Guam, the natural providers (parish priests, mayors). In addition, informants are asked to identify and explain barriers to services. One such survey was conducted by the Guam Mental Health Planning Council's Committee for Seriously Mentally Ill Adult Population and funded by the Mental Health Planning Grant.

Social area analysis as a method of needs assessments is the most indirect and most inferential approach. Social indicators, such as unemployment, poverty, divorce rates, crimes rates, etc. are used to describe communities in terms of their social area characteristics, particularly those known or thought to be associated with the need for mental health services. An advantage of this approach is that it utilizes existing data and provides the means to infer service needs within a defined geographic area.

For this initial planning process, only one method was available to the planning council: the rates of utilization. Even so, data had to be hand gathered and summarized for presentation in the plan. This will change once the MIS is on line. Within a relatively short period of time, utilization data will be computerized and summarized on a monthly basis to establish information such as admission by diagnosis, average length of stay, cost per service, etc., which is considered basic to management and planning in any institution. Additionally, a key informant survey as well as a social area analysis during the coming years can provide more accurate assessment of need for updating the Mental Health Plan.

In addition to generating the necessary data for management and planning, the MIS will enable DMHSA to monitor its own activities on a continuous basis and will

improve the Department's efficiency and effectiveness. Once staff is familiar with the system and a sufficient data base has been established, research and evaluation activities should examine the nature of mental health problems in the community and the appropriateness, quality and effectiveness of the services provided.

5. Quality Assurance

Quality assurance activities in a health or mental health care institution ensure that services are delivered in an appropriate facility of high quality and administered by qualified staff in a cost effective manner. DMHSA is well aware of the importance of quality assurance in the delivery of care, thus filling the position of a Quality Assurance coordinator during fiscal year 1990.

6. Accountability

Accountability for the appropriateness and effectiveness of services is closely tied to having a functional management information system and quality assurance procedures in place. One important aspect of accountability, as delineated by NIMH, is the outcome evaluation of treatment, e.g., what is actually happening to the client in terms of symptom control, improved functioning, job placement, etc. This information will be gathered by the new case management section of DMHSA. A procedure by which consumers and their families become co-evaluators of treatment and outcome had been a priority for Year 1 for the Planning Council and case management staff. Unfortunately it was not accomplished. Attempts are being made to revive the Guam Alliance for the Mentally Ill (GAMI), an advocacy group.

7. Inter-Agency Coordination

A major complaint during the planning stages was the perceived lack of inter-agency coordination between the various departments and agencies which provide needed services to a mental health patient. Upon closer examination it was found that there is considerable cooperation at the service level, or many patients would be in worse shape than they are now. Informal linkages exist throughout the system; what are needed are inter-agency agreements, signed at the top level of administration, which legitimize the long-standing informal relationships of the direct service providers. One such agreement was currently negotiated between the Department of Education (Division of Special Education) and DMHSA in which services are purchased by DOE from DMHSA for evaluation of possible suicide risks and emotional disturbance in children and adolescents. Other agreements will be sought during the coming year.

It should not be inferred that the lack of coordination is caused solely by indifference of the various department and agency heads; rather it can be seen as an outgrowth of the welter of confusing legislation which assigns full or partial responsibility for mentally ill, emotionally disturbed, and retarded children and adults to various agencies. For instance, the Department of Youth Affairs' mandate is "to plan, coordinate, and/or implement services and activities geared toward youth development, rehabilitation, and involvement in the community" for all young people on island up to the age of 25. The Department of Education, Division of Special Education, is charged with providing services to all handicapped children, including those with emotional disturbances. The Department of Vocational Rehabilitation is charged with providing services to disabled adults, including the mentally ill. DMHSA is charged with providing mental health and related services to children and adults in need, including the mentally retarded.

The Planning Council and DMHSA staff agreed that all efforts must be made to fix the locus of responsibility for the care of the mentally ill and emotionally disturbed children and adults with one agency only. This will involve considerable work with the legislature during the initial process, but in the

long run will benefit the consumer and the care system by providing easier access to services in the community.

8. Privatization of Services

As stated in P.L. 17-21, DMHSA's enabling law, it is the public policy of the Government of Guam to encourage the development of privately funded community-based programs for mental health, and drug and alcohol abuse. GMHPC members and consumer participants of the various workshops agree with these sentiments. The success of Catholic Social Services, which provides a variety of social services including shelter to needy individuals, and Guma' Mami, which operates a group home for retarded individuals, fosters such thinking. DMHSA administrative staff voiced their concern about the qualification of the private contractors, as specialized manpower is needed to provide direct care to mentally ill persons, and such manpower is scarce on island. Additionally, DMHSA lacks at this time the manpower to successfully monitor privately delivered services. Nevertheless, DMHSA will support privatization of mental health services if the quality of care can be ensured.

E. System Goals and Objectives

Council members refrained from setting firm goals and objectives for the mental health system as much of the coming years' activities depend on the availability of appropriate manpower. Guam's legislature funded 16 additional positions for DMHSA for FY 1989-90 and experienced and enthusiastic individuals were found to fill many of these clinical and administrative positions.

Many goals of the first submittal were accomplished: Guma IFIL, 24-Hour Crisis Hotline, Inpatient Hospital Facilities, Guma Manhoben II, Guma San Francisco, Mary Clare Home, and New Beginnings were all goals of the various sections of the plan. The new facility, therapeutic foster homes and a children's residential treatment center are seeing progress towards completion. Less tangible goals regarding employment, education, self-esteem, reduction of suicide attempts, prevention of inappropriate inpatient admissions, expansion of the mental health workforce, increased family involvement, and increased access to services are being implemented. Manpower will remain a problem but the inclusion of a Masters Degree in Nursing Program at the University of Guam will help alleviate the problem. Additionally, the University of Guam will initiate programs aimed at the recruitment and retention of nurses and social workers, and Guam's Legislators will be asked to pass a bill for special scholarships in these two categories.

The first plan's statement "DMHSA's fee schedule will be approved in the first quarter of this Fiscal Year (1989), and billing for fees will start in early 1990" was unfortunately not implemented. If implemented, this will allow negotiations with the major third-party insurers to include the care for mental illness in their coverage package. Billing activities will be tied to a fully functioning Management Information System. By the end of the fiscal year, all DMHSA key employees and supervisors will be familiar with the new IBM computers, and forms for inputting of basic mental health care data will have been developed for simple summarization. Both quality assurance and accountability are dependent on other factors, such as the new facility, available manpower and the MIS. However, policies, procedures, routines and protocols will be implemented during the next year as a foundation for the actual programs.

Inter-agency coordination will become a reality for the coming year. This task will be relatively easy, because administrative staff from the various generic support services and from the Departments of Education and Vocational Rehabilitation have participated in the planning process and promised to cooperate. Council members would like to see this plan in action and have committed themselves to the necessary activities. An additional task, also

undertaken by council members, will be the drafting of legislation which will fix the locus of responsibility for children and adults with severe emotional disturbance and adults with severe mental illness to facilitate better services delivery to these populations.

DMHSA will invite private individuals or agencies to manage the various planned residential facilities, but only if such persons and agencies are qualified and licensed providers and amenable to close monitoring of the delivered services by DMHSA staff.

Council members are pleased that several of the above goals were accomplished during fiscal years 1990 and 1991. Planning for the improvement of mental health care continues with regular meetings and with the various committees supporting and supervising scheduled activities.

Chapter 4

Seriously Mentally III Adults

CHAPTER IV

SERIOUSLY MENTALLY ILL ADULTS

A. Seriously Mentally Ill Adults

Persons in need of sustained psychiatric treatment and a variety of community support services have been given many labels including "the chronically mentally ill," "the severely mentally ill," "chronic mental patients." Most of these labels denote a sense of "hopelessness and inevitable deterioration" (Goldman & Manderscheid, 1987). These labels also tend to conceal the diversity of this population by classifying a variety of individuals under a single label (Department of Health & Human Services, 1981).

Regardless of the label, severe or chronic mental illness has its onset in childhood or adolescence and is often lifelong in duration. It is an illness characterized by exacerbations and remissions; e.g., there are periods when the illness worsens, and when it is quiescent. During a flare-up, the psychotic phase of the illness, the patient suffers an impairment in his ability to perceive reality. The patient may hear voices, believe he is being persecuted, and behave in bizarre ways.

Treatment during the psychotic periods requires medication, and at times hospitalization. During quiescent periods the patient is generally in good touch with reality, but still suffers from impairment which interferes with his ability to organize and maintain the resources required to make an unassisted stable adjustment to community life. Impairments are as follows: increased sensitivity to stress; difficulties with interpersonal relationships; a deficit in coping skills, and difficulty in transferring learning from one situation to another. Treatment must address both the acute psychotic and the quiescent phases of the illness. The first is primarily medical, directed towards interrupting the psychotic phase as quickly as possible. The second is rehabilitative in focus where efforts are made to improve and increase functional capabilities and psychological stability through skill training, psychological and environmental supports, and maintenance medication when indicated (Goldman & Manderscheid, 1987).

Severe or chronic mental illness is a major public health problem in the United States. Conservative estimates put the number of individuals suffering from this disease at almost two million. The lack of adequate services for this group of people is seen as the major failure of American medicine and social services (Torrey et al 1988). This failure is shared by the Territory of Guam.

B. Definition

GMHPC members decided to adopt the term "seriously mentally ill" as this was seen as the least stigmatizing label, carrying fewer negative connotations than either chronically or severely mentally ill. They defined the target population as follows:

"Seriously mentally ill persons have a major disorder as diagnosed under DSM-III-R, causing them to suffer ongoing primary deficits which affect their behavior, feelings, thinking, and perception of the world around them to the extent that their level of functioning is impaired, as judged by objective and subjective frames of reference. These conditions prevent the seriously mentally ill persons from carrying out major life activities, such as maintaining patterns of eating and sleeping, working and social interaction, for an extended period

of time lasting at least six (6) months."

The criteria of diagnosis, disability, and duration were taken into consideration for this definition.

C. General Description of this Population

1. Diagnosis

There are major mental disorders as described in DSM-III-R, such as schizophrenia, recurrent depressive and manic-depressive disorders, paranoid, organic, or other psychotic disorders, and behavior disorders that may lead to chronic disability such as borderline personality disorder. Reference is made to DSM-III-R for a description of all included disorders and diagnostic criteria.

2. Disability

There are frequent relapses, resulting in functional limitations in major life activities in at least two of the following areas on a continuing or intermittent basis:

- a. Is unemployed; is employed in a sheltered workshop; or has markedly limited skills and a poor work history.
- b. Requires public financial assistance for living maintenance and is unable to procure such assistance without help.
- c. Has difficulty in establishing or maintaining a personal social support system.
- d. Requires help in basic living skills such as hygiene, food preparation and/or money management.
- e. Exhibits inappropriate social behavior which results in intervention by the mental health and/or the judicial system.

D. Number of Seriously Mentally Ill Adults

This section presents findings of an applied planning study conducted to provide information to the Committee On Seriously Mentally Ill Adults as they made decisions revising the Three Year Mental Health Plan: 1989-1992. The Committee for Seriously Mentally Ill Adult Population identified the following questions as topics needing clarification. They sought answers by the collection of information from the community.

1. How many Seriously Mentally Ill (SMI) people, both those with diagnosed psychiatric conditions and those with personality disorders on the borderline of this definition, need services?
2. How does the target population vary in their service needs?
3. What are the most important services that should be given priority in decisions implementing actions over the next few years?

Two methods of data collection (see Methodologies section) were employed to quickly obtain information giving insight to:

1. summary estimates of mentally ill clientele in contact with public and

private agency services during the month of June, 1990, and estimates of needed service referrals among these clients for services known to be both (a) available on-island and (b) those needed but not available on-island; and

2. assessments of how mentally ill or mentally disabled clientele differ in their service needs and the priority importance of these services for meeting the needs of clients.

Methodologies employed included:

- a) a structured key informant survey of fourteen (14) professionals with programs in nine (9) agencies delivering social and mental health services, and
- b) two focus group interview sessions, one among service provider professionals and one among mental health clients, that reviewed and critiqued the findings of the survey.

Analyses of collected information and commentary by these key informants revealed the findings summarized on the following pages.

1. These results do not show Guam's actual prevalence rate of person's clinically diagnosed as having a defined mental illness, but they do reveal the monthly incidence of client caseload and contacts within Guam's social service system. The prevalence rate of SMI on Guam is a statistical construction based on formal clinical diagnoses stating the number of persons known to have a defined mental illness per 1,000 population. The records and reports of the Department of Mental Health and Substance Abuse provide this information. Even so, the prevalence rate does not include persons in need of mental health services but not formally diagnosed and outside of service/treatment programs because they lack a clinical definition.
2. SMI persons, those perceived to have either diagnosable mental illness or definable mental disabilities (e.g., personality disorders) comprise only a portion of clientele in contact with service programs each month. This appears to range from about 3 out of every 4 persons in programs directed at mental health clientele, to about 4 out of 100 in social service programs that may involve SMI indirectly as service providers attempt to meet the needs of the general public.

The number of monthly clientele in programs interviewed for this assessment ranged from as few as eight (8) to an estimated high of 500. Program services directed at the SMI averaged about 204 monthly clients but ranged from a low of 25 to a high of 435 persons.

3. The monthly incidence of estimated SMI contacting the six programs directed at meeting their needs ranged from a low of 4 (out of 25 clients) to a high estimate of 348 (out of 435 total clients). The average SMI caseload for the month among these six programs was 150.2 persons. It must be noted, however, that this average is reduced below the Department of Mental Health's own normal monthly caseload, estimated at 190-210 SMI clients, due to the smaller programs.
4. In working with these SMI clients, nearly everyone needed referral(s) to other services available on island. Among the six programs with services directed at SMI, the average client estimates indicate that as high as 99 percent needed referral to other services. Among the eight programs with services only indirectly including SMI, their client estimates indicated that they needed to refer about two-thirds (65.7 percent) of these people to other services. Among all fourteen programs interviewed, the data indicate that about 4 out of 5 SMI clients contacting a service program

need an additional referral.

5. About one-third of SMI clients needing referrals to other programs need services not available on island.
6. Outpatient service needs for SMI persons were identified, rated on importance and availability and discussed relevant to real-life experiences in both the survey of programs and the focus group interview sessions. Because this analysis was to help decisions for developing improvement in the delivery of services absent or hard to obtain, "availability" and comments by participants in both focus groups were given the greatest weight in prioritizing. Priority service needs requiring development efforts were assessed to be:
 - a. Social/Emotional Counseling for Personality disorders and behavioral problems.
 - b. Access to medical health services.
 - c. Case Management services.
 - d. Independent Living housing.
 - e. Supervised/Structured group home resident facilities.
 - f. Education (Schooling and Skill training).
 - g. Employment/Job counseling
 - h. Transportation mobility.
 - i. Psychiatric counseling services.
 - j. Psychiatric medication services.
 - k. Financial welfare assistance.
 - l. Clients' family counseling and involvement in programs.
7. Two recurrent themes of how the service of SMI persons vary occurred in the survey and focus group interviews.
 - a. The first was a plea for the need to develop those services that provide a "bridge" between in-patient care and independent living. Guam may be able to get the SMI into treatment and welfare programs but is deficient in its capacity to reduce the dehumanizing consequence of their dependency.
 - b. The second theme emphasized a major difference in the specifics of mental health conditions/symptoms and difference in the appropriate treatments and service needs for these. Guam may be improving its capacity for acute psychiatric care and medication treatment services, but deficient in its services for meeting the needs of SMI with definable personality disorders and severe behavioral problems, who do not respond to psychiatric medications.

Client Count Estimates

Introduction

Fourteen (14) key informants representing their particular programs in nine (9)

agencies delivering services to mentally ill and mentally disabled persons were interviewed about their services, number of clients and their perceptions of unmet needs (see Methodologies section). Agencies included both private and public organizations, and programs included both those which specify the mentally ill among target clientele, and those which are more general programs that may only contact mentally ill persons who seek support services meeting citizen needs.

For convenience, this section will refer to the first type of service directed at the seriously mentally ill (SMI) as "direct" service programs. The latter type, where SMI persons are indirectly served due to needs other than mental health will be referred to as "indirect" service programs. In this way the collection of information covered the wide range of points in the service network where mentally ill or mentally disabled persons may be seeking help. From the perspective of the professionals, this sampling obtained the insights of key informants with quite varied and diverse experiences in the community-wide effort to meet the needs of SMI clientele.

Private sector agency providers included practicing psychologists (2 informants), Guam Legal Services Corporation (1 informant), and the Advocacy Office For Developmentally Disabled People (1 informant). These professionals work outside of the public sector agencies, in more of an advocacy role to help clients and their families pursue every option available to meet their needs. Their experiences provided insights to events and perceptions from the periphery of Guam's social service system.

Public sector agency providers included the Department of Mental Health and Substance Abuse (3 informants), Department of Vocational Rehabilitation (2 informants), Public Health and Social Services (1 informant), the Superior Court's Diagnostic and Treatment Unit (1 informant), Department of Corrections (2 informants), and the Navy Family Services program (active military/dependents: 1 informant). These professionals work inside Guam's social service system in programs aimed at improving the quality of life for the civilian and military population. Although not all-inclusive of agency programs, those interviewed did cover the range of services where Guam's mentally ill and mentally disabled become known within the arena of community activity providing them support and treatment.

Appendix D - Table 1 gives an overview of the informants and their programs from which client estimate data were collected. Most (11 informants) held positions having immediate, one-to-one contact with their clientele. These included positions as doctor/nurse/psychologist (5 informants) or counselors/caseworkers (6 informants). Even so, the small scale and intimate nature of Guam's agency programs means that the three administrative informants were closely integrated with the delivery of services and client contact.

To optimize accuracy, informants were asked to verify their estimates with actual monthly reports or program records as a routine procedure during the interview. Estimates were limited to clients seen in the previous month (June 1990) to minimize the affects of recall error by referencing a time-period that was too broad or too much into the past. By asking about the previous month, the estimates were the most current information available. Informants were also asked whether the number of client contacts in the previous month were average for the year, or high or low.

As shown in Table 1, no one felt their caseloads were low for an average month while over one-fourth felt their caseloads were above average. Almost two-thirds (9 of 14) of the informants felt that their client loads in the previous month were average for the year. This ratio did not greatly differ between public and private agencies, nor between direct and indirect programs. None the less, the calculation of average estimates were controlled for both the variance of the monthly client estimate and the type of service (i.e., direct versus indirect).

This was done for several reasons.

Since the services of programs labeled here as "direct" are targeted toward SMI persons, they should make up the greatest proportion of clients in these programs. While the estimates from direct programs will more closely approximate the total number of SMI persons seeking help each month, the estimates from the indirect programs provided added insights. These programs help meet additional needs of SMI persons other than their need for mental health services. Thus, a separate analysis of indirect services gives insight to the monthly SMI caseload of programs external to mental health services yet serving SMI clientele. These programs are often the sources of initial contact in the process of identification and diagnostic referral leading to needed treatment by mental health service programs. They also make up the community network of support and treatment programs that make it possible to address clients' needs and disabilities in a holistic fashion.

Controlling for the variance in monthly client estimates (i.e., average versus high for the year) allowed for greater clarity of interpretations. Statistical averaging "washes out" the detail of extreme client counts that are both low and high compared to other programs. Yet for interpreting this data relative to the actual prevalence of both clinically diagnosed mental illness and mental disabilities (e.g., personality disorders) the higher order estimates will more closely approximate the number of persons in the population having a mental health condition.

The averages of client estimates are displayed in Table 2 (see Appendix D). These results do not show Guam's actual prevalence rate of person's clinically diagnosed as having a defined mental illness, but they do reveal the monthly incidence of client caseload and contacts within Guam's social service system. The prevalence rate of SMI on Guam is a statistical construction based on formal clinical diagnoses stating the number of persons known to have a defined mental illness per 1,000 population. Therefore, the records and reports of the Department of Mental Health and Substance Abuse provide this information. However, the aim of this study was to assess (1) the number of people seeking mental health services and active in the social service system, and (2) priorities for developing those social and mental health services critical for meeting their needs.

Findings and Discussion

The findings reported in Appendix D - Table 2 were reviewed and critiqued in a focus group interview session with professional service providers (See Methodologies section). These included a professional from the private sector and others from the departments of Mental Health and Substance Abuse and Public Health and Social Services. These participants all possessed a working knowledge of Guam's social and mental health service system. This life experience was used to (a) conduct a reality check of these findings and (b) develop a meaningful interpretation reflecting actual life events.

Comparing the average estimates of total monthly client contacting these programs with the average estimate of how many were perceived or known as SMI persons, confirms that they comprise only a portion of clients within Guam's social service system. Among all 14 programs they averaged 183.3 clients but estimates of SMI average only 85.1. These programs differed greatly between large and small. They ranged from a low of eight monthly client contacts (with 4 perceived SMI persons) to an estimated high of 435 monthly clients (with 348 perceived or known SMI persons).

Appendix D - Table 2 also displays the difference in SMI clientele between what we are calling "direct" and "indirect" program services. That is those directed at the needs of SMI persons verses general social services only indirectly involving them. Although very similar in the range spread of large and small

programs, indirect social services were in contact with an average of seven perceived/known SMI persons among all their clientele. These ranged from a low of eight clients with four perceived SMI to an estimated 500 clients with twelve perceived/known SMI persons. Yet it must be noted that SMI persons need and seek help through out the system of social services.

Looking only at the six "direct" service programs provides the better assessment of how many SMI were in active contact with agencies during the month. Again, the highest estimate given was 348 perceived or known SMI persons among a total monthly caseload of 435 clients. We must clarify that this figure is only one program's estimate, including both known SMI with clinically diagnosed mental illnesses plus clients perceived/known to have definable mental health problems, such as personality disorders and/or severe behavioral problems.

This point of clarification was discussed in the focus group interview among agency staff. Participant's from the Department of Mental Health and Substance Abuse re-emphasized that their normal monthly caseload ranged between 190 and 210 clients (about the same as the study mean of "204" for direct programs). Their professional estimate of SMI persons not in contact with their programs (i.e., unmet needs) or drifting in and out of services was an additional 30 to 50 persons (suggesting a prevalence of approximately 230 to 250 persons seeking/needing mental health services). They qualified this, however, stating that a figure of "80-90" for persons with formally diagnosed, acute conditions "may be high" compared to mental health admission and treatment records (referring to the study mean of "85" estimated SMI).

Thus, the average of 150.2 clients seeking or needing mental health services is very likely lower than actual prevalence due to the smaller programs. Yet the means of these estimates remain useful for assessing the proportion of perceived/known SMI clients involved in program caseloads. In these terms, this assessment found that, among the direct service programs interviewed, perceived or known SMI persons comprised about 3 out of 4 clients over the month (73.7% of an average 203.8 total clients contacts). Among the indirect programs delivering social services to the public, perceived/known SMI comprised about 4 out of 100 monthly clients (4.2% of an average 167.3 total clients).

The center and lower panels of Appendix D - Table 2, present average estimates of the number of these SMI clients who needed referrals to other programs for additional services. The bottom panel presents the data collected by asking the survey informants their best guess as to the number of SMI persons with unmet needs (i.e., not counted among their clientele but eligible for services). Unfortunately these latter estimates of unmet need were spotty and informants were uncomfortable with the question. We present them here only for their speculative value and to encourage a future study designed for the specific purpose of answering this question.

Returning to the estimates of SMI clients needing service referrals, the informants were also asked to separate out those SMI clients needing a referral but where the service is not available on Guam. Appendix D - Table 3 presents these findings calculated as proportions of the average SMIA caseload and the proportion of SMIA clients needing referrals, respectively.

As shown in Appendix D - Table 3, nearly every SMI client in the six direct service programs were reported as needing referral to other programs for additional services (i.e., on average a proportion of 179.3 among 150.2 clients or 99%). The indirect programs had much smaller numbers of SMI clientele. Yet most of these also had multiple needs requiring additional service referral (i.e., on average a proportion of 4.6 among 7.0 clients or 65.7%). Among all programs in this study servicing SMI clientele, about 4 out of 5 of these people needed referral to other, additional services (i.e., on average a proportion of 68.9 among 85.1 clients of 81%).

Among these SMI clients needing referral, these key informants estimated, an average that one-third had some part of their need in services not available on island. Within the focus group interview with agency staff, the commentary on problems experienced in referrals for SMI clients revealed an interpretation of how informants may have answered this question, that is different from an exact reading of the question asked. Participants discussed at length the fact that most social services programs are directed at the non-mentally ill, and even most mental health programs are geared toward acute psychiatric treatment. The consequence is that clients with personality disorders and severe behavioral problems are the most difficult to refer to another program even if a service is on-island. An unknown portion of this estimated number of unmet needs among SMI clientele may be the difficulty of accessing available services for a unique set of mentally troubled people, not just the absence of an available service. Similar comments were also recorded during the survey interviews as informants identified (1) the most common patterns in SMI client service needs and (2) those services that are (a) the easiest and (b) the hardest to fulfill on Guam. This idea that Guam is deficient in its services capacity to meet the needs of persons with personality disorders and severe behavioral problems in the SMI sub-population, emerged as a major theme of how current priorities for programs development vary among clients.

This issue will be discussed further in the presentation of data collected to assess those services deserving priority for improving the well-being of SMI persons on Guam. Other issues that emerged involved a need to make the referral process within the generic system of social and mental health services more effective and less "dehumanizing."

Assessment of Service Need Priorities

Introduction

Service need priorities were assessed using information from both the key informant agency survey and the two focus group interviews. Only one person, a social service provider, participated in both the survey and a focus group.

The survey of fourteen (14) key informants representing their particular programs documented a listing of twelve priority service needs for perceived or known SMI clients. These were rated in two ways. First, service needs were ranked according to the frequency of being listed by these agency staff as among the "most common grouping of needs among your (SMI) clients?" Second, service needs were ranked in terms of availability according to the frequency of being listed by these agency staff as among both (a) "the grouping of needs that are the easiest to fulfill" and (b) "the grouping of needs that are the most difficult to satisfy."

Only the listing of the twelve service needs were presented to the two focus groups (not the rankings). Both groups, one composed of agency staff from Mental Health and Public Health and one composed of SMI clients, used the listing as a guide to focus participant discussions on personal experiences with the service needs of SMI clientele, their availability or accessibility, and importance for improving the lives of SMI persons on Guam. This open-ended, independent "focus" upon selective service needs by both groups was employed as a third criteria to order the listing for presentation to the Guam Mental Health Planning Council. The listing and criteria determining the order are displayed in Figure A (see Appendix D).

Findings and Discussion

As listed in Appendix D - Figure A, this assessment found the need for "Social and emotional counseling" to have the highest ranking of importance and be the hardest service to obtain for SMI clients. Within the agency staff focus group the Public Health participant noted that "the health care assessment process often ignores assessment of mental health" (conditions or service needs). This

group of professionals from Public Health and Mental Health also discussed their awareness of the severity of this need for persons in the criminal justice system (the same point was made by the two key informants at the Department of Corrections in their survey interviews).

In the client focus group, social/emotional counseling was an immediate service problem for one of the participants. For the other participants, their mental illness conditions were such that medication was an appropriate part of treatment. However, "J's" case illustrated an apparent imbalance in the development of different types of mental health treatment services on Guam for different types of mental illness. As J explained to the group, "medication treatments have not worked; they (Mental Health) acknowledge this; they said I need intensive counseling therapy but they don't have the people for it, so they said all they could do was give me medication and weekly counseling." A professional advocate from the private sector assisting the client session added, "I see many people like (J) whose disability and understanding of self doesn't fit the scheme at mental health of medical treatment and dependent care."

This interpretation is consistent with the views of professionals from the key informant survey. They made a clear distinction between "social/emotional counseling" and psychiatric counseling or psychiatric medication as important elements of treatment services needed by their SMI clientele. As shown in Appendix D - Figure A, "Psychiatric counseling" was the second most frequently listed service need in terms of importance but then listed as among the easiest services to fulfill. "Psychiatric medication" received a lower rating in terms of importance and was less frequently mentioned as either among the easiest or hardest service needs to fulfill.

The agency staff focus group also discussed this problem. The participant from Public Health related her experiences contacting SMI persons in the delivery of her services to their families (i.e., the SMI could be the client in need or another family member seeking additional help). "We work with the families to help these people (SMI), but there's no clear procedure or service to help us facilitate diagnosis, and then find a treatment, and it all depends on the persons' willingness to accept mental health referral." In this discussion the agency group came to view this service problem as more endemic of staffing and manpower development problems in Guam's larger system of social services. The interpretations of this focus group pictured the issues of both absent services (e.g., social/emotional counseling) and access to services (e.g., medical health) as problems solved by manpower development. These issues were recurrent in discussions of the alternative service need priorities. They emerged in the discussions of needs for medical health services, welfare services, and the need for case management services. The added message from this study's data sources being noted here, is the well-known need to make referral processes within Guam's system of social and mental health services more effective and less "dehumanizing."

Continuing a discussion of the findings with this in mind, Appendix D - Figure A shows that medical health and financial welfare assistance received tied rankings (fifth) from the survey data in terms of their importance, but medical health services received the second highest rating as one of the hardest needs to meet for SMI clients. The experiences of one participant exemplified this issue over access in his search for a primary care physician. He's been on medication for intense arthritic pain for ten years, but, "I can't find (a doctor) to stay with me ...(pause), I've gone to everyone I can ... but I'm dependent on the MIP (Medically Indigent Program) to pay for a doctor." The other participants told of similar experiences with obtaining welfare assistance. The agency staff focus group also discussed difficulties obtaining services for SMI from Public Health's welfare programs and Guam Memorial Hospital.

The participant from Public Health, however, related these problems with availability to problems of access. She commented that, "Too often the mentally

ill client gets excluded by difficult in-take and eligibility processing." A professional from Mental Health interjected the comment that "programs are oriented to the non-mentally ill, they (caseworkers) prefer them." Another summarized the discussion, saying "most of the problems getting services is not lack of a specific service but how the services system works." The client focus group added within their discussion that their problems with access to social and mental health services decreased when they were able to get a social worker doing case management work for them.

These focus group discussions gave insight to understanding the findings from the key informant survey. Welfare needs were most frequently listed as one of the easiest services to meet, yet several informants added comments that it was easy for them working with a client, not necessarily easy for clients. Further-more, they listed case management services as one of the hardest SMI needs to meet. In fact it was tied with medical health services as among the most difficult service needs to satisfy.

Making the system more responsive to the unique pattern of needs troubling individual clients is how "we" professionals see these issues. But the priority from the perspective of clients was the impact of unresponsiveness on their sense of self. The following comments from the client focus group conveyed this point quite explicitly.

"They don't help much, no clear answers, no clear directions; I must do paperwork several times."

"I've had such trouble with these social workers who have no skills to work with me; ... they need worker skills to be able to work with a person who gets angered, upset, frustrated."

"They ignore me; it's their attitude ... I don't like being disabled."

Frustrations and obstacles as clients seek social and mental health services can be dehumanizing. The desire to be a human in the community was the apparent meaning of client preferences for independent living stated in their focus group. Two of the clients currently lived in the new Guma Ifil residential group home (opened January 1990). Even so, the anticipated hope implied by these two as they discussed their other service needs was to eventually move out to be members of the community; "I want to get to where I can live in my own place." Confirming the priority weight of services and assistance helping SMI obtain independent living (and housing), responses to the key informant survey rated these among both the most important needs and the hardest to satisfy. In this assessment Independent Living Housing emerged as one of the top five development priorities, along with a need for Supervised or Structured Residential Group Homes (see Appendix D).

The agency staff focus group also discussed services for independent living, and supervised or structured residential group homes. They viewed these as essential mechanisms for a "bridge" between in-patient care and moving back into the community. Guma Ifil was seen as necessary but not sufficient or large enough to meet the demand of all SMI in need. The group saw this issue as having shifted this past year, with Guma Ifil being a start to develop the first step in the transition of SMI moving away from in-patient care, but still a need for another residential group home to serve as a second step and provide housing for SMI capable of independent living but homeless. As one stated it, (the need now) "is for special housing, like GHURA (Guam Housing and Urban Renewal Authority); and this is a real problem for our elderly mentally ill, too, so something like Guma Trankilidat" (a government housing complex for senior citizens).

The SMI persons in the client focus group provided case illustrations confirming these service needs and why they felt them to be important.

Having been in the mental health system about 20 years, M's case was that she had been treated "like a slave" by family relatives before moving to the Guma Ifil residential treatment home. She had spent about six months as an in-patient over this earlier period; "I got counseling but couldn't do laundry." M was never able to get GHURA Section 8 housing assistance and obtaining welfare services and food stamps was always a struggle. Guma Ifil is not only providing M with much needed case management services helping her meet needs for financial welfare assistance but it has renewed her aspirations for moving toward independent living. She identified her current unmet need as education (schooling and skill training) that would help her get employment. She is excited about promises of the JOBS program being implemented that could help her obtain necessary work experience. She's never tried to get a job because she lacks transportation and been dependent most of her adult life.

K entered mental health treatment services on Guam in 1968 as a teenager. With an abusive, alcoholic father he has "run away from home and at different times "lived at my uncle's" or "Sagan Dinana" (a park building in Agana, i.e., homeless). Referring to Guma Ifil, "now I have a place to go to rest; to read." Before Guma Ifil K, tried working at a bar doing clean-up work because he had no high school diploma and no transportation for anything else. He identified his current unmet need as education to get a G.Ed. degree. He aspires to get a janitorial job with GovGuam, and is now getting paid work experience at Mental Health

J moved to Guam just over a year ago from California, where he was homeless and receiving mental health services. "I lived at Ipao for 2-3 weeks (a public park). California kept sending me my SSI checks so I bought and lived in a car. But Guam doesn't get SSI, so now they're saying I owe that money back. I got a job on a farm where he let me live in an old school bus. Then after about six months I got in trouble with him and moved back to the car. For the last three months I've been living in a place under Mod Rehab" (Moderate Rehabilitation is part of the GHURA Section 8 rental subsidy programs to encourage landlords to maintain low-income rental housing). J has been employed part-time as a recreational instructor teaching wind surfing. But bad weather or too few students means no work. He's struggled to get food stamps yet in July he made too much to qualify and then there was no work in August. Other than case management services to help meet mental illness, medical health and independent living needs, J identified another need to be education for increasing his employability.

The service need priorities for education and employment help were also illustrated by these three cases and confirmed by information from both the key informant survey and agency staff focus group. Transportation is a repeatedly documented need among Guam's low income families and social welfare clientele. SMI as a sub-population of this segment in the community also have this need. Even so, as suggested by the difference between the cases of J and M or K, this need may vary among SMI where persons with personality disorders or severe behavioral problems have less need (more similar to low-income people) than those with psychiatric conditions controlled by medication. This speculation is consistent with the lower ranking assigned to transportation from the key informant survey in terms of both importance and availability, yet the fact that it was listed as a service need.

The realities of Guam's service system for social and mental health portrayed by the assessment of these data emphasize a need to establish varied types of adult residential treatment for SMI that provides them the opportunity to move toward community living in stages of decreasing restriction. If this can be developed then it may become possible to further develop services to reduce or minimize the dehumanizing aspects of being mentally ill. An integral aspect of these services would be counseling services for clients and their families to better cope with peoples' interpersonal reactions to serious mental illness in the community. These would be the essential structural mechanisms of the services "bridge"

between inpatient care and independent living for Guam's SMI. The final service needs completing this bridge would be education (schooling and skill development), job or employment counseling and transportation to secure self-sufficiency and self-esteem.

In conclusion, although several of these need priorities are particular to the development of Guam's mental health service system, the underlying issues alluded to by all informants are broader problems of the larger system of all social services.

Methodologies

This assessment study was requested to obtain information that was empirically trustworthy as an immediate portrayal of realities and need priorities within Guam's system of social and mental health services. The time frame from start to use of findings for writing revisions to Guam's Three Year Mental Health Plan: 1989-1991 was extremely short (June through September 1990). The Committee on the Seriously Mentally Ill decided to take a more qualitative and multiple methods approach to satisfy these pragmatic conditions. Furthermore the procedural process implementing these methodologies was set-up to promote rapid utilization by direct participation of the Committee's co-chairs in the design of instruments and analyses of collected data.

A key informant survey and focus group interviews were the two methodologies selected. These methods could quickly obtain trustworthy data that could be analyzed in an expedient fashion. The purpose was to gain sufficient insight for informed decisions making revisions to particular goals and objectives of the Three Year Plan. Specific questions and the instruments were designed in meetings of the Committee's co-chairs with members of the Community Development Institute's research team (CDI). CDI then proceeded to collect the data and compiled it for interpretive analyses, also conducted in meetings with the co-chairs. This accomplished immediate feedback reporting and increased utility since the products of the study involved input from the decision makers who applied the findings into the planning process.

The definition of serious mentally ill shown and read to all informants participating in both the survey and focus groups is the one developed by the Guam Mental Health Planning Council for the original Three Year Mental Health Plan: 1989-1990.

"There are major mental disorders under DSM-III-R, such as schizophrenia, recurrent depressive and manic-depressive disorders, paranoid, organic, or other psychotic disorders, or a disorder that may lead to a chronic disability such as borderline personality disorder."

Key Informant Survey. The sampling procedure compiled a list of informed professionals working with Guam's seriously mentally ill (SMI), who represented the full spectrum of private and public agencies involved in delivering services to SMI persons. The co-chairs produced a list of twenty-nine (29) names in eighteen (18) separate agencies. All persons were contacted at least once to request interviews which were conducted until time ran out and data analyses had to be completed for utilization. Consequently, the findings of the study were based upon an availability sample of fourteen key informants representing their particular programs in nine agencies or organizations. Given the time frame for collecting data, the study interviewed half of the targeted key informant population identified.

Focus Group Interviews. Data collected from the survey interviews were compiled and employed as the "focus" for group interview discussions with a set of agency staff professionals and a set of SMI clients. These focus groups were conducted following the established procedures of this methodology which has been developed

in countless business and social service applications in the United States. This methodology provided a reality check to the key informant findings and obtained additional input for interpreting all data and clarifying its portrayal of reality.

The SMI Committee co-chairs sat in on these focus group sessions which helped them obtain immediate contact with the collected information. The agency staff group consisted of three service professionals from the departments of Mental Health and Substance Abuse (2) and Public Health and Social Services (1). The client focus group also consisted of three persons currently receiving services for conditions of mental illness.

In addition to these participants a facilitator led the group discussions asking questions or stating probes (e.g., "could you explain," "what do you mean by ..." and so on) that maintained the groups' attention on the study's question topics. Statements and responses were recorded by a research assistant who sat on the side writing notes and marking those that were verbatim quotes. A debriefing between the facilitator and research assistant was conducted afterward to be sure they had captured the group comments and their meanings. Notes recorded by the facilitator, who concentrated on the discussion, were combined with notes by the research assistant, who concentrated on recording statements.

These multiple sources of information from a variety of perspectives within Guam's social services system provided a quick overview of realities within that system. Analyses looked for the consistencies and repeated messages which provided insight to that reality.

In addition to these participants a facilitator led the group discussions asking questions or stating probes (e.g., "could you explain," "what do you mean by..." and so on) that maintained the groups' attention on the study's question topics. Statements and responses were recorded by a research assistant who sat on the side writing notes and marking those that were verbatim quotes. A debriefing between the facilitator and research assistant was conducted afterward to be sure they had captured the group comments and their meanings. Notes recorded by the facilitator, who concentrated on the discussion, were combined with notes by the research assistant, who concentrated on recording statements.

These multiple sources of information from a variety of perspectives within Guam's social services systems provided a quick overview of realities within system. Analyses looked for the consistencies and repeated messages which provided insight to that reality.

E. Needs Assessment

In 1990 the Guam Mental Health Planning Council conducted a needs assessment for persons with serious mental illness. The goals of the needs assessment were: (1) to develop current information on the actual number of people who are seriously mentally ill; (2) to develop an understanding of the services needed by seriously mentally ill adults recognized nationally as well as on Guam that there are many more seriously mentally ill people, including both the services needed which are currently available in the community and the services which are not currently available in the community; and (3) to prioritize the services which are needed but are not available in the community in order to aid in the development of the goals and objectives for this chapter.

The needs assessment process utilized both key informant interviews, and focus group discussions in order to meet the stated goals. Section D contains the needs assessment report. The goals and objectives have been amended as a result of information and understanding which the GMHPC has gained as a result of this needs assessment process.

F. Vision of an Ideal System for Seriously Mentally Ill Adults

Individuals with serious mental illness should receive care from a comprehensive system of mental health and other necessary services to meet their multiple and changing needs. It is understood that a system of care is more than an array or a continuum of services; it must contain the components and the mechanisms for service coordination, integration and delivery.

Two important values guide this vision:

1. The system of care should be client-centered, with the needs of the client and his family dictating the types of mix of services provided; and
2. The system of care should be community-based, making it possible that services be provided in the least restrictive and most clinically appropriate place.

In addition, several principles were identified as being necessary for the development of the proposed system of care.

1. Each person is unique and each person's treatment and rehabilitation is a unique and multifaceted process. Therefore, services and support should be tailored to each individual, rather than preprogrammed or based on prototypical client needs. Emphasis should be less on curing than promoting rehabilitation and community integration.
2. The seriously mentally ill have the same basic needs as any other person and should have access to the same social roles; spouse, parent, friend, worker, tenant, church member, club member, shopper. Artificial environments and lifestyles that segregate serious mentally ill persons or distort or deny these social roles should be avoided.
3. Each person's unique choices and values must be respected. To the extent possible, the choice of living arrangement should be based on the individual's value and personal preferences. Clients should be aided in making successful choices.
4. Case management should be provided to individuals with serious mental illness and their families to ensure that multiple services are delivered in a coordinated and therapeutic manner. Individuals should be able to move smoothly through the system's interdependent components in accordance with their needs.
5. Services should be provided within the least restrictive and most normative environment. Inpatient and residential treatment care should occur only after all efforts in the natural setting have failed.
6. Services should be culturally, racially and socially relevant and appropriate.
7. The rights of seriously mentally ill persons must be protected at all times, and greater and more effective advocacy efforts should be promoted.
8. There should be mechanisms in place for planning and coordinating needed services throughout the mental health and generic support system.
9. Efforts must be made to identify all funding sources for the financing of services to individuals with serious mental illness.

Using the previously mentioned principles as a foundation, the community-based system of care for Guam's seriously mentally ill should minimally contain the

following components:

Mental Health Services, to include:

- 24 hour Crisis Intervention Services
- Psychiatric Counseling
- Social-Emotional Counseling/Group Therapy
- Medication Treatment
- Acute Care Short-Term Inpatient Treatment
- Client's Family Counseling

Residential Services, to include:

- Closed Therapeutic Group Homes
- Open Therapeutic Group Homes
- Supervised Apartment Living
- Therapeutic Family Care
- Independent Living

Education, Vocational Training and Skill Development

Social Welfare Assistance, to include:

- Financial and other Welfare Assistance
- Employment and Job Counseling Assistance
- Case Management
- Medical and Physical Health Services
- Transportation
- Advocacy and Legal Services
- Recreation and Entertainment

G. Guam's Services for Seriously Mentally Ill Adults

Guam has a generic support system such as found elsewhere in the United States. Case management, a good social worker, or individual stamina can procure the following:

Housing and Shelter:

1. Private family homes, and houses and apartments available for lease or rent.
2. Low-cost public housing and Section 8 housing through the Guam Housing and Urban Renewal Authority.
3. Guma Mami, a non-profit corporation funded \$250,000.00 by DMHSA, provides supervised housing for mentally retarded adults in two distinct group homes; one home serves eight men or women who need assistance with skills of daily living and self help skills, and one home serves four men or women who exhibit moderate to severe behavior problems.
4. Guma Ifil is a supervised apartment program operated by the Department of Mental Health and Substance Abuse which serves 16 men and women who are seriously mentally ill.
5. Guma San Jose, operated by Catholic Social Services under a FEMA grant, offers temporary shelter for homeless persons.
6. The Saint Vincent de Paul Society received a \$29,000.00 grant in September, 1990 by DMHSA, to operate a drop-in center for homeless

persons. See Chapter VI for details.

7. ALEE, operated by Catholic Social Services, is a shelter for women and children who are victims of family violence and has at times sheltered women with serious mental illness.
8. Guma Trankilidat is a low-cost housing development for senior citizens and handicapped adults who are able to care for themselves.

Social Services:

The Department of Public Health and Social Services provides:

Food Stamps,

General Assistance, Aid to the Permanently and Totally Disabled, Aid to the Blind, Old Age Assistance, or Aid to Families with Dependent Children. \$151 per month, or, if the person has a home, \$351 per month. (As stated in Chapter II, SSI has not been extended to the residents of Guam).

Health care by local physicians, paid for by Medicaid or the Medically Indigent Program (MIP), also limited health services at the Southern Regional Medical Center in Inarajan.

Dental care, by local providers, paid by Medicaid or MIP on a limited basis and only if there is a medical need for such care.

Limited Homemaker Services, primarily provided by Interfaith Volunteer Caregivers, Inc. There are no publicly funded homemaker services for adults on Guam.

General and Medical Social Work, provided by Department of Mental Health and Substance Abuse, the Department of Public Health and Social Services, Catholic Social Services, and Guam Legal Services Corporation.

If eligible, all the services provided to seniors 60 years and older under the Older Americans Act.

Transportation:

Guam Mass Transit -- with a limited schedule and limited routes.

SPIMA, for seniors or handicapped persons.

Western Pacific Association of Disabled People offers transportation to disabled people on an on-call basis.

Interfaith Volunteer Caregivers, Inc., if a drive is available.

Vocational, Educational and Rehabilitation Services:

Department of Vocational Rehabilitation (DVR)

DMHSA's Job Bill Service

Guam Vocational Training Center, Inc.

Goodwill Industries

AHRD (Agency for Human Resources Development)

Department of Labor -- Special Section for Disabled Persons

Western Pacific Association for the Disabled (WPAD)

University of Guam Extension Services, for parenting training, life skill training; also project HORIZON, an academic tutoring and counseling service.

Additionally, there are private and military organizations,

such as CIRO, the Navy apprentice program and several local hotels.
Guam Community College - Adult Basic Education program.

Protection and Advocacy Programs:

The Advocacy Office, which offers Protection and Advocacy for Developmentally Disabled (PADD), Protection and Advocacy for and Mentally Ill Individuals (PAMI), and the Client Assistance Program (CAP) for vocational rehabilitation clients.
Western Pacific Association for the Disabled (WPAD)
Guam Legal Services Corporation
Public Defender's Office
Adult Protective Services, Department of Public Health and Social Services
Guam Association for the Mentally Ill (GAMI, Inc.) -- presently being reorganized
Guam Developmental Disability Council

Mental Health Services:

The Department of Mental Health and Substance Abuse provides:

Acute Care Inpatient Services
Crisis Intervention, either at Guam Memorial Hospital Emergency Room or DMHSA facility; trained staff is available 24 hours for consultation and assessment which may lead to admission or referral for outpatient services..
Day Treatment: 3 days per week
Medication Clinic
Case Management: assistance with family, work and social adjustment
Counseling Services: intake, screening, evaluation, therapeutic counseling
Case Management.
Guma IFIL, supervised residential service for adult mentally ill persons.

In the private sector, one psychiatrist, three licensed psychologists, and several other licensed therapists are available to treat emotional disorders and mental illness.

In addition to the above services and programs, there are also numerous civic, cultural, business and voluntary organizations which support mentally ill persons through Christmas activities and monetary gifts throughout the year.

H. Analysis and Discussion

Guam has an array of services for its seriously mentally ill people. Some progress has been made in this past year toward the development of a system of services which work together to meet the needs of seriously mentally ill people. However, the deficiencies, that is: lack of facilities, inadequacy of existing facilities, lack of services, shortage of trained providers, lack of on-going training for current providers, lack of coordination and a lack of humaneness in the provision of services.

"Mental illness is the suffering of a person which is not accepted by society." This definition was given by a consumer participant at the 1989 workshop, and in essence, sums up the many problems inherent in the delivery of mental health care. Society does not want to accept or deal with mental illness. The mentally ill are increasingly disenfranchised, stigmatized and devalued in American

society, and this is not different on Guam, except perhaps that here an element of superstition and fear is also involved in shaping the community's attitudes towards mental illness and the individuals suffering from it.

These attitudes prevent many mentally ill individuals from seeking the care they need, and also impedes the development of a good system of care. Public opinion, which can easily sway legislative decision making and budgetary consideration, has never wholly consolidated behind the issues of mental health needs. Service providers, consumers and their families, and the advocates on island usually face a lonely battle when fighting for facilities, services and programs. For this reason Guam still has the same gaps in the delivery system as identified ten years ago. Mental health is not a popular subject for legislators and administrators. Guam, like many developing countries, expends its major efforts on the development of the economy and the infrastructure, and health and social services lag behind.

Even if all necessary services would be available to the people of Guam, they would not necessarily be accessible to the general population. Accessibility is defined as a measure of the degree to which a system inhibits or facilitates the ability of an individual or group to gain entry to and receive appropriate services. Considerations, besides the ability to pay, include geographical, temporal, and socio-demographic accessibility.

Financial access pertains to the ability of a population, or a portion thereof, to apply for needed services. For persons unable to afford health insurance, Medicaid and MIP remove financial barriers to needed health care. Nor are there any such barriers to receiving mental health care, as such care is currently provided free of charge to Guam's residents (as discussed in Chapter III). Counseling services provided by the other government and private agencies (Catholic Social Services, SANCTUARY) are also free of charge to the client. Psychotherapy provided by the private psychiatrist, the licensed psychologists and counselors are sometimes covered under third-party reimbursement or require self-pay.

Geographical access pertains to the location of needed services. As most of the health, mental health, and social services agencies and providers are located in the central or north-central portion of Guam, it is plain that people in the southern part of the island face a barrier in accessing needed services, since residents from that part of the island must travel an average of 45 to 60 minutes to receive such services. As Guam has only a limited public transportation system, access to a car is an important consideration in receiving necessary care.

Temporal access refers to the ability of clients to receive services at the time when either they need them or can make use of them. Because of transportation problems, and more importantly, the fact that work hours often coincide with the hours during which needed services from government agencies are usually provided, many persons have difficulty in obtaining such services.

Socio-demographic access deals with the beliefs, cultural mores, attitudes and languages of a community. Despite the advanced westernization of Guam's culture, there are still many superstitious beliefs surrounding not only mental health and mental illness, but also the facility in which such services are currently provided. Coupled with this is the stigma attached to someone with mental or behavioral problems, and this causes many families to not seek help when they need it, particularly when there are already other access barriers present.

Language can also be a barrier to access. Since most of the population speak English as either a first or second language, one easily assumes that there exists only a limited language barrier and that this only affects the elderly Chamorros and Filipinos and the newly arrived immigrants. But there is a much larger, more important aspect to the delivery of mental health care. In the

realm of mental health and emotional problems, it is difficult to translate one's innermost thoughts and feelings into a foreign language which might lack the subtlety of one's own culture, and at times the providers are not familiar with the ethnic background and cultural practices of the clients in need of services.

For a number of people with a serious mental illness the necessary appropriate service is not available and cannot be accessed. The existing services, primarily provided by the Department of Mental Health and Substance Abuse, are based upon the medical model. For this reason, if your serious mental illness is one of those which fits well into the medical model, such as schizophrenia as an example, there are a variety of services available. As gaps in the delivery system have been identified and are being filled, such as development of a case management service or of therapeutic residential care, then more of the needs of a person with a serious mental illness which "fits" the medical model are being met. In this regard progress is seen in developing a system of services and overcoming some of the barriers to access of those services.

However, there are a number of people who are seriously mentally ill (that is, they fit the definition which has been accepted by the GMHPC) whose disability does not fit well into the medical model. An example is a person with an anti-social personality disorder. For those people whose serious mental illness does not fit the medical model, almost no services in the delivery system are appropriate, or, in the alternative, are made available. People with one of the various personality disorders, those who fall into catch-all categories such as organic brain syndrome and people with mental retardation combined with a serious mental illness are, at best, underserved by existing services on Guam.

The provision of optimal mental health care for seriously mentally ill people will require a reduction in the barriers to full access to services, the development of needed services, the development of non-medical models of service which will serve the needs of those persons whose disability does not fit the existing model, an increase in mental health manpower and in manpower training, and greater involvement of the client and his/her family in the provision of care.

1. Inpatient Services

The Department of Mental Health and Substance Abuse provides inpatient psychiatric care to persons who are suffering from acute psychiatric disorders that require hospitalization. The inpatient unit can serve a maximum of 17 people at one time. The average census at the inpatient facility is 8. The present inpatient unit has served the community since 1984.

The mission of the inpatient unit is to provide short term care to persons who are experiencing acute psychosis. It is an integral part of a community based mental health program in that it provides short term hospitalization as needed. As such, the program supports the various outpatient and community programs. It does not provide long term institutionalization to persons with chronic mental illness or other disabilities.

2. Community-Based Residential Treatment

The Adult Residential Treatment program opened in March, 1990. The program provides 24-Hour supervision and support to seriously mentally ill persons living in individual apartments. The goal of the program is to provide a therapeutic living environment in an apartment setting which is close to public transportation, shopping, entertainment and public recreation facilities.

All of the residents receive case management, day treatment and/or medication supervision if needed, therapeutic counseling for individuals, groups and families as indicated and life skill education. This is a large step in moving the seriously mentally ill clients toward greater independence and self-

sufficiently in the community.

In addition to the residential treatment program, there is a need for open and closed group homes, where 4 to 8 clients live together with trained staff living on the premises in the role of house managers and role models. Closed group homes are needed for seriously mentally ill clients who are unpredictable and potentially dangerous to self or others, and who need structured support and supervision during waking hours over long periods of time. Open group homes are seen as a half-way station between inpatient treatment and community living. Open group homes could provide structure, supervision and therapeutic counseling during rehabilitation and adjustment periods to prepare the client for either the Adult Residential Treatment program, described above, or joining his or her family in the community.

3. Therapeutic Family Care

Service providers and consumers have clearly expressed a desire to develop a program of support and services which would enable the natural family or extended family of a person with serious mental illness to provide a therapeutic living environment at home. With proper training, replacement of lost income, and adequate support services such as home help, respite care, and support groups, a natural family might be better able to retain a family member in his own environment rather than putting him at risk for inpatient or residential care. This would perhaps not be less expensive, but much more in keeping with the island's tradition of taking care of one's family members.

4. Manpower and Inter-Agency Cooperation

The lack of mental health manpower in all categories has already been detailed in Chapter III under "Systems Concerns." The lack of cooperation so necessary to the delivery of services was also described in this Chapter.

5. Case Management

For more than one year the Department of Mental Health and Substance Abuse has operated a case management unit within its outpatient service program. Although the program is still growing (see Goal 3, Objective 3.2, page 69) and does not yet meet the needs of all seriously mentally ill persons receiving outpatient care, it has begun to transform the fragmented community services into a recognizable, integrated system. Case Management services now mobilize multi-disciplinary teams to more effectively address the mental and physical health, as well as the social, vocational/educational and economic needs of seriously mentally ill persons.

6. Client and Family Involvement in Treatment

The family should be an integral part of the treatment process, and family integrity should be maintained, if at all possible, during treatment. "Family" should be as designated by the client -- either his natural family, members of his extended family, an adopted family, friend, or other significant person in his life, regardless of sexual orientation.

Clients and families need to be much better educated and trained about the possible etiology of mental illness, its symptoms and manifestations, and the action and side effects of medication. This de-mystifies the illness and helps patients and their families to acquire the skills to develop better coping mechanisms.

Home help and respite care are needed for families who care for persons with serious mental illness. Recreational programs for patients and/or their families should also be established. Therapeutic services, such as individual and family counseling, should be brought to the client's natural environment -- his home --

at a time convenient to him and his family. The present working hours of DMHSA (as well as the other agencies providing generic services) are weekdays from 8:00 a.m. to 5:00 p.m., the time most people are also employed. This presents a barrier to family involvement in client care.

Clients and their families need to be educated about their rights as consumers, their power of advocacy, and their power to influence changes in legislative and service provisions.

7. Image of Mental Illness and DMHSA

Lastly, the negative image of DMHSA must be examined, since embedded in this image lie the reasons for the suspected under-utilization of the offered services. Some of the possible reasons have been listed earlier in this Chapter where socio-demographic access barriers have been discussed. Other reasons might also contribute to the reluctance of local people to use the facility and services.

One of them might be an adherence to the cultural value, treasured by both the Chamorro and Filipino populations, that personal problems are private affairs and that it is embarrassing to discuss them with, or ask for help from, anyone outside the close and extended family or the natural community providers, such as the village priest or mayor, or a suruhanu (local faith healer). This contrasts sharply with the U.S. where the values have encouraged the formalization and professionalization of helping relationships and where it has become accepted to tell one's troubles to strangers. The culture is slowly changing; Guam is adopting modern, industrial values with a corresponding breakdown of the natural helping system at the family level and, most clearly, at the village level. Formal services are becoming increasingly prominent.

There is yet another reason: Since DMHSA is the only mental health facility on island, the chance of a relative or other acquaintance working at DMHSA or being seen entering or leaving the facility is great. Confidentiality is difficult to maintain despite the best system safeguards.

In addition, there are many stories of someone close having had negative experiences at DMHSA. The bureaucratic nature of the offered services can be blamed for that, as well as the lack of resources and manpower to provide the requested services. People feel that they are expected to "spill their guts" during the initial assessment, only to be told that they are not qualified for services or must wait a long time for an appointment, and that this violates their integrity and dignity. Furthermore, there is still the stigma of being labeled "crazy" when going for any services to DMHSA. One consumer shared with the working group that, even though she was considered to be "better", she was "hearing voices." She did not report this to her therapist out of fear that "he would think that I'm even crazier than I am; I was already labeled and stigmatized, and did not want to make it worse."

It becomes obvious from these discussions, as well as from recent demonstrations at the public hearing for the proposed new mental health facility by residents who did not want "such people" in their neighborhood, that Guam and DMHSA need a well-planned public relations campaign to educate the island about mental illness and the services provided by DMHSA.

I. GOALS, OBJECTIVES AND STRATEGIES

GOAL 1: PROVIDE INPATIENT MENTAL HEALTH ACUTE CARE AT AN APPROPRIATE LEVEL, IN A PLACE SEPARATED FROM FORENSIC CLIENTS AND ALCOHOL AND SUBSTANCE ABUSE PATIENTS.

Objective 1.1: Build a mental health facility specifically designed for provision of inpatient mental health acute care and tailored to the particular needs of the island of Guam to replace the present hopelessly inadequate facility, expanding and improving the base for serving the seriously mentally ill and other mentally ill populations by 1993.

Status of Implementation:

Completion date for the new facility is expected to occur during the summer of 1993. A state-of-the-art design was applied to provide a more comprehensive array of services. The new facility will be the first structure solely designed for mental health and substance abuse services. (See Appendix A.)

Lead Agency: DMHSA together with GMHPC and the Guam Legislature (for funding).

GOAL 2: ESTABLISH VARIED TYPES OF ADULT RESIDENTIAL AND RESIDENTIAL PLACEMENT SERVICES FOR INDIVIDUALS WITH SMI IN ORDER TO PROVIDE MENTAL HEALTH TREATMENT IN THE LEAST RESTRICTIVE SETTING FEASIBLE AND TO PREPARE THEM FOR INDEPENDENT COMMUNITY LIVING WHENEVER POSSIBLE BY 1992.

Objective 2.1: Establish supervised apartments for SMI adults.

Status of Implementation:

Guma IFIL, an adult residential facility for SMI adults opened officially on January 2, 1990, with 15 apartment units and a 16-Hour supervisory staff of six. (See Appendix B.)

The possibility of expanding the staff to 8 is being considered. The program will be evaluated after one year, measuring success by length of stay at the facility, independent living in the community, and reduced inpatient admission for the residents.

Lead Agency: DMHSA together with GMHPC and in conjunction with GHURA, Guam Housing Management (Department of Administration) and other social service providers.

Objective 2.2: Establish open and closed group homes for Guam's individuals with SMI to provide rehabilitation and treatment at the most appropriate level for clients who need a "bridge" between inpatient care and independent living in the community or at Guma IFIL.

Strategies for Implementation:

Investigate federal, local and private funding sources which might possibly fund open and closed group homes on Guam. Investigate the types of homes that were successful elsewhere and present this information, together with a cost/benefit analysis, to DMHSA staff and the GMHPC for deliberation and action. Continue to support efforts by Guam's Washington Delegate to amend the Social Security Act to extend SSI benefits to eligible citizens of Guam. Implement a public education program about this issue.

Lead Agency: DMHSA, together with GMHPC, GHURA, and in conjunction with the Protection & Advocacy Office for the Developmentally Disabled and Mentally Ill (PADD & PAMI) and the Western Pacific Association of the Disabled (WPAD).

Objective 2.3: Establish a housing referral service to identify available rental housing in the community and aid SMI individuals in obtaining such housing. Service would include active support in finding funds for rental and arranging for utilities and furnishings.

Strategies for Implementation:

Analyze the scope of work required to establish this program and seek funding for the appropriate staff and facilities for a housing referral service.

Lead Agency: DMHSA, together with GMHPC, GHURA, and in conjunction with the Protection & Advocacy Office for the Developmentally Disabled and Mentally Ill (PADD and PAMI) and the Western Pacific Association of the Disabled (WPAD).

GOAL 3: PROVIDE ADDITIONAL SERVICES TO SMI INDIVIDUALS TO REDUCE, MINIMIZE AND IDEALLY ELIMINATE THE DEHUMANIZING ASPECTS OF BEING MENTALLY ILL BY MEETING THE PRACTICAL NEEDS OF LIVING IN THE COMMUNITY BY 1992.

Objective 3.1: Provide increased services, including social and emotional counseling SMI with behavioral problems and personality disorders.

Strategies for Implementation:

Seek and obtain funding for an expanded number of social workers, psychologists and other counselors to fill the critical need for increased counseling services.

Lead Agency: DMHSA in conjunction with GMHPC.

Objective 3.2: Improve and expand case management services in order to increase access to all necessary services, particularly medical health services and financial welfare assistance and to coordinate services within the generic care system to

enhance the client's treatment and well-being.

Strategies for Implementation:

For the next three fiscal years, add yearly two case managers to existing staff to handle increasing workload. Workload should not exceed 12 clients per case manager.

After one year, evaluate case management service; measure of success is client satisfaction.

Lead Agency: DMHSA's Divisions of Medical and Clinical Services, PAMI and WPAD.

Objective 3.3: Develop an active program for training and employment of SMI in order to increase self sufficiency and self esteem.

Strategies for Implementation:

Analyze the scope of work required to establish a job training and counseling program and seek funding for the appropriated staff and facilities for a training program, a job referral service and a group shelter workshop to be run by the clients or based on their services. Expand this beyond present JOBS program in which clients work for DMHSA at DMHSA, generally doing maintenance work. Obtain funding and hire appropriate staff to operate this program.

Lead Agency: DMHSA, together with GMHPC, Guam Department of Labor, and the Agency for Human Resource and Development, and in conjunction with the Protection & Advocacy Office for the Developmentally Disabled and Mentally Ill (PADD and PAMI) and the Western Pacific Association of the Disabled (WPAD).

Objective 3.4: Provide educational counseling and increased access to educational institutions by the SMI.

Strategies for Implementation:

Expand counseling services to include advice about and aid in obtaining education at high school or post-high school level. Educate appropriate personnel at UOG, GCC and other schools concerning SMI.

Lead Agency: DMHSA, together with GMHPC, DOE and GCC, and in conjunction with the various institutions of higher and intermediate learning.

Objective 3.5: Provide counseling information and support for clients and their families to better cope with serious mental illness.

Strategies for Implementation:

Educate clients and their families about patient rights; about their illness, cause, diagnosis, treatment and prognosis. Increase client and family participation as part of the treatment team. Investigate consumer-operated home help and respite care.

Lead Agency: DMHSA, in conjunction with GMHPC and the Guam Alliance for Mental Illness, Inc. (GAMI).

GOAL 4: UPGRADE SERVICE TO SMI INDIVIDUALS THROUGH EDUCATION, INFORMATION, COMMUNICATION AND COMMUNITY INVOLVEMENT.

Objective 4.1: Implement a program of manpower development and in-service training of staff and potential staff.

Strategies for Implementation:

Seek and obtain funding for manpower development and in-service training. Actively lobby for establishment of additional training programs at GCC and UOG. Although emphasis would be on DMHSA personnel, educational efforts would extend to other service agencies in order to improve coordinated support for SMI.

Lead Agency: DMHSA in conjunction with GMHPC, UOG, GCC and other support agencies and educational institutions together with the Guam Legislature (for funding).

Objective 4.2: Develop accurate statistical data on services provided and conduct an annual needs assessment in order to provide services in tune with requirements of the SMI.

Strategies for Implementation:

New computer systems have provided the capacity for better preservation of statistical information and analysis of on-going needs. This will improve with time and with the opening of the mental health facility. In 1990 a needs assessment was conducted to assess existing needs and to develop more accurate estimated of the number of SMI persons on Guam. See page 40 and Appendix D.

Lead Agency: DMHSA in conjunction with GMHPC.

Objective 4.3: Enhance the image of DMHSA and reduce stigma attached to receiving mental health services.

Status of Implementation:

A "Mental Health Week" was celebrated island-wide in 1990 and will be celebrated again in 1991. (See Appendix C.) Design a mass media campaign to coincide with the opening of the new DMHSA facility. Write articles and short reports on the various forms of mental illness and their treatment. Give descriptions of the various services, as spot advertisements on the TV/radio stations, and in Guam's two newspapers.

Lead Agency: DMHSA in conjunction with GMHPC, GAMI, the various advocacy groups on island, the UOG communications department and mass media on Guam.

Chapter 5

Seriously Emotionally Disturbed Children & Adolescents

CHAPTER V
SERIOUSLY EMOTIONALLY DISTURBED
CHILDREN AND ADOLESCENTS

The island of Guam does not provide a comprehensive system of mental health care services especially created for children. Rather, children and adolescents are being served by government agencies such as the Department of Mental Health and Substance Abuse according to the children's needs by the various existing programs and services. However, children's services are in the planning stages. One of the department's psychiatrists specializes in the treatment of children and adolescents, and he has been contributing to the planning in conjunction with the GMHPC. The new mental health facility, which began construction in January 1991, has a separate floor for children's services: e.g., counseling and a children's inpatient unit with 16 beds. Furthermore, efforts have begun in the realization of a children's residential treatment center. A 39-acre site has been located and funding is being sought by DMHSA for the design. Planning activities centered on transforming the existing array of mental health and other generic services into a comprehensive system of care available and accessible to all children and adolescents with serious emotional disturbances and their families.

A. Definition

After much deliberation, council and committee members agreed on the following definition:

"Children or adolescents up to and including the age of 18, with an Axis I DSM-III-R diagnosis of mental illness, who are significantly impaired for their age group; and that such conditions or behaviors have occurred for at least six months."

The criteria of diagnosis, disability and duration were addressed in this definition.

GMHPC members decided to use "serious emotional disturbances" rather than "severe mental or emotional illness" when discussing the conditions of the children and adolescents, as this seems to carry less stigma and holds greater hope for recovery. They also specified for inclusion: children and adolescents with Pervasive Personality Disorders; autism; mental illness of biological or organic origins; Attention Deficit/Hyperactive Disorders and other conduct disorders; anxiety disorders; avoidance disorders; depression with or without suicide attempts; disruptive anti-social behaviors; eating disorders; substance abuse; sexual abuse; dissociation disorders; elimination disorders; the traumatizing effects of physical, sexual, and/or emotional abuse; mental retardation with emotional abuse; mental health system.

A second category is children "at risk", and includes: a. children of mentally ill parents or parents who are substance abusers, b. offsprings of parents who have been abused, c. offsprings of teenage parents, d. children who have other handicapping conditions, and e. children who are clients of the Child Protective Services, such as abused and neglected children and those with failed adoptions or foster placements due to behavioral or emotional problems.

The third category is children who are considered to be socially maladjusted and presently classified as status offenders or juvenile delinquents by Guam's Criminal Justice System.

B. General Description of this Population

Children and adolescents with serious emotional disturbances have unique developmental needs and require specialized mental health and educational approaches. The general requirement is for a stable, affiliate family relationship which allows the acquisition of the social and practical skills necessary to perform the activities of daily living in accordance with the developmental stages of maturation. Families of these children need help in providing appropriate care and support. In situations where the family is unable to meet the child or adolescent's needs, alternative home environment must be found.

C. Number of SED Children and Adolescents

No reliable data exists on island for the number of SED children. DMHSA statistics show that 135 children and adolescents received therapeutic outpatient treatment during 1988, for an average monthly count of 10.1. Additionally, a monthly average of 3.8 patients were treated at Guma Man Hoben, the residential facility for children and adolescents. Only a very few number of children or adolescents were admitted to the inpatient facility due to its unsuitability for this age group. Unfortunately, at this time the above figures are not broken down into diagnostic categories. The proposed MIS (as described in Chapter III) will be able to provide such information during the next planning cycle.

Information from one of the private psychologists shows that therapeutic treatment was provided to approximately 95 children and adolescents and their families in the "at risk" category, and that she referred several to DMHSA for psychiatric treatment.

A further indication of children at risk and in need of services would be the statistics provided from the Child Protective Services, which indicate that 552 children were referred to this agency during FY 1988 and information from the Government of Guam Department of Youth Affairs, which operates a detention center for status offenders. In 1988, 492 children and adolescents aged 8 to 19 spent varying lengths of time in this facility.

Equally indicative of children at risk and in need of services are the statistics of the Diagnostic and Treatment Services, Division of Probation Services, Superior Court of Guam, which show that during 1988 counseling was provided to 316 young people.

To this must be added the number of youth who have sought shelter at SANCTUARY, a non-profit temporary residence for troubled children and adolescents who are unable to remain in their own homes for various reasons. During 1988, 67 children and adolescents sought shelter and services at SANCTUARY; an additional 25 received other services, such as crisis intervention, referral and counseling.

Yet another set of statistics helpful for the planning of services for emotionally disturbed children have been compiled from the records of the Government of Guam's Department of Education, Special Education Branch, which needed treatment from mental health professionals.

D. Needs Assessment

The various ways by which need for services is commonly assessed have been discussed in Chapter III, under the section of "System Concerns." At this

time, we only have the above cited statistics from the different agencies and programs concerned with the welfare of Guam's youth and the actual utilization data for children and adolescents who came to DMHSA for treatment. This data is believed to greatly under represent the population in need.

For lack of other information, prevalence estimates supplied by the Joint Commission on Mental Health were used to project the number of children and adolescents with serious emotional disturbances on Guam. These statistics claim that 11.8% of all children residing in the U.S. are in need of mental health services. Of those, 69% are considered to be "at risk": they already have a moderate level of impaired social functioning and are at risk of later developing mental and emotional disturbances. An additional 23% have a serious level of impaired social functioning, multi-agency need, and diagnosis of DSM III-R of short or long duration. Three percent have acute impairment of social functioning, a DSM III-R diagnosis, and multi-agency involvement, and may be dangerous to self or others. The other 5% have severe, persistent and pervasive impairment of social functioning, DSM III-R diagnosis, multi-agency involvement, and may present a danger to self or other.

Translated to Guam, these statistics would project the following number of children and adolescents with emotional problems, using the 1980 census (1990 not available) information as baseline data:

Total number of children through age 18:	47,965
Total number with emotional problems (11.8%)	5,660
Of those:	
"At Risk" (69%)	3,905
With serious impairment (23%)	1,301
With acute impairment (3%)	170
With severe and persistent impairment (5%)	283

Looking at the above figures, it becomes evident that the planning of a comprehensive, community-based system of care for this population must minimally be for 1,754 young people: those with serious, acute, or severe and persistent impairment. As the national estimates are considered to be very conservative by many mental health professionals and as Guam has a very high incidence of suicide attempts by children and adolescents, and since there is also a high prevalence of physical, sexual and emotional abuse, we should assume that the above figures are even higher. Additionally, Guam must also plan for the "at risk" category in this population, as the seeds for later serious, acute, or severe and persistent impairment are shown in this group.

E. Vision of an Ideal Mental Health Services System for Children

Children and adolescents with serious emotional disturbances should receive care from a comprehensive system of mental health and other necessary services to meet their multiple and changing needs. With this it is understood that a system of care is more than an array or a continuum of services; it contains the components and the mechanisms for services coordination and integration.

There are two important values which provide the basis for this vision:

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services to be provided, and
2. The system of care should be community-based, making it possible for services to be provided at the least restrictive level.

In addition, there are several guiding principles for this development of the proposed system of care:

1. Emotionally disturbed children should have ACCESS to all services that address the child's physical, emotional, social, educational, spiritual, vocational and recreational needs. Such services should be delivered irrespective of race, religion, ethnic origin, sex, physical disability or other characteristics, and should be sensitive and responsive to the cultural differences and traditional heritage of the people of Guam.
 2. Services should be INDIVIDUALIZED in accordance with the unique needs and potential of each child, as guided by an individual and comprehensive service plan, and the families or surrogate families of the emotionally disturbed children should be full participants in all aspects of planning and delivery of services.
 3. There should be mechanisms in place for PLANNING AND COORDINATING needed services from child-caring agencies and programs.
 4. CASE MANAGEMENT should be provided to emotionally disturbed children and their families to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the care system in accordance with their changing need.
 5. Services should be provided within the LEAST RESTRICTIVE AND MOST NORMATIVE ENVIRONMENT that is clinically appropriate. Institutionalization should be a last resort if all efforts in the natural setting fail.
 6. There should be a mechanism to ensure SMOOTH TRANSITION TO THE ADULT SERVICE SYSTEM, therefore emotionally disturbed children efforts should be promoted to the fullest extent.
 7. The RIGHTS of emotionally disturbed children must be protected at all times, and greater and more effective advocacy efforts should be promoted.
 8. It is absolutely imperative that PARENTS of emotionally disturbed children become FULL PARTNERS in the treatment of their children. Treatment should strengthen the FAMILY, not tear it apart.
 9. Efforts must be made to identify all FUNDING sources for the financing of services for children and adolescents.
- F. Guam's Services for Children with SED.

Children and adolescents with SED often require multiple services that involve several agencies. Below is a listing of services or programs that encompass the various needs and comply with the P.L. 99-660 and 101-639 mandates:

1. Health Services:

Opportunities for recreation are provided by the Department of Education, the Department of Parks and Recreation, the Department of Youth Affairs, and many military and private organizations, such as Little League and the various swimming clubs on Guam. Guam also has chapters of the Boy Scouts and Girl Scouts organizations of the U.S. which offer recreational activities as well as learning opportunities.

2. Mental Health Services:

Mental Health Services on Guam pretty much exemplify the opposite ends of the

spectrum: inpatient services at one end and outpatient services at the other. Several important community services are missing in this spectrum.

Inpatient services are rendered at the Department of Mental Health and Substance Abuse at the old Guam Memorial Hospital, a facility which Guam's consumers and providers alike consider unfit for human occupation. It is the only available facility on island for all mentally ill inpatients: the severely mentally ill (children and adults), alcohol and/or drug dependent patients, and forensic cases. Children under 16 are not admitted to the inpatient facility because it is an adult program.

Limited residential treatment is provided by Guma Man Hoben, a child and adolescent residential treatment center adjacent to the old Guam Memorial and DMHSA. The program is designed to serve its young clients in a comprehensive fashion by providing a continuum of services to enhance psychological coping mechanisms, social skills, educational and vocational opportunities and physical and spiritual well-being. Guma Man Hoben I and II are "open", non-secured facilities, and maximum length of stay is 24 months. A maximum of six young people can be accommodated in each facility, segregating male and female clients.

Outpatient services for SED children and adolescents include psychiatric evaluation and services; psychological evaluation through contract; emergency and crisis counseling; screening and evaluation for new clients; medication supervision; individual, family, and group therapeutic counseling; and at present very limited case management.

3. Rehabilitation Services:

Several government agencies provide rehabilitation services: A joint effort by the Department of Education's Special Education Program and the Guam Memorial Hospital offers occupational physical therapy and speech and language pathology. The Department of Vocational Rehabilitation offers other pertinent programs.

4. Employment Services:

Employment opportunities exist through various programs: DOE's Individual Transition Plan (ITP), Department of Vocational Rehabilitation's Individual Written Plan (IWRP), and summer employment programs by the Department of Youth Affairs and the Agency for Human Resources and Development which involve public and private companies.

5. Housing and Shelter:

Low-cost and Section 8 housing is available to eligible families through the Guam Housing and Urban Renewal Agency. However, there is a long waiting list and no priority is given to families with a problem child. Temporary shelter is provided by SANCTUARY, a non-profit organization. ALEE, a shelter operated by Catholic Social Services for victims of family violence, houses mothers and children on a temporary basis. Guma San Jose, also operated by CSS, provides short-term residential care to homeless individuals and families. Guma Mami, a non-profit facility, houses mentally retarded young adults. Guma Man Hoben I and II, residential treatment programs for children, are described under "Mental Health Services." The Department of Youth Affairs provides shelter for status offenders. Off-island placements are available for acute cases and plans for a therapeutic foster program and a children's residential treatment center-campus are seeing considerable progress.

6. Educational:

The Department of Education (DOE) is charged with the educational needs of all children on Guam, Kindergarten through Grade 12, including special education for gifted, exceptional, learning disabled or handicapped children according to their needs. An inter-agency agreement was drawn up between DOE and DMHSA and DOE for the three levels of care: 1st level - counselor provides therapeutic assistance for the child, 2nd level - DOE Special Education assistance in school, 3rd level - self-contained day school with consultation. All three levels of care are assisted by DMHSA.

In addition to providing alternative programs and home-bound instruction, DOE operates the Brodie Memorial School for mentally retarded children and youth. Guam also has many private schools, administered by Guam's various religious denominations.

The Guam Community College provides vocational instructions for Grades 10 - 12, and beyond. The Department of Youth Affairs (DYA) provides Juvenile Vocational Rehabilitation for its clients, and sponsors the Summer Employment Program for the island's high school students.

7. Medical and Dental Services:

Guam has an adequate number of medical and dental practitioners that provide services for people with health insurance or the financial means to pay for care. Families with restricted incomes are eligible to receive medical attention through the Maternal/Child Health program of DPHSS. In addition, the Medicaid and Medically Indigent Program (MIP) supply the means to secure medical services from private practitioners in the community. Dental care is provided free of charge to all of Guam's children up to the age of 16; children 16 to 18 receive dental care from private practitioners under reimbursement from Medicaid or MIP.

8. Social Services:

DPHSS administers the Child Protective Services (CPS). CPS investigates reported cases of child abuse and provides adoption and foster care services as well as homemaker assistance to troubled families. The Division of Medical Social Work, under the Bureau of Professional Support Services of DPHSS, provides intake, assessment, counseling and referral to needed community services for families and their children. The Guam Navy Family Service Center and the Anderson Air Force Base Family Service Center provide social work intervention to members of the military community.

9. Juvenile Services:

P.L. 17-12, the "Family Court Act," is the mandate "for the treatment or commitment of a mentally defective or mentally disordered or emotionally disturbed child." Court-ordered off-island placements, which the government may incur the cost, occur when the Territory of Guam lacks local provision of treatment for the child. The Diagnostic and Treatment Services Unit (DTSU) provides assessment and counseling to children who come in contact with the Family Division of the Superior Court as a result of delinquency, truancy, "beyond control" designation, or any person petitioned in need of services. If so ordered by the Family Court, children ages 8 to 18 are placed in the custody of the Department of Youth Affairs, which operates Juvenile Hall, Guam's Youth Correctional Facility.

10. Prevention Services (Including Substance Abuse):

A listing of available services would not be complete without a discussion of the many prevention programs on island. Especially networking was the teen suicide prevention and intervention program, based on an Interagency Agreement between DOE and DMHSA. DOE received the prevention training from DMHSA and now offers intervention counseling to students considered "at risk." A similar program is also provided by the Navy Family Services Center. In addition, the major child-oriented agencies and organizations sponsor programs geared towards the prevention of drug and alcohol abuse which certainly touches on the mental health of Guam's youth. (These programs are more specifically detailed in the chapter on the Prevention and Treatment of Alcohol and Other Drug Dependencies). Equally important are the programs designed to increase the youth's self-esteem and self-actualization, making them resistant to peer pressure, and enforcing emotional stability. Of similar importance are the parenting classes provided as a joint project between the Department of Public Health and Social Services and the University of Guam Extension services, which teach better parenting skills and hopefully, lead to the prevention of child abuse, and consequently, emotional disturbances of parents and children. DOE and DTSU also teach these classes. Chapter VII on the drug and alcohol issues provides a comprehensive description of prevention programs for children and adolescents.

11. Other Support Services:

Guam has a mandated Protection and Advocacy (P&A) program for Developmentally Disabled and Mentally Ill Individuals. This agency also operates the Client Assistance Program (CAP), and supports the Marianas Association for Retarded Citizens (MARC). Guam Legal Services Corporation and Public Defender Corporation offer legal services to children and adults who are eligible. The Western Pacific Association for the Disabled (WPAD) provides information, referral, and advocacy for disabled children and adults. The Guam Alliance for Mental Health, Inc. (GAMHI), a self-help, non-profit advocacy and support organization comprised of consumers, families and friends of mental health services, is at present not in operation. Related organizations are the Victims/Witness assistance program under the Attorney General's office, and the Victims Advocates Reaching Out (VARO) volunteer services and the Sons and Daughters United program for sexually abused children.

12. Financial Security:

The Department of Public Health and Social Services (DPHSS) administers the Aid to Families with Dependent Children. In addition, this Department also administers the Food Stamp Program and the WIC program, for which many of Guam's children are eligible.

G. Analysis and Discussion

Guam has all the generic health and social services that children and adolescents with SED might need. These services are available to anyone in need as long as they meet the eligibility criteria. Newly immigrated families from the other Micronesian islands or elsewhere might experience initial problems as some of these services are tied to a residency requirement. Nevertheless, children on island can have their basic needs for food, medical, dental, health, and education met by the existing services and programs. However, there is an urgent need for shelter, either in foster or group homes, for children without family who are housed at DYA's Juvenile Hall or Cottage Home, or SANCTUARY.

A definite lack of community-based mental health and specialized support

services to aid SED children and their families has been identified. Those needed services are, ordered from the least to the most restrictive, as follows:

1. Non-Residential Services:

- a. Organized prevention, early identification and intervention services, reaching across agencies and departments, and including public, military and private providers of child-oriented services.
- b. Case Management assigned to each SED child and his family to assure the most appropriate and timely services delivery, where the case manager becomes a partner with the child and his family to broker services for them, and advocates on their behalf.
- c. Home-based services, such as the Homebuilders program which proved to be very effective in the U.S. mainland, homemaker/home help services, and respite care.
- d. Day treatment, which combines education, therapeutic intervention and after-school recreational activities.
- e. Emergency/Crisis intervention, which includes 24-hour crisis telephone line, emergency outpatient services (by-passing the Guam Memorial Hospital ER), or mobile crisis teams which respond to children and families in crisis at their own home.
- f. Sufficient trained manpower to staff the above programs.

2. Residential Services:

- a. An increase in foster homes and the establishment of therapeutic foster homes staffed with well trained and supported foster parents.
- b. A new Residential Treatment Campus for children and adolescents, located in the community and away from the proposed new mental health facility, which will provide open and closed (non-secure and secure) therapeutic group care in home-like individual buildings.
- c. Therapeutic Camp Services to provide continuation of therapeutic treatment during the long periods of vacation (Christmas and summer time).
- d. A separation of Residential Shelter, Residential Detention, and Residential Correction Services, with the appropriate therapeutic modalities for each level, at the proposed new Department of Youth Affairs' Juvenile Detention Center.
- e. A segregated children's floor at the proposed new mental health care facility, which can provide limited respite care, limited crisis residential care, as well as inpatient hospitalization.
- f. Sufficiently trained manpower to staff the above facilities, programs and services in a professional manner.

The above identified needed services and programs would, in combination with the existing mental health care services and generic support services, constitute the components of the comprehensive community-based system of care.

Chapter III presents a detailed discussion of some of the access barriers to receiving mental health care. Two additional major barriers for receiving services for children were identified during council and committee meetings:

One deals with the lack of cooperation among service providers. This is described in greater detail in Chapter III under "Systems Concerns." Related to

this is the apparent lack of well-defined authority over the welfare of children and adolescents. The Department of Youth Affairs is charged, through Guam Public Law 14-110, with the well-being of the island's youth. Public Law 13-207 charges the Department of Education with the provision of necessary services to exceptional or handicapped children, including those with severe emotional disturbances. Public Law 17-21 charges the Department of Mental Health and Substance Abuse with the provision of services "to include as needed services for children, the elderly and adults." In addition, the juvenile services of the Family Court of Guam's Criminal Justice System are charged with providing mental health services (diagnosis and treatment) to status offenders who might, or might not, have serious emotional disturbances.

The second concern deals with the frustrations suffered by parents when they try to negotiate the bureaucratic maze to procure services for their children. At the planning workshops, consumer-parents greatly lamented the lack of "human touch" in the delivery of services. They also complained that they are often not well informed about their rights and their children's rights and what role they can play to help make the system work more efficiently and effectively for their children. Parents who are "aggressive" are seen as troublemakers, yet it seems that only brash assertiveness can "get things done." Another complaint is that professionals use educational or mental health jargon, which is not easily understood by many parents and excludes them from decision-making process. Often parents get so frustrated and angry at teachers and mental health professionals that their emotions hinder productive communication. Parents feel that professionals are on a "power trip," that they take control of their lives and the lives of their children, that the children become the property of the various departments. They become "Special Ed children" or "Mental Health children" and parental authority is usurped, leading to an even greater division in an already troubled family situation. This litany could continue, and is only in part mitigated by the fact that parents on the mainland are faced with the same problems. They seek practical solutions through the formation of support and advocacy groups and greater interaction with the mental health care system. Parents on Guam have voiced their intention to do the same and are now organizing themselves to create a collective and stronger voice in the community.

H. GOALS, OBJECTIVES AND STRATEGIES

The previously mentioned programs, services and actions are needed components of the envisioned comprehensive community-based care system. It is possible to have such a system on Guam that emulates the "spirit" of Public Laws 99-660 and 101-639, but financial and manpower constraints will always be taken into consideration discussing Goals and Objectives for the next three years.

NON-RESIDENTIAL SERVICES

GOAL 1: PROVIDE PREVENTION, EARLY IDENTIFICATION AND INTERVENTION SERVICES, REACHING ACROSS AGENCIES AND DEPARTMENTS AND INCLUDING MILITARY AND PRIVATE PROVIDERS OF CHILD-ORIENTED SERVICES TO DECREASE THE PREVALENCE OF SUICIDE ATTEMPTS AND SERIOUS EMOTIONAL DISTURBANCE.

Objective 1.1: To achieve a 20% reduction in attempted suicides by children and adolescents by 1992.

Status of Implementation:

Through an inter-agency agreement in 1990, the Department of Education (DOE) received early identification training by DMHSA Counseling on "high risk" children and adolescents. DOE is now equipped to identify possible suicide risks and provide appropriate counseling, rather than have the child referred to DMHSA.

In 1990, make an inventory of all available services in this category and evaluate them for their appropriateness - ACCOMPLISHED.

In 1991, convene a working group under the direction of the GMHPC committee for this priority population and develop a prevention, identification and intervention program - ACCOMPLISHED. *This committee is known as the Committee for Children and Adolescents with Serious Emotional Disturbances.*

In 1992, implement this program island-wide and evaluate its effectiveness at the end of the year.

Lead Agency: GMHPC in coordination with DMHSA's Research, Planning and Development unit and in conjunction with GMHPC and the cooperation of DOE, DYA, DPHSS, Family Court, Navy Family Center, AAFB Family Services Center, pediatricians physicians, psychiatrists, psychologists and other mental health care providers.

GOAL 2: CASE MANAGEMENT SERVICES SHALL BE PROVIDED TO AT LEAST 75-100 CHILDREN AND ADOLESCENTS DEEMED HIGH-RISK OF SED OR DIAGNOSED WITH SED BY 1992.

Objective 2.1: To improve access to all necessary services and coordination within the case management system in a "user friendly" manner for all children currently in the system and each newly diagnosed child.

Status of implementation:

In 1990, hire one social worker and one Program Aide II for DOE's Headstart Program and one full-time case manager for DMHSA - ACCOMPLISHED.

Lead Agency: DMHSA and DOE (Headstart Program).

GOAL 3: WITHIN THE NEXT THREE YEARS (1989 - 1992), ADD HOME-BASED SERVICES TO THE COMPREHENSIVE CARE SYSTEM FOR SED CHILDREN AND ADOLESCENTS.

Objective 3.1: To minimize inappropriate admissions to inpatient and residential services.

Objective 3.2: To provide therapeutic care in the most normative and least restrictive setting.

Strategies for Implementation:

In 1990, investigate the feasibility of the Homebuilders program. Make a cost/benefit analysis based on the experience of other communities.

Also in 1990, identify community workers who are willing to be trained as home care assistants and respite workers for families with SED children. Design a curriculum of four-contact hours to train these workers. In order to make the services culture-relevant, priority for recruitment and training should be given to members of the extended family.

In 1991, deploy the home care assistants and respite workers as needed. Identify Homebuilder Program funding sources for this program.

In 1992, recruit manpower for the Homebuilder Program and commence training. Training will depend on the educational level and previous experience of the recruits. Deploy Homebuilders after training.

Evaluate the success of the home care assistants and respite workers. Success will be measured by client satisfaction and decreases contact with the mental health care system for emergency care.

Leading Agency: DMHSA in conjunction with GMHPC's committee for this target population, and the University of Guam's Departments of Nursing, Social Work, and Psychology for training needs.

GOAL 4: ESTABLISH A COMPREHENSIVE DAY TREATMENT PROGRAM WHICH COMBINES EDUCATIONAL AND THERAPEUTIC INTERVENTION WITH AFTER SCHOOL RECREATION BY 1992.

Objective 4.1: To provide a structured, therapeutic environment during and after school hours, spanning the working day.

Status of Implementation:

In 1990, investigate the feasibility of a cooperative agreement between DOE-Special Education, DMHSA and the Department of Parks and Recreation to provide such services - **ACCOMPLISHED.**

Identify needed manpower, training for such manpower, and funding for the program.

In 1991, implement the program and enroll SED children and adolescents - **ACCOMPLISHED.**

In 1992, evaluate the program. Success will be measured by client satisfaction and decreased contact with the mental health care system.

Lead Agency: DMHSA, in conjunction with the GMHPC committee for this target population and close cooperation with DOE-Special Education the Department of Parks and Recreation and the University of Guam's Physical Education Department.

GOAL 5: INSTITUTE 24-HOUR EMERGENCY/CRISIS INTERVENTION SERVICES, WHICH SHALL INCLUDE A 24-HOUR CRISIS HOTLINE, EMERGENCY OUTPATIENT SERVICES, AND MOBILE CRISIS TEAMS FOR HOME INTERVENTION BY 1992.

Objective 5.1: To provide to children and adolescents with SED and their families immediate help during crisis or emergency.

Objective 5.2: To prevent inappropriate involvement of public safety officers and inappropriate treatment at either the GMH ER or DMHSA inpatient facility.

Status of Implementation:

The Crisis Hotline was implemented in 1991. (See Appendix H.)

Acquire additional FTE and funds to next year's (1991) budget request. Make a cost/benefit analysis for the Crisis Intervention Services. Recruit and train staff.

Lead Agency: DMHSA, GMHPC, in conjunction with Parent Advocacy Group.

RESIDENTIAL SERVICES

GOAL 6: MAKE AVAILABLE A SUFFICIENT NUMBER OF THERAPEUTIC FOSTER HOMES FOR AT LEAST 20 CHILDREN AND ADOLESCENTS WITH SED TO FILL EXISTING AND PROJECTED NEEDS BY 1992.

Objective 6.1: To provide alternative residential treatment to DYA, Cottage Homes, SANCTUARY, Guma Man Hoben, or inpatient care.

Objective 6.2: To identify and train parents/personnel for at least six (6) such homes over the next three years.

Status of Implementation:

\$304,857.00 has been requested by DMHSA for FY '92 for funding of six therapeutic foster homes and parents.

In 1991, train foster parents and start a foster parent support group. After training, assign children to the foster homes.

In 1992, evaluate the success of foster homes by measuring length of stay in the foster home and willingness of the foster parents to accept new children in their home.

Lead Agency: DMHSA, in conjunction with GMHPC's committee for this target population and in close cooperation with DPHSS Child Protective Services, the Family Court, DYA, SANCTUARY and the University of Guam for training needs.

GOAL 7: BUILD A RESIDENTIAL TREATMENT CAMPUS FOR AT LEAST 60-70 CHILDREN AND ADOLESCENTS, LOCATED IN THE COMMUNITY BY 1992.

Objective 7.1: To provide appropriate residential services at levels best suited to each individual client.

Objective 7.2: To prevent inappropriate inpatient treatment.

Status of Implementation:

A 39-acre site has been located, \$30,000 has been appropriated for surveying and legislation (Bill 197) has been written for funding the master plan.

Lead Agency: DMHSA Administration, in conjunction with the Government of Guam Executive and Legislative Branches, with lobbying support from GMHPC members, providers and consumers.

GOAL 8: ADD THERAPEUTIC CAMP SERVICES TO THE DAY TREATMENT SERVICES FOR AT LEAST 75-100 CHILDREN AND ADOLESCENTS WITH SED BY 1992.

Objective 8.1: To provide continuation of therapeutic treatment instigated during the school year during the long periods of vacation time, e.g., Christmas and summer seasons.

Status of Implementation:

ACCOMPLISHED as a result of the implementation of a summer program initiated by DOE's Special Education Section. Fifteen students from the fourth to eighth grade participated in the initial program.

In 1992, evaluate the program. Measure success by continuous attendance and client satisfaction.

Lead Agency: DOE, in conjunction with the GMHPC's committee for this target population and the above named agencies and organizations.

GOAL 9: ESTABLISH INPATIENT HOSPITAL FACILITIES FOR CHILDREN AND ADOLESCENTS WITH SED BY 1992.

Objective 9.1: To provide appropriate inpatient care separated from adults with mental illness, alcohol and drug dependent patients, and forensic cases, in an environment conducive to treatment and improvement.

Status of Implementation:

Two beds currently exist at the Guam Memorial Hospital.

Construction for Phase I (1st and 2nd of 3 floors) of the new Mental Health and Substance Abuse Facility commenced on January 1991. This new facility will have a separate children's floor with 16 beds, expandable to 20 beds.

Occupancy is expected to occur during the latter part of 1993.

Lead Agency: DMHSA, GMHPC, the Executive Legislative Branches for the continuation of construction funding.

GOAL 10: CONTINUALLY AND ENERGETICALLY RECRUIT MENTAL HEALTH CARE MANPOWER ON AND OFF-ISLAND TO SATISFY THE STAFFING NEEDS OF THE VARIOUS SERVICES AND PROGRAMS OF DMHSA AND OTHER RELATED SERVICES ON ISLAND.

Objective 10.1: To provide appropriate and continuous care by professional staff to children and adolescents with SED.

Status of Implementation:

Additional staff was hired for Case Management, Counseling and Guma Manhoben I & II.

Lead Agency: DMHSA, GMHPC, in conjunction with DOA and UOG for training and education.

GOAL 11: ENHANCE TREATMENT AND CARE FOR SED CHILDREN AND ADOLESCENTS BY EMPOWERING THEIR PARENTS AND FAMILIES TO PARTICIPATE IN THE TREATMENT OF THEIR CHILDREN AND THE PLANNING AND IMPLEMENTATION OF NEW SERVICES.

Objective 11.1: To provide support and technical assistance for the formation of a private, non-profit Parent's Advocacy Group not connected to any Government office or agency.

Strategies for Implementation:

Invite parents to form an Advocacy Group. Educate the Parent's Advocacy Group about all aspects, causes, diagnosis, treatment and care of SED. Assist the group in identifying local and federal information and resources.

Assist with the identification of funding sources and the preparation of grant proposals for funds to operate the Parent's Advocacy Group.

The group plans to open an information and referral center to minimize "runaround" and to identify the responsible agency for treatment.

The group would like to become the locus of responsibility, i.e. function as "ombudsman" for children with SED and their families. They also would like to contract with DMHSA and DOE for case management services, as it is felt that a non-profit, private agency would not be as much hampered by bureaucracy and loyalty to a particular department as either DMHSA or DOE employees, and since parents, who have been through the system, "know the ropes."

The group hopes to tap into the voluntary and civic

organizations on island, in order to secure funding support as well as identify "foster grandparents" or other volunteers willing to work with the group and SED children.

The group wants to establish a "Family Buddy System" by which families from the same ethnic background as the SED child and his family would give support in a culturally appropriate fashion, particularly to newly arrived immigrants.

The group wants to explore the natural support systems of families with SED, such as extended families, neighbors, village mayors and parish priests and clergy, to see what kind of support can be gained from them.

Objective 11.2: To provide to clients and their families convenient access to mental health services.

Strategies for Implementation:

Lobbying for greater sensitivity in scheduling appointments and therapy sessions. Government agencies and offices should conduct business until 9:00 P.M. at least once a week to allow the procurement of services without losing time from work. The same applies to counseling sessions. Also, the proposed group would like to see family counseling be provided in the natural setting, i.e., the home, during early evening hours of weekdays and/or on weekends.

Lead Agency: DMHSA with the GMHPC's committee for SED children, the Advocacy and Protection office, and WPAD.

GOAL 12: PROVIDE TRAINING TO ALL INDIVIDUALS WORKING WITH OR SERVING CHILDREN AND ADOLESCENTS WITH SED AND THEIR FAMILIES.

Objective 12.1: To bring in professional(s) specializing in children and adolescents with SED living in cross-cultural environments.

Lead Agency: DMHSA, DOE's Special Education Section and Headstart Program, and Parent Advocates.

GOAL 13: AT THE PROPOSED NEW DEPARTMENT OF YOUTH FACILITY, SEPARATE THE RESIDENTIAL SHELTER FROM RESIDENTIAL DETENTION AND RESIDENTIAL CORRECTIONS SERVICES.

Objective 13.1: To provide shelter, security, diagnosis, treatment and rehabilitation at the level most appropriate to each individual residential at the DYA juvenile correction center.

Strategies for Implementation:

Continue previous and present efforts of DMHSA staff to affect the above necessary separation of court-ordered placements at DYA. Continue with technical assistance in regard to programming and staffing of services at three levels.

Lead Agencies: Department of Youth Affairs, in cooperation with the Family Court and the Diagnosis Treatment Unit of the Superior Court, with technical assistance from DMHSA and GMHPC and the participation of a parent's representative to monitor and evaluate process and programs.

I. Transitional Services for SED Children and Adolescents.

A fully integrated, community-wide system of care for children and adolescents with SED should make provisions for a smooth transition from children's services to the adult world and adult mental health care and support services.

There are many factors which hamper such a smooth transition. Adolescents don't cease to be ill on their 18th birthday; they "age out" of services designed for children and adolescents and become young adults still in need of mental health care and other support services, often for long periods of time. "Aging out" usually means a transition from school to the world of work, but many young adults have no prevocational or vocational training and are not employable. Further, they may not be viewed positively by vocational rehabilitation agencies which look for successful outcomes in job placement.

There are also philosophical differences which may complicate the transition from the child to the adult service system. While the system of care for children and adolescents is based on a growth-promoting, "habilitative" philosophy, the adult service system is based on a philosophy of disability and rehabilitation. This might present problems for youths and their families, possibly discouraging their use of needed adult services (Stroul & Friedman, 1986).

Guam has, at this time, no specially designated services for children and adolescents with SED, and consequently, there are no transitional services. Rather, children and adolescents are treated according to their need, and not their age. If a young person is unwilling or unable to pursue an academic education, he or she will be encouraged and guided to the Guam Community College for prevocational and vocational training, if at all possible. At age 18, the Department of Vocational Rehabilitation takes over. Therapeutic counseling continues at DMHSA, usually with the same counselor, to prevent interruption of treatment. However, once DMHSA implements special children's services with the completion of the new facility, transitional services will become a services component.

J. Financing for the Care of SED Children

Special local funding is available for the care of children and adolescents with SED: Guma Manhoben I & II, the proposed children's residential treatment center, the proposed therapeutic foster care program. DMHSA depends on the federal block grant and local appropriations for the financing of various services. Construction funding for the new mental health facility, which includes the separate children's unit, comes partly from the Department of the Interior, and in part from the local General Fund.

1. Request an increase in local appropriations, especially earmarked for children's mental health care needs.
2. Apply for CASSP grants from the National Institute of Mental Health, Child and Adolescent Service System Program, in order to affect the necessary changes and add the programs and services needed to provide a responsible community-based system of care to Guam's children and adolescents with

SED.

3. Investigate private foundations, such as the Wood Johnson Foundations for the possible funding of a demonstration project for SED children. If available, DMHSA will apply for such funds.
4. Instigate a fee-schedule, making it possible to receive revenues from third-party reimbursements and self-pay.
5. Use multi-source funding for several proposed projects, such as the Foster Care, Therapeutic Foster Care, Respite Care and the Homebuilder, Day Treatment and Day Camp programs, as well as the planned Residential Treatment Center. Federal and local funds will be combined in all these instances.

Chapter 6

Mentally Ill Homeless

CHAPTER VI

MENTALLY ILL HOMELESS

Homelessness is more than not having a place of residence. It also involves a lack of food, clothing, medical services and social support. Furthermore, it is associated with feelings of hopelessness, helplessness and despair. While there are many economic and social reasons for being homeless, mental illness is a major one.

No reliable figures are available at this time but nation-wide estimates claim that 30% to 50% of the homeless are severely and/or chronically mentally ill (Vergare, 1986).

Mental illness exacerbates homelessness, which certainly does not improve a person's mental health. Mainland research is attempting to determine if homelessness leads to meeting life's demands with difficulties or, conversely, if mental illness precedes homelessness (Hall, 1987). Initial findings suggest that poor mental health leads to an inability to cope with many aspects of daily living and may result in homelessness. However, it is also argued that those initially without significant mental illness may become overwhelmed by a homeless lifestyle and subsequently develop complex symptoms. It seems that there is a reciprocally determined relationship between homelessness and mental illness (Lamb, 1984).

The mentally ill homeless encounter a multiplicity of problems. They lack financial resources, are often involved with alcohol or other drug abuse which exacerbate symptoms, and are often arrested for "unusual" behavior. They become fearful, distrusting and withdrawn from others (Bachrach, 1984). Living in poor and dangerous conditions without proper hygiene and nutrition, many lead to medical problems of infestation, infection, peripheral vascular disease, cellulitis, leg ulcers, and a variety of other chronic diseases. Major and petty trauma is frequent, second only to robbery, assault, and rape cases.

The homeless mentally ill population has become a sizeable problem in the U.S. mainland. Estimates range from a conservative figure of 300,000 to over 2 million. Several social, political and economic factors contribute to homelessness in the mentally ill population, but the largest factor is the de-institutionalization policy in the 1960s and 1970s when many mentally ill were removed from what was then considered anti-therapeutic living conditions in large state mental hospitals. Unfortunately, these mentally ill persons were without skills to function in their new social environment and the newly established community mental health centers did not have enough funding or trained personnel to provide care in an adequate manner. The result was homelessness for many, and their numbers continue to increase.

A. Guam's Mentally Ill Homeless

Guam has never had a state mental health facility and there are only 17 inpatient beds available for a mix of mental health patients of all ages and diagnoses. One can hardly blame de-institutionalization for the homeless found on the island. In fact, there are quite a few people willing to state that Guam does not have a problem with homeless people, except perhaps for the occasional "eccentric" or "post-hippy" transient who can be seen roaming the streets and beaches on occasion. Generally, people are more embarrassed by these people's presence than annoyed but it was felt that sooner or later these people will leave the island for some other destination. This myth, however, masks a very real and growing problem on Guam.

It was not difficult for the GMHPC members to identify and define the homeless on Guam. Council members who are also providers of social services are well aware of this particular problem and also know where the homeless can be found: on particular beaches, in public places, abandoned dwellings, and certain fast food restaurants with tolerant management. Guam has some features shared with only a few places in the U.S.: a year-round tropical climate, easily accessible showers on the public beaches, and fairly tolerant attitudes towards individual life styles. Consequently, it was harder to quantify the number of homeless mentally ill since it can be assumed that some people have come to Guam to enjoy the "alternative" lifestyle of a "beach bum", roaming the beaches by day and sleeping in picnic shelters at night. It also happens that individuals come to Guam virtually on their last penny after having spent considerable time traveling in the Asian countries or Australia. They throw themselves on the mercy of Guam's social system, ask for help from home, or are eventually gone again - sometimes with a airline ticket provided by the Government of Guam or Catholic Social Services. These homeless people were eliminated from the council's consideration.

There is a second group of homeless individuals on island warranting more attention. They are some of the newly arrived immigrants from the other Micronesian islands who have not found work and consequently cannot afford to rent a place to live in. There is a long waiting list for low-cost housing, so shelter has to be found elsewhere, usually in an abandoned house or someone's garage or shed.

While this problem should also be attended to, the GMHPC members decided to prioritize and focus on the third category of homeless people: those without a home and little chance of getting one because of their precarious physical and mental conditions and exceptional circumstances.

B. Definition

There was agreement among council members that the general term "homeless" means being "without a fixed place of residence." To comply with the stipulations of P.L. 99-660 and 101-639, the "homeless" definition along with the one for "seriously mentally ill," as established in Chapter IV, resulted in a definition for the "homeless mentally ill." However, the GMHPC members and the participants of workshops and meetings agreed that such a definition would not address the most needy and vulnerable of the island's homeless individuals. Consequently, the council formulated the following definition:

"Guam's homeless mentally ill are persons with mental illness, emotional disturbances, or mental retardation, who do not have their basic needs of shelter, security and food met and who have no means to secure them. They may be living in a dwelling but without support or structure, which negates their ability to progress and grow forward in a constructive way."

It must be noted that this definition includes the mentally retarded as well as the mentally ill, and addresses the population at risk, e.g., persons who might become homeless for lack of care or support, and children and adolescents without a home who are currently housed at the Department of Youth Affairs' Juvenile Hall and Cottage Homes, at SANCTUARY or at DMHSA's Guma Man Hoben.

C. General Description of this Population

Homeless mentally ill, retarded or emotionally disturbed persons are individuals with differing and varying wants and needs. The causes for homelessness might be 1) eviction due to non-payment of rent and/or a poor landlord-tenant relationship, 2) inability or unwillingness of family members or friends to continue with care previously given, 3) an actual attempt at independence which has failed, or 4) a breakdown in the social network which has allowed a vulnerable client to slip from its protection. While behavior and level of functioning might be similar to that of other persons with serious mental illness, some special characteristics apply to this particular population:

1. There is a basic and immediate need for a place to live, for food, medical attention and financial assistance.
2. The prevalence of drug and alcohol abuse is generally higher.
3. There is usually a low level of interest or even a reluctance to seek mental health services.
4. There is rarely an advocate or confidant familiar with the person's circumstances leading to homelessness;
5. Members of this target population are much more at risk for being victims of accidents and crime.

D. Number of Mentally Ill Homeless

Guam, like most communities in the U.S. Mainland, has no reliable statistics on the mentally ill homeless. However, some approximate figures were made available by mental health and social service providers.

In the 9-30-89 submittal it was stated that there were "between 15 to 18 mentally ill persons, past and present clients of DMHSA, requiring care in a residential treatment facility as other living arrangements have become impossible or anti-therapeutic". The adult residential facility has become a reality and now supervises sixteen units. Most of the mentioned clients are now granted the opportunity to live in a less restrictive environment. The old plan also mentioned that "There are between 8 to 10 retarded persons with severe emotional disturbances and/or behavioral problems, and two such persons are cared for off-island." A group home now exists, known as the Mary Clare Home, and cares for many of these individuals. The old plan further states that "there are approximately 15 to 20 young people in residential care at the Juvenile Hall of the Department of Youth Affairs, SANCTUARY and Guma Man Hoben who have no home to return to. In addition, two youths receive care in a residential treatment center off-island for lack of appropriate facilities on Guam. Plans are underway for a comprehensive treatment facility for children and adolescents with severe emotional disturbances, and another group home was implemented at DMHSA known as Guma Manhoben II to separate the female from male clients. Again, the old plan stated that "Catholic Social Services reported that they provided temporary shelter and food at Guma San Jose to 36 "mentally unstable" persons from Oct. 1988 through July 1989. The Department of Vocational Rehabilitation reported two handicapped persons as homeless. Altogether we can count between 60 and 65 adults and 20 to 25 youth in need of suitable and appropriate living arrangements.

DMHSA granted the St. Vincent de Paul Society \$29,000.00 to operate a drop-in center, which was Goal 1 of the old plan, for homeless persons. The drop-in center, known as Guma San Francisco, officially opened on October 24, 1990 and

now can serve any homeless person.

E. Needs Assessment

The principles of a thorough needs assessment have been described in Chapter III. It is questionable whether these principles can be wholly translated to the homeless population on island since there are several problems with data collection. For one, in and out-migration of persons is not monitored. The records of Guam's police department are of little help either. Guam either does not have a "vagrancy" or "loitering" law or it is not well enforced due to its ambiguity and the trouble these laws cause in other jurisdictions. Homelessness comes to the attention of local authorities when something goes wrong. A complaint about "trespassing", "disorderly conduct" or "public intoxication" might cause incarceration at the Rosario Detention Center for a night, followed by release the next day. The records for these misdemeanors do not identify homelessness. By the same token a homeless person might or appear to be ill and is thus transported to the hospital's emergency room. There are no criteria or standard procedures by which to identify a homeless person and it is at the discretion of the attending physician at the Emergency Room whether mental health staff should be called in for a mental health status assessment. Often a person is released without social support or a follow-up of the person is not requested. Only through outreach services and direct information from the populace can one presently gain an approximate oversight of the number of homeless. To these numbers might be added another set of figures: persons who come to the mental health and/or social service authorities or the police department asking for help in placing a mentally ill and/or retarded or socially maladjusted relative in temporary or permanent custody or alternate living arrangements. These persons can be seen as being "at risk" of becoming homeless.

F. Vision of an Ideal System for the Mentally Ill Homeless

The GMHPC members allowed themselves only one vision for this particular population: there should be NO homeless mentally ill person on Guam. Living arrangements, programs and services for each individual, and programs unique and appropriate to the person's condition and age shall be provided by a community-based comprehensive system of care with the same underlying values as described for seriously mentally ill adults in Chapter IV and for children and adolescents with serious emotional disturbances in Chapter V.

G. Guam's Services for the Mentally Ill Homeless

The available generic social and health services and the mental health care services, described and discussed earlier in Chapters IV and V, are available to the homeless mentally ill population once they have been identified and are willing to accept assistance.

H. Analysis and Description

Homelessness is a relatively new phenomenon on Guam. Perhaps one can see it as another undesirable aspect of westernization. There is hardly a social problem found in the U.S. that cannot be encountered on Guam, albeit on a smaller scale and proportionate to the population.

While not all of the homeless are mentally ill, their lifestyle and behaviors are

seen as dysfunctional by society. If at all possible, homeless persons visible on the beaches, in public picnic areas and around government agencies and certain restaurants are ignored, if not shunned, by the community. The less visible ones are being sheltered and cared for by some of the island's mayors, by Catholic Social Services' ALEE shelter (for victims of wife and child abuse), at Guma San Jose shelter (for homeless men and families) or at Guma San Francisco (temporary shelter for any homeless person). Homeless children and adolescents, in addition to the above-mentioned services, can be cared for at the Department of Youth Affairs' Juvenile Hall and Cottage Homes, SANCTUARY, and DMHSA's Guma Man Hoben. The latter group is always at risk of becoming the "visible" homeless.

Homelessness is a problem in society, yet at the same time society seems to greatly contribute to the problem. Council members agree that the burden of caring for a mentally ill or emotionally disturbed child or adult over long periods of time often becomes too much for a family. Without proper intervention and support, families find themselves unable to shoulder this burden any longer, leaving the children or adults to fend for themselves or causing them to be admitted to an inappropriate program. Additionally, a number of emotionally disturbed children are locked up in their homes without any of the necessary therapeutic support services. They have a roof over their heads but in a non-therapeutic environment. Others have a "home" per se, but the home is not appropriate for their care for any number of reasons. All of these children and young adults again are potentially the homeless of the future.

Two issues eventually become central to the planning process for the target population: the identification of the homeless mentally ill on island and the prevention of future homeless individuals.

Several services or programs were seen as essential to accomplish these two tasks:

1. The establishment of an outreach program for this target population. There are two ways of doing this: by going to places that the homeless are commonly found, and by establishing a drop-in center, which the homeless can go to for day time shelter, nourishment, showers, clothing, and above all, information about other available services.

The Drop-In Center has become a reality for Guam. DMHSA staff also acquired a grant for special funds for the mentally ill homeless. DMHSA assisted the community in establishing this center and will train and provide personnel. It was a joint DMHSA/community effort by which business organizations and civic groups were asked to donate, food, clothing, soap and towels and volunteer manpower. It is anticipated that by word-of-mouth the homeless will come to the Drop-In Center and mental health staff will help identify those in need of mental health services and make the appropriate referrals for treatment and case management for linkage with the generic support system. It is also hoped that the homeless, by attending the center, will identify others in the community unwilling to visit the center. Outreach teams from DMHSA will then try to find these persons to make a field assessment and to invite them to partake of the available mental health and other services.

2. Education and training of police officers, ambulance attendants, correction officers at the Rosario Detention Center and Hospital Emergency Room staff are seen as an essential part of the outreach/identification program for the homeless mentally ill. Council members feel that police and correction officers do not always know the difference between intoxication by alcohol and drugs or belligerence, physical or mental illness. It has happened in the past that physically or mentally ill persons were detained and mishandled at the detention facility when immediate medical attention was necessary.

In addition, all homeless persons coming in contact with the law enforcement or ambulance/hospital system should be reported to DMHSA at once so an assessment and possible intake can be initiated. This will initially take a major effort and a great deal of cooperation. In the long run, however, it will make everybody's job easier and will improve services to the homeless mentally ill.

3. A change in local law seems necessary. Existing laws do not make any provisions for committing mentally retarded adults who are dangerous to themselves and others to special residential facilities. It should be determined if such a civil commitment law is in the best interest of this particular population and whether such a law would decrease homelessness among the mentally retarded.
4. The old plan stated that "A 'closed' or 'secure' residential facility for mentally retarded persons with emotional disturbance and/or severe behavior problems is absolutely necessary. This need has been recognized for a number of years and is currently being addressed. Staff of Guma' Mami, the "open" residential facility for mentally retarded persons, are preparing a proposal for such a facility which could house four to six individuals." This group home has been accomplished and is now known as the Mary Clare Home.

The above listed services and programs need to be combined with the services already described for the severely mentally ill adults and children and adolescents with SED in order to provide a comprehensive system of care for this very special population.

The homeless mentally ill have the same basic needs of shelter, security, food, medical care, transportation and financial support. Shelter is the paramount necessity among those listed. This population needs the therapeutic services provided by DMHSA appropriate to their diagnosis. Case management will be instrumental in providing proper linkage with the generic support services. None of this will be effectual unless the community becomes aware of and acknowledges the mentally ill homeless population and recognizes their need and worthiness for care and concern. A community ought to take care of all its members, regardless of their circumstance and "worthiness." Every person should take to heart the observation of the theologian Karl Barth:

"No community, whether family, village, or state, is really strong if it will not carry its weak and even its very weakest members. They belong to it no less than the strong, and the quiet work of their maintenance and care, which might seem useless from a superficial view, is perhaps more effective than common labor or cultural or historical conflict in knitting it closely or securely together."

The sentiments of this statement are particularly pertinent to the population of Guam, as there is a centuries-old tradition of providing care to all in need within the extended family and community. However, this tradition has been weakened by demographic changes, modernization, and western acculturation. In Guam, as everywhere else, the question of resource allocation must be kept in mind but not at the expense of those most in need.

I. GOALS, OBJECTIVES AND STRATEGIES

Some of the goals, objectives and strategies listed in Chapters IV and V are also applicable for the Mentally Ill Homeless. (See Appendix F for planning process.) Below are some specific goals for this population:

- GOAL 1A:** ENSURE THAT EVERY SERIOUSLY MENTALLY ILL PERSON RECEIVES APPROPRIATE TREATMENT FROM DMHSA AND HAS THE OPPORTUNITY TO OBTAIN HOUSING, REHABILITATION, AND OTHER PERTINENT SERVICES AND SUPPORTS BY 1992. DURING THE FIRST YEAR OF OPERATION THE CENTER WILL FULLY MEET THE SERVICE NEEDS OF AT LEAST 75% OF ALL CLIENTS SERVED.
- GOAL 1B:** REDUCE THE NUMBER OF INDIVIDUALS WHO ARE HOMELESS, INCLUDING THE MENTALLY ILL WITH AT LEAST 200 INDIVIDUALS SERVED EACH YEAR FROM 1989 - 1992.
- Objective 1.1:** Establish a Drop-In Center for Guam's homeless population who are without a permanent residence and/or are mentally ill by 1990.
- Objective 1.2:** Public awareness will be increased so local mayors, officials, police officers, or private citizens refer homeless people to the center.
- Objective 1.3:** Homeless, including mentally ill homeless, will come in to the center for meals, showers, and changing/washing clothes. During this intake and service delivery, a survey of needs will be made and referrals arranged.
- Objective 1.4:** Trained DMHSA staff will be on-call to observe the homeless for signs of mental illness. In collaboration with inter-agency linkages (referrals), all homeless, including the seriously mentally ill population, will be offered the opportunity for mental health treatment, housing assistance, and other services and support available on island.

Status of Implementation:

A Drop-in Center has been established under the leadership of the St. Vincent de Paul Society on Guam through the assistance of the Mentally Ill Homeless Committee networking in the community. (See Appendix G.) The committee will continue planning workshops to develop the operations of the Drop-In Center.

It is expected that the homeless mentally ill will come to the Drop-Center for food, showers, short-term emergency accommodations and counseling/referral assistance, etc.

The Drop-In Center will be under the management of the St. Vincent de Paul Society. Trained DMHSA staff, on call, will observe the homeless for signs of mental illness and offer them the opportunity for treatment. In collaboration with

inter-agency linkages, i.e., Guma Mami, Guma Manhoben, CSS, GHURA, Department of Public Health and Social Services, Advocacy Office, etc., referrals will be arranged to assist clients with personal and employment skills, and other services and supports available on island.

A measure of successful outcome is the number of homeless individuals who will receive treatment from DMHSA by the end of the year.

An evaluation assessment tool will be developed as a means of determining how many of the expected 200 individuals to be served are mentally ill and the level of satisfactory service delivery attempting to meet their needs.

Lead Agencies: DMHSA will maintain the communication and partnerships of the Mental Health Planning Council, its Committee on the Mentally Ill Homeless Population (see Appendix F) and the St. Vincent de Paul Society, which will develop and implement the strategies for achieving Goals 1A and 1B.

GOAL 2: ESTABLISH APPROPRIATE FACILITIES ADEQUATE FOR THE NUMBER OF PEOPLE IN-NEED, TO PROVIDE "CLOSED" OR "SECURE" GROUP HOME FOR MENTALLY RETARDED INDIVIDUALS WITH MENTAL ILLNESS OR SEVERE BEHAVIORAL PROBLEMS BY 1992.

Objective 2.1: Expand the client capacity of the "Mary Clare Home" from its present capacity of four client residents to a capacity for ten residents, or more, by 1992. The "Mary Clare Home" was established to achieve former Goal 3 of the original Guam Mental Health Plan, 1988 - 1991, to provide an appropriate home for MR and MI individuals who are presently homeless or live under inappropriate circumstances. The home should offer protection and therapeutic treatment, as well as life-skill and social-skill education.

Objective 2.2: Establish another facility which would serve the severe and profound mentally retarded who are extremely low functioning and require constant custodial care by 1992. One group home cannot serve the entire island.

Objective 2.3: Legislative action is necessary to ensure continuous funding for the "Mary Clare Home", and the new strategy is to establish it as a contracted service under DMHSA.

Status of Implementation:

The "Mary Clare Home" operated under Guma Mami with support from DMHSA is currently operating. (See Appendix E.) In addition to Guma Mami this home provides a "closed" group home for mentally retarded persons with mental illness and/or behavioral problems. Guma Mami already operates Guam's only group home for trainable mentally retarded individuals.

The "Mary Clare Home" has a maximum capacity of four residents. Currently (1990) eight additional persons have been identified as meeting eligibility criteria for the home,

with three of these actually seeking residence and placed on a waiting list for the program. Another two individuals with severe behavioral problems (e.g., possible personality disorders) have sought residency, but do not clearly fit the profile of clients best served by this particular program. Thus, at least five persons beyond the program's maximum capacity are not receiving needed services, and these include persons who merit the establishment of a different program that does not yet exist.

Family of the profoundly mentally retarded do not have the necessary training nor the support services to adequately care for the MR. There are 30-40 MR and their families who continue to suffer because services are not available. There are still some mentally retarded who are currently institutionalized either at Guam Memorial Hospital or St. Dominic's Senior Care Center. The Omnibus Budget Reconciliation Act of 1987 requires the transfer of all nursing home residents with mental illness or developmental disability to an appropriated setting. Guma Mami knows of two such individuals who have inappropriately institutionalized.

Funding is still problematical, as DMHSA's available finances for this purpose allow the purchase of services only as a temporary allocation of funds under the Governor's power of transfer.

Legislative action is necessary to ensure continuous funding for the "Mary Clare Home," and the new strategy is to establish it as a contracted service under DMHSA.

Lead Agencies: Guma Mami, DMHSA, the Marianas Association for Retarded Citizens, the Department of Public Health and Social Services, and other advocacy groups.

J. Financial Sources

After identification and acceptance of aid, generic social support and care of mental illness of Guam's mentally ill homeless and retarded individuals will be financed through multiple funding sources, both federal and local. Housing costs will be paid for by the HUD/GHURA Low-Cost or Section 8 programs; medical care will be provided through Medicaid; food stamps will fill nutritional needs, and welfare payments will provide a small cash allowance. Additionally, training and educational programs, funded by the Special Education grants for children or the Department of Vocational Rehabilitation grants for adults, will be utilized as indicated and suitable.

Funding for the new Drop-In Center will be provided through a special federal grant for the mentally ill homeless.

Guam's legislators have promulgated legislation for the establishment of residential care facilities for children, adolescents and adults, with funding for these facilities promised for the coming fiscal year 1990 - 1991.

Chapter 7

Prevention and Treatment of Alcohol and Other Drug Dependencies

CHAPTER VII
PREVENTION AND TREATMENT OF
ALCOHOL AND OTHER DRUG DEPENDENCE

Each of the previous three chapters has referred to substance abuse as helping to create or exacerbating the problems of mentally ill adults, emotionally disturbed children, and the homeless. Because of this, and because many people involved in prevention and treatment work on Guam felt a need to unify and coordinate efforts, the Guam Mental Health Planning Council agreed to include this chapter.

Although prevention and treatment are often considered separately, the members of the Committee on Drug/Alcohol Prevention and Treatment feel strongly that they should be considered and planned for together. They are part of a continuum of care that extends from prevention to intervention to treatment and to aftercare.

Prevention programs are most important for those considered to be at risk, children of substance abusers for example. However, to a large extent, prevention can and should be aimed at an entire population. This is particularly true for alcohol which is the most readily available and most abused drug.

Intervention is required for those considered at risk and for those suspected to be chemically dependent. In many cases intervention at an early stage of dependency can be effective. If intervention occurs early enough and a person remains drug free, the impact on the overtaxed treatment system is avoided.

Treatment must be done when use of a drug has begun to adversely affect a person's life and work. Treatment can consist of detoxification (ridding the person's system of the drug) which needs to be done under medical supervision, rehabilitation including counseling and possible use of substitute substances, and aftercare to help a person adjust to life without drugs.

Prevention, intervention and treatment are inter-related and cannot be conducted in isolation. Prevention programs help to identify those at risk and those needing intervention by providing signs and symptoms of abuse and dependency. Treatment can help in prevention by demonstrating that use of a drug is a problem and not an ordinary part of life.

One more note needs to be made in this introduction. Increasingly, tobacco products are being included in discussions of drug abuse. The Surgeon General has recently recognized formally the fact that nicotine can be as addicting as heroin for some users. Even more recently, researchers at the National Institute of Drug Abuse have linked smoking to abuse of other drugs. Many people now consider tobacco a "gateway" drug. Therefore, efforts to reduce tobacco use are included in this chapter.

A. Alcohol and Drug Abuse

1. Alcohol Misuse and Alcoholism

Alcohol is the most widely available and most abused drug in Guam and the United States. Although the majority of individuals can and do use alcohol responsibly, there is a sizable portion of the local and national population who are unable to do so. National estimates identify at least 10 million adult problem drinkers, roughly seven percent of the population. In addition, there are an estimated three million youths who have problems with alcohol.

The economic costs to society associated with alcohol abuse and alcoholism are staggering: approximately 50 billion dollars per year. This figure includes the costs for lost productivity, health care, motor vehicle accidents, fire losses, violent crimes, and social programs. Other adverse effects of alcoholism and alcohol abuse are not as easily measured since no dollar amount can be placed on broken homes, battered spouses, or disturbed children.

Substantial health care costs to society result from alcohol abuse and alcoholism. Alcoholism is the prime cause for cirrhosis of the liver which ranks among the ten leading causes of death. Cancer of the liver, the pancreas, esophagus and mouth are all associated with excessive alcohol consumption. There is conclusive proof that excessive alcohol intake contributes to damaged fetuses, neonatal deaths, and developmental disabilities in infancy. The misuse of alcohol leads also to increased risks of injury and death to the abuser, family members, and others, particularly through motor vehicle, fire-related, and other accidents.

National statistics show that an estimated 50 percent of accidents occurring on the road are caused by drivers who are under the influence of alcohol, and that two-thirds of the motor vehicle fatalities are alcohol-related. Fifty-three percent of fire deaths, 45 percent of drownings, 22 percent of home accidents, and 36 percent of pedestrian accidents are linked to alcohol misuse.

Of all arrests, 55 percent involve alcohol consumption. Violent behavior attributed to alcohol misuse accounts for 64 percent of murders, 41 percent of assaults, 34 percent of rapes, 29 percent of other sex crimes, 30 percent of suicides, 56 percent of fights or assaults in the home, and 60 percent of child abuse.

2. Drug Abuse

Over the past decades drug abuse has become a social problem, as well as a health problem. The widespread use of heroin and the increasing popularity of illegal "recreational drugs," particularly marijuana, cocaine, and hallucinogens and, of late, "crack" and "ice", are of great concern, as well as the misuse of prescription drugs such as the amphetamines and the barbiturates.

Part of the problem stems from the fact that the U.S. has been a drug-oriented culture. The use, even abuse, of drugs was a widely accepted part of everyday existence. The predominant message from the health care industry, television, radio, newspaper, and entertainment was that drugs are good. Licit and illicit drugs are readily available to cure headaches, colds, and backaches; to relieve depression, to give us energy and pep; to curtail appetites; or to induce sleep. A society accustomed to finding easy answers for problems, as well as instant gratification, is susceptible to drugs. A low tolerance for stress, anxiety, and boredom is conducive to the practice of locating and using quick and easy remedies. Fortunately, this is changing, but that we will reap its legacy for years to come.

Nevertheless, drug use does not necessarily lead to drug abuse. There is a vague and shifting line which separates "good" from "bad" drugs, prescription from non-medicinal use. In making a determination of drug use, or drug abuse, a distinction must be made between experimental use, social or recreational use, circumstantial or situational use, intensified use and compulsive use. Experimental use of drugs is seen as short-term, has no pattern, and is motivated by curiosity, or a dare by peers. Social or "recreational" use tends to be more patterned than experimental use, and involves family members or friends. Marijuana and cocaine are the drugs of choice used on these occasions and "getting high" is a euphemism

for such activities.

Circumstantial or situational use is promoted by a perceived need or desire to achieve a known effect that is deemed helpful in coping with a specific situation. For instance, a student studying for an exam might use amphetamines ("speed") in order to stay awake and alert. In most cases use of the drug is discontinued once the particular situation has passed. If not, there is the danger that the user's system will quickly become accustomed to the drug's effects and will require higher and higher doses to reach the originally desired effect.

Intensified use involves long-term, patterned, low-level use, with drugs becoming a part of life, as with tranquilizers and barbiturates. Although this regular use of drugs may be defined as a drug dependency, the user in this category is generally able to function normally in the community.

Compulsive drug use is frequent and intense. Individuals in this category cannot discontinue use of the drug without experiencing severe physical and psychological discomfort. The user is "hooked" and becomes preoccupied with the task of obtaining the necessary drugs to prevent withdrawal symptoms. Often the user lives from one "fix" to another, and in doing so represents the highest risk of adverse consequences to himself and society. Such a person is "addicted" to a particular drug, or has become, according to a more recent and widely accepted terminology, "drug dependent." A drug dependent person will resort to crime in order to support this "habit".

The Department of Mental Health and Substance Abuse has adopted the following classification: rational use, drug misuse, and drug abuse. Rational use is the use of any prescribed or over-the-counter drugs in appropriate amounts for therapeutic purposes for appropriate lengths of time. Drug misuse is the inappropriate use of drugs intended for therapeutic purpose.

Drug abuse is non-therapeutic use of any psychoactive drugs, including alcohol, in a manner that adversely affects the user's life. Drug abuse is universal in today's society, touching all ages and social classes, and making no differentiation between sexes. However, there are generally more male than female users of illegal drugs.

It is difficult to classify the drugs themselves. There is such a wide array of amphetamines ("uppers", "speed") and tranquilizers, barbiturates and sedatives ("downers"), and the various combinations thereof, that they defy definition, especially since new synthetic drugs have joined the illegal drug market. Some consider marijuana as a recreational drug, even though more adverse effects from smoking or imbibing this drug, have been verified.

There is extensive argument whether or not cocaine should be classified as a "hard" drug along with heroin and other opiates. Of the hallucinogens, LSD (lysergic acid) and PCP ("angel dust") are the most widely known and used. "Crack" and "ice" seem to be the "in" drugs at the moment for youthful drug users; they are dangerous, often deadly.

B. Definitions

Alcoholism is generally defined as the habitual and indiscriminate use of alcoholic beverages manifesting itself in a loss of control, with the consequences of impaired social or economic functioning and the progressive deterioration of health.

Drug abuse is defined as the non-medical use of any drug in a way that adversely affects of the user's life, e.g., by inducing or contributing to criminal behavior, by leading to poor health, economic dependency, or incompetence in discharging family responsibilities or by creating some other undesirable condition. Another definition states that drug abuse is the illegal use of a controlled substance, or use of a drug in a manner or to a degree that leads to adverse personal or social consequences.

Public Law 17-21 defines alcoholism as "a category for persons whose alcohol intake is great enough to damage their physical health, or their personal or social functioning or when it has become a prerequisite to normal functioning." The same law defines drug abuse as "the use, without compelling medical reason, of drugs which results in psychological or physiological dependency as a function of continued use in such a manner as to induce mental, emotional, or physical impairment and cause socially dysfunctional or socially disordering behavior."

Members of the committee for Alcohol and Drug Prevention and Treatment were asked to provide definitions of persons in need of substance abuse prevention and treatment services. They stated that

"Prevention activities should be available to persons at risk of abusing alcohol or other drugs because of their vulnerability to identified risk factors, such as dysfunctional family situations or addictive personalities."

and

"Treatment should be provided to any person whose use/abuse of a mind-altering substance is interfering with his life and family/work relationships" and that such treatment should be extended to "those whose lives are affected by interaction with alcohol or drug abusers."

C. Numbers of Persons with Alcohol and Drug Dependency

1. Alcohol Dependent Persons

On Guam, as elsewhere, reliable and realistic information on alcohol abuse is not yet available. The lack of a computerized data base to record indicators of incidence and prevalence contribute to this. However, data such as mortality rates and police accident and arrest records, one can infer that alcoholism is a severe problem on the island, particularly considering the impact that an alcoholic person has on his family, place of employment, and the community.

According to the Guam Police Department, from 1982 to 1986, an average of 580 people were arrested for drunk driving and an average of 14 persons were arrested for public drunkenness. Of 172 spouse assaults reported in 1983, 131 were alcohol-related. In fact, statistics for these years show that alcohol-related assaults comprised 75 percent of the total offenses.

Guam's Chief Medical Examiner recently reported that the majority of traffic accidents are due to drunk driving; from 1976 to 1984 76 people died on the island's roadways as a result of excessive alcohol intake. The Chief Medical Examiner also stated that alcohol was involved in 90 percent of all homicides. Cirrhosis of the liver develops in approximately eight percent of all chronic alcoholics. Guam has a high number of deaths caused by cirrhosis. It ranked as a leading cause of death in eight out of ten years, with an average annual rate of 13.6/1,000 for the last ten years. The U.S. rate for such deaths is 0.14/1,000 population.

Some insight into alcohol usage on island was obtained through a survey commissioned by the Department of Mental Health and Substance Abuse. Of 269 persons questioned, 42 percent drank alcoholic beverages. Out of this number, 78 percent drank occasionally, nine percent drank alcohol frequently, eight percent drank daily on a moderate basis, and four percent reported themselves as being heavy drinkers.

2. Drug Dependent Persons

Guam's drug problem can be directly correlated to the Vietnam War, when soldiers from the military zone frequently came to the island for rest and recreation. Guam is also used as a transshipment point to and from the Asian sources of many hard drugs. The influx of military personnel, as well as the island's strategic location, made it easy to import drugs. In the mid-1970's approximately 2,000 users of "hard" drugs (mostly heroin) lived on the island and often sustained their habit through illegal means. During those years an average 20 to 30 drug-related deaths were common.

By 1980, joint efforts of the local police, the federal Drug Enforcement Agency, and the U.S. Attorney's staff had lowered the number of heroin users to approximately 650. This downward trend has continued, and less than 200 heroin users were reported to be on island in 1985. No data, or even estimates, of the use of cocaine is available. Marijuana is smoked by a large portion of the population, either habitually or on social and recreational occasions. There are also no data available on the use and abuse of prescription drugs.

It is difficult to measure incidence and prevalence of drug use. Data is derived through self-reporting, police records, hospital admission sheets, or confidential informers, and is therefore sporadic. A island-wide data system which would capture all drug and alcohol-related data is seen as an important prerequisite for measuring incidence and prevalence and providing data for a needs assessment.

The population at-risk of becoming alcohol or drug dependent includes children of alcoholics, children of low-income families, physically and sexually abused children, high school dropouts, juvenile delinquents, children of divorced parents, teen parents, children of incarcerated adults, single parents and battered wives. Guam has a large number of children and young adults in this category and prevention services must be targeted to them.

D. Vision of an Ideal System

Besides the delivery of mental health services described earlier in Chapter III, Public Law 17-21 charges the Department of Mental Health and Substance Abuse with the provision of alcohol and drug abuse prevention programs and services. These programs and services shall include:

1. affecting policy to change conditions to minimize the availability of drugs and other negative substances;
2. training significant individuals, such as parents, teachers, mayors, and parish priests with prevention skills;
3. providing information via clearinghouse for drug and alcohol information;
4. promoting alternatives to drug and alcohol use, particularly among the youth; and
5. education to include dissemination of accurate information, as well as

enhancing social competence.

The previously mentioned statements make it obvious that the Department of Mental Health and Substance Abuse is charged with the prevention as well as the treatment of substance abuse. This is made quite clear by the policies formulated by the agency which put emphasis on the:

1. preservation of the dignity of the individual in the prevention and treatment of alcoholism and drug abuse;
2. support and fostering of the growth and development of quality services to individuals in need, and that these services will be offered in the least restrictive setting possible;
3. treatment services which address the cultural issues germane to the residents of Guam including the natural providers concept (such as clergy, village mayors, village elders, suruhanus), cross-cultural program designs, and special emphasis groups as appropriate such as women, youth, and the elderly;
4. priority placed on the continuation of quality services and the addition of those services which fill gaps in the existing service system and avoid unnecessary duplication of effort; and
5. legislation favorable to the provision and receipt of services by all in need in the areas within its responsibility.

The tenet of Public Law 17-21 and the above policies are the foundation of the ideal system as envisioned by the committee on Drug and Alcohol Abuse Prevention and Treatment. The committee states that such a system must incorporate the following elements: efforts to coordinate the services that already exist efficiently and effectively to minimize duplication of efforts and to maximize services delivery with minimal costs; and an increase in manpower and funding support for prevention, education, treatment and law enforcement.

The delivery of alcohol and drug services should be a continuum of care to include prevention, education, intervention, treatment and law enforcement without gaps in the continuum. Services must be provided as appropriate for the client, either in a residential or in a community setting. In particular, the following prevention and treatment services are desirable.

1. Prevention

Prevention must be considered a priority in the struggle against alcohol and drug abuse. It is more cost-effective than treatment or intervention. If no emphasis is placed on prevention by the various agencies concerned with alcohol, tobacco and drug abuse problems, the public at large will get the message that these will always be a problem on Guam and that nothing can be done about them.

The major goal of prevention efforts is to reduce the incidence and prevalence of alcohol and other drug-related problems, and promote overall health and "wellness". The public health model of prevention recognizes that prevention is a dynamic process and seeks to reduce both the supply of and demand for alcohol, tobacco, and other drugs by focusing attention on three elements: the agent, the host, and the environment.

According to this model, the agent is defined as alcohol, tobacco, and other drugs. The host is defined as the individual or groups, their susceptibility to alcohol, tobacco and other drug-related problems, and knowledge and attitudes that influence their drinking, smoking and other drug-using behavior. The environment is defined as the setting or context in which the drug-using behavior occurs or is influenced, and includes

specific institutions, the community in which they exist, and the larger society and its norms.

The characteristics identified by research as contributing to the effectiveness of prevention programs are divided into three broad categories:

- a) those pertaining to program comprehensiveness and intensity;
- b) those pertaining to strategies; and
- c) those pertaining to planning.

Successful prevention efforts must focus on more than a single system or single strategy and should address multiple systems (youth, parents, school, work place, community organizations, and the media), and use multiple strategies (provide accurate information in a timely fashion, develop life skills, create positive alternatives, train community volunteers and other influential people, and change community policies and norms).

These efforts should involve the whole community and address not only those individuals identified as being at risk, but also other youth and adults' attitudes and knowledge. Prevention programs need to be recognized as a broader, generic approach to health promotion and disease prevention, with emphasis on social skills development.

Prevention strategies that focus on the agent are aimed at reducing both the supply of and the demand for addictive substances by addressing the following factors: 1) availability, 2) pricing & taxation, 3) advertising & promotion, 4) enforcement, 5) deterrence, 6) content, 7) labeling, 8) health & safety, 9) warning labels and 10) other related issues.

These are social policy approaches aimed at reducing supply and are a vital component of any comprehensive prevention program for substance abuse.

Equally important are efforts focused on the host to develop life skills, so that individuals can improve their chances of living personally satisfying and enriching lives as they constructively confront complex, stressful life conditions. As a result, their perceived need for alcohol, tobacco and other drugs can be reduced or eliminated.

Demand reduction strategies go beyond the individual and extend into the environment. Alcohol, tobacco and other drug use is influenced by many factors: 1) legal, 2) economic 3) family, 4) social, 5) cultural, 6) political, 7) geographic, 8) religious, 9) ethnic, and 10) educational.

Demand reduction strategies which focus on the environment enhance the community's capacity to counteract these environmental factors. Through advocating appropriate actions, policies and procedures, prevention practitioners and public policy-makers can shape the norms and systems of culture in a way that is supportive of and conducive to healthier lifestyles.

Because the agent, the host and the environment are interactive and interdependent, prevention efforts must deal with all three elements. Efforts must focus on the general public and expand to more specific populations and high risk groups. Prevention must be understood in the context of a continuum of care that consists of prevention, intervention and treatment. Early detection (intervention) and referral to the appropriate services is critical to prevent the development of more severe problems in the future. Treatment strategies that include acute and crisis care, aftercare and ongoing support for recovery attempt to arrest the disabling effects resulting from the misuse of, or addiction to alcohol,

tobacco and other drugs, in order to avoid further problems or disability.

There is agreement among prevention specialists that prevention of substance abuse should be targeted to the very young. Parents are the ideal target group for prevention services. Parents are the major single influence in their child's development, and are faced with an enormous and complex job with little or no training. Increased parenting skills development as a preventive effort is one strategy which recognizes parents as prevention practitioners. Encouraging parents to become actively involved in prevention will result in empowering them with skills in nurturing their children to be free of alcohol, tobacco and other drugs. Parent training needs to be included as a community strategy for preventing substance abuse.

Knowledge about child development, effective communication, nurturing, positive self-image, and helping to develop decision-making and problem-solving skills help to enhance child-parent relations and may serve as a deterrent to drug-taking behavior. It is important, therefore, that parents are the primary targeted group for prevention and intervention efforts. In addition, youth leaders in such diverse programs as Boy Scouts, Girl Scouts, 4-H, recreation programs, summer camps, and others should be taught prevention skills. These programs help in the prevention effort by helping young people develop self-esteem and by giving them wholesome activities. Greater recognition should be given to the fact that these programs are an important component of any prevention program.

2. Treatment

Treatment is necessary when prevention efforts fail. Alcoholism is regarded as a chronic, incurable, progressive disease, characterized by early, middle and late stages. Drug addiction is difficult to cure. Consequently, the goals of treatment services are to maximize the client's human potential by promoting healthy lifestyles free from chemical dependency, and to provide ongoing support for lifelong recovery .

Components of alcohol and drug treatment services must include as a minimum:

- a) a treatment facility for detoxification and rehabilitation where a client may reside for at least four weeks;
- b) aftercare services that support a client in the community;
- c) community support groups for the client and his family; and
- d) a sufficient number of trained alcohol and drug health professionals and counselors to provide the best possible treatment.

E. Guam's Alcohol and Drug-Related Services

1. Prevention

There exists on Guam various prevention programs sponsored or administered by government, private and non-profit organizations. In addition for the Department of Mental Health and Substance Abuse, the Government of Guam has benefitted from federal support for alcohol and other drug abuse programs in several forms. First and foremost, under the Drug-Free Schools and Communities Act of 1986 (and as amended, Title V of the Elementary and Secondary Education Act of 1965), the Territory of Guam has received federal monies for the express purpose of prevention and intervention. In FY 87, the first year of the program, Guam received a total of \$1,291,937 (with \$904,356 allocated to the local Department of Education, and \$387,581 allocated

to the office of the Governor).

Discretionary grants from the U.S. Department of Education also assist the Territory in prevention efforts. Operation-Be-Free, a two-year program, was funded for \$200,000. The Western Pacific Substance Abuse Institute resulted from this funding. The Department of Education's Fund for the Improvement of Post Secondary Education (FIPSE) awarded a total of \$270,000 to Guam's two post-secondary institutions to develop comprehensive campus-based prevention programs for students, faculty and staff. The Department of Education has just recently awarded the University of Guam \$111,000 to provide prevention skill training to Department of Education personnel for one year.

2. Interdiction

In FY '89, the Guam Bureau of Planning applied for and was awarded \$285,000 under U.S. Public Law 100-690 (Drug Control and System Improvement Formula Grant Program), for developing and supporting a Drug Control and System Improvement State Strategy. The focus of this grant award is interdiction, and the aim is to provide a coordinated system not only for Guam, but the region at whole. More specifically, the following agencies and programs comprise this project:

Bureau of Planning - Administration of Programs and
Independent Evaluation of Grant

Department of Corrections - Drug Detection and Rehabilitation Program

Department of Law - Narcotics Prosecution Program

Department of Commerce - Narcotics Importation Reduction Program

Department of Public Health and Social Services - Pharmaceutical Diversion
Program

Guam Police Department - Drug Identification and Detection Program

Superior Court of Guam - Drug Identification and Detection Program

Department of Mental Health and Substance Abuse - Drug Identification and
Detection Program

Department of Youth Affairs - Drug Rehabilitation Program for Incarcerated Youth.

3. Training of Alcohol Abuse Intervention and Rehabilitation Workers

The Department of Mental Health and Substance Abuse Prevention Branch, in cooperation with the Alcohol and Drug Treatment Unit, provides, upon request, alcohol abuse intervention training to supervisory level employees of the Government of Guam. A three-day course has been developed including: Psychological and Behavioral Effects of Alcohol; The Disease of Alcoholism; Alcohol in the Workplace; Local and National Statistics; The Three Levels of Prevention; Alcohol Abuse Intervention Techniques (including supervisory role play exercises); Available Civilian Treatment Resources; Needs Assessment; Management Policies; Alcohol Abuse Policies in the Workplace; and Action Plans.

DMHSA's Prevention Branch has a history of collaboration with other agencies and community groups with the goal of creating a drug-free communities. DMHSA has sponsored Project PRO (Parents Reaching Out), a Head Start Parenting Program funded by the Office of Substance Abuse Prevention, and the Dededo

Drug-Free Youth Organization. DMHSA also supports Project COPE at the University of Guam which trains teachers to build self-esteem in their students.

A regional role for Guam in training workers in substance abuse prevention has been encouraged by various visitors to the Pacific islands. Dr. D. Hawks, a consultant with the World Health Organization (WHO) recommended in 1985 that a "training workshop be held in Guam for Micronesian health workers on the prevention and control of alcohol-related problems." In 1988, Dr. Naotoka Shinfuku, also from WHO, echoed Hawks' views. Shinfuku stated that "Guam should play a leading or at least a more active role in providing technical and financial support to deal with the ever-increasing alcohol and drug-related problems of neighboring Micronesian countries, which have limited resources to support prevention, intervention and treatment services." He further suggested "that Guam hold an annual training program to prevent and reduce alcohol problems in Micronesia." The Western Pacific Substance Abuse Institute in 1989 was the first of its kind and went a long way towards meeting this goal. A second Institute was held in 1990.

4. DMHSA's Alcohol and Drug-Related Services

Besides the above mentioned prevention and interdiction services, DMHSA provides services to persons whose lives are affected by substance abuse. DMHSA is the only public agency mandated to perform such services for the island population. The Department recognizes the disease of alcoholism and other types of chemical dependency as medical problems which require capable intervention and treatment services to facilitate a life-long period of recovery. All of the programs are open to the public and are designed to help not only those suffering from a drug or alcohol problem, but also those whose lives have been affected by living with a substance abuser (e.g., co-dependency).

a) Medical Services

Medical Evaluation

A client can be referred to the Medication Clinic if a counselor feels that there may be complications arising from the sudden withdrawal of alcohol or other drugs. Laboratory tests may be ordered and prescriptions written for medications. A physician is on call for emergency medical situations.

Detoxification

Medical intervention may be needed to minimize the physiological symptoms of withdrawal from drugs. Detoxification may be done on an outpatient treatment basis if the person has appropriate support and assistance. Hospitalization may need to be considered for some clients.

Antabuse

This medication can be prescribed for clients' treatment for alcoholism. Antabuse helps to preclude drinking by causing a strong, aversive, physical reaction when mixed with alcohol, which may be life-threatening. Therefore, the commitment to taking antabuse is a commitment to avoid drinking alcohol. Clients who have medical clearance, are in a stable home and work environment and are highly motivated to stop drinking stand the best chance of benefiting from this treatment.

Trexan

This medication is used with clients who have been detoxified from narcotics. It acts to block the physiological effects of all opiate drugs including heroin, thereby discouraging the use of these drugs.

b) Counseling and Referral Services

Screening/Evaluation

A trained substance abuse counselor conducts an interview to collect medical information and a brief personal history from the client. The counselor makes an assessment with a comprehensive list of treatment recommendations. Referrals for services not offered at DMHSA can be made at this time. Screening/evaluation can usually be accomplished in one or two sessions.

Drug and Alcohol Counseling

Individual, group and or family therapy which is both supportive and confrontational, or a combination of all these, may be utilized. Emphasis is placed on increasing self-esteem and encourages family involvement in treatment. Sessions are usually one hour long and are held weekly.

Alcohol Education and Treatment Group

This is a five week program which focuses on helping people with their drinking problems. Presentations on alcoholism, participation in group therapy and attendance at Alcoholics Anonymous are included in the program. Family participation is strongly encouraged.

Chemical Dependency Support Group

These are on-going weekly groups which address a client's need for support in building a healthier lifestyle and understanding relapse.

Referral Services

Clients are introduced to other community support programs such as ALANON, Narcotics Anonymous and Adult Children of Alcoholics. There is no cost for counseling services. Clients are expected to pay for laboratory tests, physical examination and detoxification medication when needed. Sessions may be scheduled after normal working hours.

F. Analysis and Description

Guam's provisions for alcohol and drug-related services are incomplete. Four major problems have been identified:

1. the absence of residential treatment services;
2. the lack of adequately trained professionals;
3. the lack of an island-wide data system for the express purpose of capturing alcohol and drug-related data; and
4. the lack of cooperation among agencies charged with prevention, interdiction and treatment of substance abuse.

This three-year plan is a formal attempt to improve the coordination, development, implementation and evaluation of prevention and treatment services, using a balanced approach to programming which targets families, groups, communities and the island of Guam as a whole. Despite Guam's small size and the presence of only one level of government, historically public

agencies do not maximize opportunities to work in collaboration for the common good of the island population. There has been a lack of communication, and an even greater lack of interest in joining forces to establish a consolidated prevention effort, even though the available federal funding would allow and even support such efforts. This problem of inter-department collaboration has been described in greater detail in Chapter III.

The planned new mental health and substance abuse facility, as described in Chapter III, will provide a 16 bed (12 for males, 4 for females) alcohol and drug treatment center. Completion is expected to occur in early 1993.

DMHSA's human resource development plan (HRDP), as described in Chapter III, will address specialized training and manpower needs for alcohol and drug abuse prevention, interdiction and treatment. Navy officials are willing to share their treatment and counseling expertise with Guam's professionals if the bureaucratic obstacles can be overcome.

The lack of a computerized data base to record indicators of chemically dependent behavior severely hampers the Department of Mental Health and Substance Abuse in establishing true incidence, and to forecast need. Establishment of a centralized data collection system to document and define treatment, enforcement, and community information from all relevant sources on Guam is critical. This information will be used to better plan, implement and evaluate effective programs and services in the community.

Cultural and social barriers also exist. The dynamics of reciprocity are firmly rooted in Guam's island culture. The imbibing of alcoholic beverages is often associated with food and with being hospitable, both in the offering and the accepting. To refuse a drink is to be impolite, and the polite host can thus enable a guest to continue an addiction. Alcohol misuse and abuse are socially acceptable, with strong resistance from the public to "regulate" such behavior. Evidence of such resistance is the fact that the legal drinking age is 18 on Guam, while age 21 is the norm in all 50 states. Another indication of resistance to change is the absence of legislation prohibiting smoking in government buildings. A third indication is the prevalent use of betel nut (Areca catechu), for which residents of Guam have a special dispensation to import onto the mainland through U.S. Customs.

The dynamics of denial, a core component in all chemical dependency, further exacerbates the island's efforts in prevention. Some government officials simply do not believe in prevention, claiming that "no one could ever be truly drug-free." Some personnel are threatened by the prevention movement, erroneously equating the movement with requiring total abstinence for all populations, regardless of risk.

Clients in need of detoxification and rehabilitation services are further hindered by dynamics of the culture which discourage revealing family information. It is culturally inappropriate to "air one's dirty laundry" to any outsider, and most treatment professionals are not from the indigenous culture. Promises of confidentiality are not always believed, whether in filling out an anonymous questionnaire or in filling out an intake form for medical services.

In addition, treatment services are not attractive to clients in need. As the only legally mandated provider of treatment services (other than for members of the military and their dependents), DMHSA has, for the most part, a negative image in the community. This has been described in great detail in the previous Chapters.

Another barrier to seeking treatment for substance abuse is financial.

Clients in need of such services would often prefer the services of private providers, rather than going to the public Mental Health facility. However, the "Free Law" prevented the inclusion of mental health and substance abuse services in negotiated contracts between the Government of Guam and the three major HMO's. This too has been described in Chapter III. The "Free Law" has also prevented off-island private providers from coming to Guam for the purpose of offering substance abuse treatment.

G. GOALS, OBJECTIVES AND STRATEGIES

The following goals are based on a total population of 150,000 for Guam and an estimated 15,000 people who have some degree of drug and/or alcohol dependency (based on U.S. statistics):

1) EDUCATION/PREVENTION

Goal 1: Promote awareness of alcohol and drug abuse, to include healthy ways to reduce stress, the signs and symptoms of chemical dependency, and where to go for help.

Target: 75 percent of Guam's population should recognize the problems associated with drug and alcohol abuse prevention and treatment.

Objective 1.1: To form a Drug/Alcohol Prevention and Treatment Task Force to ensure coordination of programs by 1992: ACCOMPLISHED

Strategies for Implementation:

Identify all existing government, private and community-based programs, and invite their participation.

Establish regular meetings.

Maintain membership in the Regional Alcohol and Other Drugs Abuse Resource Center (RADAR) and other national prevention organizations.

Measurement: Meeting minutes will be forwarded to the Guam Mental Health Planning Council.

Lead Agency: Prevention and Training Unit, Department of Mental Health and Substance Abuse.

Objective 1.2: To ensure a coordinated and ongoing media campaign on prevention of drug and alcohol abuse by 1992.

Strategies for Implementation:

The Guam Drug/Alcohol Prevention and Treatment Task Force members will share existing media programs and coordinate efforts.

Seek advice from local media people to ensure that messages will achieve the desired result.

Include both printed and electronic messages in Chamorro, Tagalog, Chinese, Korean, Japanese, Micronesian languages and other ethnic languages found in Guam.

Measurement: Materials will be forwarded to the Guam Mental Health Planning Council.

Lead Agency: Guam Drug/Alcohol Prevention and Treatment Task Force.

Objective 1.3: To continue ongoing prevention programs which target all populations and to ensure inclusion of components of all other strategies to include stress management by 1992.

Strategies for Implementation:

Provide ongoing support and training for school-based prevention teams organized in Guam's schools.

Conduct an annual Youth-For-Youth Prevention Conference.

Co-sponsor an annual Western Pacific Substance Abuse Prevention Institute.

Conduct quarterly presentations on the BABES Program targeting children in the Head Start program and child care centers.

Develop an audio-visual training resource to be used with youth and parents in high-risk groups.

Facilitate the development of the Nurturing and Keiki Play Morning Programs, to target child-care service personnel working with pre-school children.

Measurement: Quarterly report will be provided to the Guam Mental Health Planning Council.

Lead Agencies: Prevention and Training Unit, Department of Mental Health and Substance Abuse and Department of Education.

Objective 1.4: To form a local chapter of the National Council on Alcoholism by 1992: **ACCOMPLISHED**

Strategies for Implementation:

Identify organizational steps needed.

Establish regular meetings.

Measurement: Meeting minutes will be forwarded to the Guam Mental Health Planning Council.

Lead Agency: National Council on Alcoholism and Drug Dependency Steering Committee (Guam Chapter).

Objective 1.5: To advocate local legislation that will support the reduction of supply and demand for drugs and alcohol by 1993.

Strategies for Implementation:

Survey existing legislation to determine what currently exists.

Compare existing Guam legislation with selected states.

Increase awareness of all drug and alcohol retailers.

Write legislation to require a four-hour educational program on sale, regulations, and enforcement for retailers prior to issuance of licenses.

Increase awareness of drug and alcohol abuse to doctors.

Measurement: Report on existing legislation, copies of any proposed legislation, and course content will be forwarded to the Guam Mental Health Planning Council.

Lead Agencies: Guam Health Planning Agency and National Council on Alcoholism and Drug Dependency Steering Committee (Guam Chapter).

2) RESEARCH AND MANAGEMENT

Goal 2: To collect data on drug and alcohol abuse prevention and treatment problems on Guam in a consistent and coordinated manner.

Target: Statistics generated will benefit all drug and alcohol abuse prevention and treatment programs.

Objective 2.1: Establish a central management information system (MIS) to manage all data related to drug and alcohol use and abuse on Guam by 1993.

Strategies for Implementation:

Include funding in legislation described in Objective 5.1 for personnel and equipment for the MIS.

Information in the MIS should include, but not limited to

- confidential surveys
- importation statistics on alcohol and tobacco

- products
- controlled drugs prescribed by physicians
- statistics on drug and alcohol-related crimes and deaths
- alcohol and drug-related accident statistics
- alcohol and drug-related hospital admissions
- alcohol and drug related medical treatments

Measurement: A quarterly report will be forwarded to the Guam Mental Health Planning Council and the Guam Drug/Alcohol Prevention and Treatment Task Force.

Lead Agency: The Guam Health Planning Agency

3) MANPOWER

Goal 3: To increase the number of trained professionals and volunteers working the drug and alcohol field.

Target: There are currently approximately 25 professionals and 100 volunteers in the field. The target is to increase both by 40 percent.

Objective 3.1: Train volunteer youth and community leaders in drug and alcohol prevention/intervention techniques by 1992.

Strategies for Implementation:

Develop/identify workshop which could be used to provide volunteer leaders with information and techniques on drug/alcohol prevention and intervention, building self-esteem, and health alternatives to drug and alcohol use.

Market course to youth and community program leaders.

Identify funding sources and apply for these funds for course development and facilitator expenses.

Annually, conduct at least two Alcohol Abuse Intervention Training workshops for Government of Guam supervisors.

Measurement: A quarterly status report on the number and quality of workshops and the number of volunteers trained will be forwarded to the Guam Mental Health Planning Council.

Lead Agency: Prevention and Training Unit, Department of Mental Health and Substance Abuse

Objective 3.2: To establish appropriate courses at local institutions including the military to train professionals and volunteers by 1992.

Strategies for Implementation:

Survey offerings of mainland and foreign universities for relevant courses.

Assist local institutions in developing courses and recruiting instructors.

Measurement: Local course offerings forwarded to the Guam Mental Health Planning Council.

Lead Agencies: University of Guam, Guam Community College and military installations.

Objective 3.3: Develop credential standards for drug and alcohol counselors and prevention volunteers by 1992.

Strategies for Implementation:

Review certification standards elsewhere.

Draft local legislation to establish relevant standards.

Measurement: Draft legislation forwarded to the Guam Mental Health Planning Council.

Lead Agencies: Drug and Alcohol Unit, Department of Mental Health and Substance Abuse and Guam Association of Social Workers (GASW).

Objective 3.4: Increase the number of professional drug and alcohol prevention and treatment workers by 1992.

Strategies for Implementation:

Determine which agencies need additional professional staff and include funding for new positions in legislation proposed in Objective 5.1.

Draft legislation to require health plans to list as providers, certified addiction counselors and other professionals who deal with drug/alcohol abuse treatment.

Measurement: Proposed legislation forwarded to the Guam Mental Health Planning Council.

Lead Agencies: Department of Mental Health and Substance Abuse and Guam Drug/Alcohol Prevention and Treatment Task Force.

4) DELIVERY OF TREATMENT SERVICES

Goal 4: To provide chemical dependency treatment to identified children, adolescents, and adults with drug and/or alcohol problems.

Target: Currently, chemical dependency treatment is provided to approximately 500 people per year. This number will be increased by 100 percent by 1994.

Objective 4.1: Encourage early identification and intervention for drug and alcohol abusers by 1993.

Strategies for Implementation:

Develop systems of identification to be used by any agency coming in contact with abusers.

Implement a referral process to ensure intervention at the earliest possible time.

Provide training workshops to all relevant agencies.

Establish a government-wide Employees' Assistance Program (EAP) through legislation.

Measurement: A quarterly report on number and quality of referrals will be provided to the Guam Mental Health Planning Council.

Lead Agency: Treatment Unit, Department of Mental Health and Substance Abuse.

Objective 4.2: Make detoxification services available to all drug/alcohol abusers classified as dependent and to other drug dependent by 1993.

Strategies for Implementation:

Develop a "standard operating procedure" for admission for detoxification.

Provide medical supervision, both internal medicine and psychiatry, for length of detoxification.

Make inpatient detoxification services available to all alcohol abusers classified as dependent and to other drug dependent people when outpatient detoxification is not enough.

Make outpatient detoxification services available to alcohol abusers classified as dependent.

Measurement: A copy of the admission and supervision procedure will be forwarded to the Guam Mental Health Planning Council.

Lead Agencies: Internal Medicine, Guam Memorial Hospital, and Psychiatry Section, Department of Mental Health and Substance Abuse.

Objective 4.3: Provide smoking cessation programs during 1992.

Strategies for Implementation:

Support legislation to designate public areas as smoke free.

Coordinate a public awareness campaign on the hazards of tobacco use and second-hand smoke.

Measurement: Quarterly reports will be forwarded to the Guam Mental Health Planning Council.

Lead Agencies: Guam Drug/Alcohol Prevention and Treatment Task Force and Department of Public Health and Social Services.

Objective 4.4: Provide emergency/crisis intervention services 24 hours a day for substance abuse by 1992.

Strategies for Implementation:

Develop a 24-hour crisis hotline for substance abuse.

Explore having the private sector provide such services.

Measurement: Quarterly reports on progress will be forwarded to the Guam Mental Health Planning Council.

Lead Agency: Drug and Alcohol Unit, Department of Mental Health and Substance Abuse.

Objective 4.5: Establish residential treatment facilities for drug and/or alcohol abusers by 1994.

Strategies: Identify existing buildings which could be used or if necessary construct such facilities for all ages.

Establish residential treatment programs to last at least 28 days.

Measurement: Quarterly reports will be forwarded to the Guam Mental Health Planning Council.

Lead Agency: Drug and Alcohol Unit, Department of Mental Health and Substance Abuse.

Objective 4.6: Develop aftercare programs for clients following residential treatment by 1994.

Strategies for Implementation:

Develop program to follow clients for at least one year, to include counseling and other modalities.

Measurement: The proposed aftercare plan will be forwarded to the Guam Mental Health Planning Council.

Lead Agency: Drug and Alcohol Unit, Department of Mental Health and Substance Abuse.

5) FUNDING

Goal 5: To ensure commitment to prevention and treatment programs through local funding.

Target: Prevention programs should reach all of Guam's population. Treatment programs should reach those who have been identified as having a

chemical dependency and their families.

Objective 5.1: Write legislation that would mandate the use of taxes on alcohol and tobacco products for prevention and treatment programs by 1992.

Strategies for Implementation:

Determine how taxes on alcohol and tobacco products are currently being used.

Legislation should establish a separate fund into which taxes will be deposited (similar to the Guam Tourist Attraction Fund), and should identify what agency or board will have jurisdiction over funds.

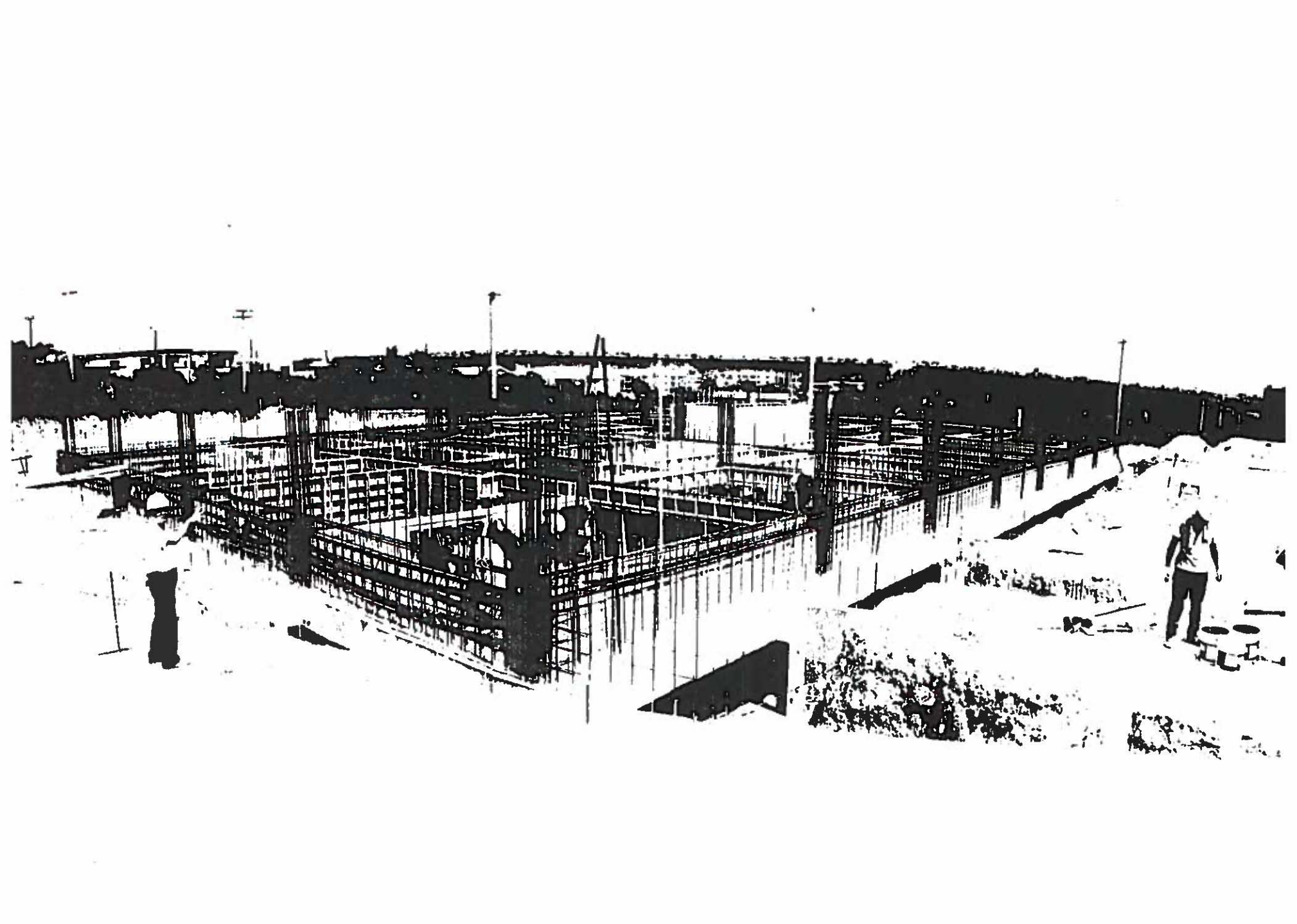
The agency or board with jurisdiction should formulate rules on how funds will be allocated. Such rules should be subject to public input before adoption.

Measurement: Proposed legislation will be forwarded to the Guam Mental Health Planning Council.

Lead Agency: Prevention and Training Unit and Drug and Alcohol Unit, Department of Mental Health and Substance Abuse and Department of Public Health and Social Services.

Appendices

Appendix A



Appendix B

***You are cordially invited to attend the
Department of Mental Health
and Substance Abuse***

Adult Residential Treatment Services

Open House ~ Merienda

Date: March 21, 1990

Time: 3:00 p.m. ~ 5:00 p.m.

Place: Mariposa Apt. Building

(Across from Old GMH, Tamuning)

Appendix C

Mental Health Awareness Week proclaimed

By Ronald J. San Nicolas, Social Worker

The week of October 21 - 27 has been proclaimed by Governor Joseph F. Ada as Mental Health Awareness Week. This year's event is being co-sponsored by the Department of Mental Health and Substance Abuse and the Dededo Drug Free Youth Organization. Like most states in the nation, Guam's observation of Mental Health Awareness Week attempts to focus on providing the general public with information on topics related to mental health, mental illness, and the various types of programs that are currently available.

A more important goal and theme of the week's observation is to dispell the stigma or the public's negative perception which for the most part, has clouded it's understanding of psychiatric/emotional disorders and the importance of attaining a sound mental health well-being.

Unfortunately, individuals stricken with emotional and mental disorders have not been well accepted by the community and have often-times been identified as the "lepers of modern day society." As christians called by Jesus Christ to love one another, his call and message brings to mind a emphasis on serving the poor and the ill of our society. The church today continues to play a vital role in it's works of charity, especially to those with serious mental illness.

God has graced our island with the Guma San Francisco drop-in center for the homeless and the mentally ill. A joint project of the St. Vincent DePaul Society and the Department of Mental Health: the drop-in center demonstrates that the community and religious affiliation can be resourceful and a niche in which the poor may experience the love of God.

Guam's care for the mentally and emotionally ill has a significant dimension that may be unique to that of other psychiatric treatment approaches. This dimension takes into consideration the realm of spirituality and God's healing power. Each May the staff and consumers of the Department gather to celebrate the feast of St. Dymphna, patroness of the emotionally ill.

mitted in keeping this devotion and promoting the saint's powerful intercession.

We pray that God will bless all individuals that are burdened by emotional despair and mental illness. We pray too that God will bless all the professionals and staff of the Department of Mental Health that they may be filled with God's tenderness, compassion, and care. Finally, we pray that our community may be more receptive to the needs of the emotionally and mentally ill. For more information about mental health services, please call 646-9261 through 69.



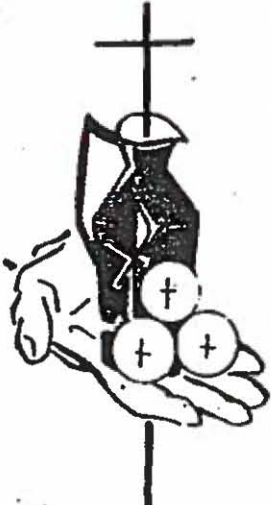
There is only one thing to consider when you choose your family's health plan.

Your Family.

GovGuam Employees:

Don't stop short of giving your family the best.

Join FHP before January 26th.



Appendix D

Appendix D

Table 1

OVERVIEW OF AGENCY PROGRAMS GIVING ESTIMATES OF SERIOUSLY MENTALLY ILL ADULTS AMONG CLIENTELE FOR THE PREVIOUS MONTH

	<u>Type of Service Agency Provider</u>		
	Public Agency	Private Agency	TOTAL
Total	10	4	14
<u>Position of Person Interviewed</u>			
Doctor/Nurse	3	2	5
Psychologist			
Counselor/Caseworker	4	2	6
Director/Administrator	3	0	3
<u>Type of Services</u>			
Direct *	4	2	6
Indirect *	6	2	8
<u>Variance of Monthly Client Estimate</u>			
High for the year	4	1	5
Average for year	6	3	9
	<u>Type of Services</u>		
	<u>Direct*</u>	<u>Indirect*</u>	
Total	(6)	(8)	(14)
<u>Variance of Monthly Client Estimate</u>			
High for the year	2	3	5
Average for year	4	5	9

* "Direct" refers to programs specifically including seriously mentally ill adults among clientele; "Indirect" refers to programs targeted at a client pool that may include seriously mentally ill adults.

Table 2

AVERAGE ESTIMATED CLIENT COUNTS BY TYPE OF
PROGRAM AND VARIANCE OF ESTIMATE

	Variance of Monthly Estimate:		
	<u>Average Month</u> <u>for the Year</u>	<u>Above Average</u> <u>for the Year</u>	<u>Total</u>
<u>Monthly Clients</u>			
Direct (N=6)*	137.8	336.0	203.8
Indirect (N=8)*	196.3	109.5	167.3
Total (N=14)	167.0	222.8	185.6
<u>Estimated SMIA</u>			
Direct (N=6)	141.5	167.5	150.2
Indirect (N=8)	7.0	7.0	7.0
Total (N=14)	83.9	87.3	85.1
<u>SMIA Needing Service Referral</u>			
Direct (N=6)	145.7	160.0	149.3
Indirect (N=8)	5.7	3.0	4.6
Total (N=14)	75.5	55.3	68.9
<u>SMIA Needing Service but Not Available On-Island</u>			
Direct (N=6)	11.3	160.0	48.5
Indirect (N=8)	3.0	1.0	2.5
Total (N=14)	7.2	80.5	25.5
<u>SMIA with Unmet Needs</u>			
Direct (N=6)	16.0	50.0	33.0
Indirect (N=8)	6.0	Unk	6.0
Total (N=14)	11.0	50.0	24.0

* "Direct" refers to programs specifically including seriously mentally ill adults among clientele; "Indirect" refers to programs targeted at a client pool that may include seriously mentally ill adults.

Unk = Not one of these 3 informants felt they could make an

estimate of Unknown SMIA's needing their services.

TABLE 3

PROPORTIONS OF ESTIMATED SERIOUSLY
MENTALLY ILL CLIENTS NEEDING REFERRALS
IN THE PREVIOUS MONTH

	DIRECT SERVICES (N=6)	INDIRECT SERVICES (N=8)	TOTAL (N=14)
Average Estimated SMIA Clients	150.2	7.0	85.1
Proportion Needing Referral(s)	99.4 %	65.7 %	81.0 %
Proportion* Needing Service Not Available	32.5 %	54.3 %	37.0 %

* Proportion of SMIA clients needing service referral.

Figure A

Assessment of Service Need Priorities
from Key Informant Survey and Focus Groups

Outpatient ** <u>Service Need:</u>	Key Informant Survey		Focus Groups	
	<u>Ranking of Importance:</u>	<u>Ranking of Availability:</u>	<u>Agency Staff:</u>	<u>Clients:</u>
A. Social/Emotional Counseling (Personality Disorders Behavioral Problems)	1	Hardest #1 (Not available)	X	X
B. Medical Health Services	5 (tie)	Hardest #2 (tie)	X	X
C. Case Management Services	6 (tie)	Hardest #2 (tie)	X	X
D. Independent Living Housing (Rental)	3	Hardest #3	X	X
E. Supervised/Structured Group Home Residence	7 (tie)	Hardest #4	X	X
F. Education (Schooling & Skill Development)	4 (tie)	Hardest #5		X
G. Employment/Job Counseling	4 (tie)		X	X
H. Transportation/Mobility	7 (tie)	Hardest #6		X
I. Psychiatric Counseling	2	Easy for Clinically Diagnosed Psychiatric Disorders		
J. Psychiatric Medication	4 (tie)			
K. Financial Welfare Assistance	5 (tie)	Easy for Social Workers or Case Workers		X (Not easy without SW or CW)
L. Clients' Family Counseling	6 (tie)		X	

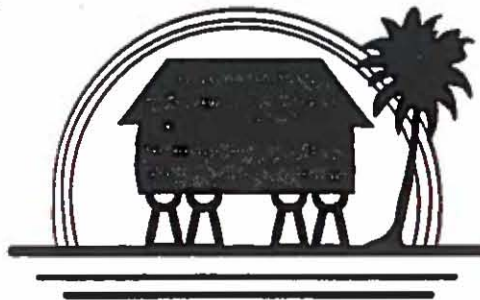
* Ordered by lowest availability (i.e. Hard to obtain) and importance and comments by both staff and client focus groups.

Appendix E



Mary Clare Home Guma' Mami

"Special Home For Special Adults"



March 22, 1990

Appendix F

PLANNING GUAM'S PROGRAM SERVICES FOR
INDIGENT PERSONS NEEDING
HOUSING ASSISTANCE, INCLUDING
THE MENTALLY ILL

Committee On The Homeless Mentally Ill
Guam Mental Health Planning Council
Final Report: September 8, 1990

Committee Members:

Wayne Antkowiak	(DPHSS)
Evelyn O. Cruz	(Advocacy Office)
Vicky LI. Duenas	(DMHSA)
Sr. Mary Joanne Getz	(Alee Shelter)
Mary Guerrero	(GHURA)
Tita Matanane	(Guam Housing)
Richard Punzalan	(DMHSA)
Lola Rojas	(Guma Mami)
John Weisenberger	(Guam Legal Services)
Josephine Rosario	(Catholic Social Services)

Prepared by Dr. Randall L. Workman
University of Guam
Community Development Institute
Guam Cooperative Extension
Under Work Order Request No.
WO2300004

EXECUTIVE SYNOPSIS

Current Objective: To work with Guam's network of programs involved in housing, health, transportation, adult education and employment to develop a strategy establishing a drop-in center for indigent people that can refer those in-need to services and to help service delivery.

To use this developed strategy to revise the Guam Three Year Mental Health Plan: 1988-1991 before September 15, 1990.

Background: The Guam Mental Health Planning Council was established in May 1989 by Executive Order No. 89-11. This met Federal requirements of U.S. PL 99-660 to utilize input from such councils for mental health plans and programs receiving federal assistance. Council members are either consumers and/or family members, advocates or providers of generic human services (e.g., health, education, welfare, housing, transportation) and mental health care. The Guam Mental Health Planning Council has four committees, each responsible for one portion of actions to achieve its goals: (1) Seriously Mentally Ill Adults, (2) Drug and Alcohol Abuse, (3) Emotionally Disturbed Children and (4) The Homeless Mentally Ill. Guam's 1988-91 Mental Health Plan was prepared with the Council's input and a formal Public Hearing during May - September, 1988. (Available from Mental Health and Substance Abuse).

The Council has implemented actions to achieve stated goal. The Council is in the process of updating the current plan to account for these events. Over the long term, this will become the foundation of the next three year plan (1992-94).

The responsibility to provide for the well-being of Guam's citizens is mandated to all of its public agencies. The Council's aim is to bring about real change that truly solves problems among Guam's indigent persons, including the mentally ill and those with behavioral problems.

Real solutions meeting the needs and solving service delivery obstacles among Guam's persons with mental or serious behavioral problems cannot be limited as only the responsibility of the Department of Mental Health and Substance Abuse. All agencies or programs delivering generic human services to Guam citizens must be involved. This is the reason for the current objective of the Committee on Homeless Mentally Ill, to work toward real solutions.

Committee Participants Involved 1989-1990:

Martha Crisostomo	(St. Vincent De Paul Society)
Joanne Cruz	"
Michael Cruz	"
Josephine Cruz	"
Maria Lane	"
Mae Duenas	"
John Blas	"
Doris Carrillo	"
Mary Torres Baleto	"
Fr. Andrew Mannetta	"
Joe Rosario	(Guma San Jose, CSS)
Daniel Domaocal	"
Donna Pelena	"
Lola Rojas	(Guma Mami)
Sr. Mary Joanne Getz	(Alee Shelter)
Bennett Chigiune	"
Dr. Estrelita Redding	(DMHSA)
Richard Punzalan	"
Vicky LI. Duenas	"
Wayne Antkowiak	(DPHSS)
Evelyn O. Cruz	(Advocacy Office)
Celso Llaneta	(Advocacy Office)
Mary Guerrero	(GHURA)
Tita Matanane	(Guam Housing)
Senator Gordon Mailloux	(Guam Legislature)
Aleta San Nicolas	(Goodwill Industries)

ACTIONS and CURRENT EVENTS

1. The original Goals/Objectives/Strategies of the 3 year Guam Mental Health Plan: 1988-1991, were re-drafted. Former Goals 1 and 2 were revised to New Goals 1A and 1B, and the former Goal 3 was revised to new Goal 2. (See Appendix A).
2. Goal 3 (New Goal 2) has been initially achieved with the establishment of the Mary Clare Home and follow up actions for continued funding and expansion need to be planned during the next year (1991).
3. Former Goal 1 has been initially achieved and an implementation strategy has been planned. A "Call for Proposals" soliciting bids was released in July 1990 and at least two proposals received. A grant of \$29,000 was awarded to the St. Vincent De Paul Society of Guam to operate a Drop-In Center for the homeless, starting September 1, 1990.
4. Planning Workshops were conducted to design a detailed strategy and develop greater interagency commitments for accomplishing goals 1 and 2 of the 3 Year Plan. The final revision of the Goals/Objectives /Strategies submitted as the Update of the 3 Year Guam Mental Health Plan: 1989-1991, combined Goals 1 and 2 into one goal with several new objectives.
5. A Key Informant Survey among professionals/officials was conducted to document the problem need and define the issue of Guam's homeless.

PLANNING WORKSHOPS (Held July 28 and September 8, 1990)

Committee members and participants met July 28 to begin designing a Logic Model of required events and actions if the goals are to be fully achieved and real solutions implemented. This work continued in a second workshop held September 8, 1990.

The group started with the realization that any on-going effort will fail unless fundamental obstacles hindering past inter-agency and island-wide cooperation were reduced. The first draft of the Logic Model being developed specified events and actions to address this issue (see Figure 1). The second workshop expanded this Logic Model by adding sequenced events and actions necessary to achieve the current goals. (See Figures 2 and 3).

A Key Informant Survey was designed to collect perceptions among island professionals and officials of the current problems/needs. Results were presented at the second workshop to give information helping the attendees specify the situation context that must be addressed by coordinated program efforts.

Figure 1

ASSUMPTIONS:

1. That professional people are moved by value systems.
2. If we clarify these value interests for different professionals, then we can connect them to a universal value system promoting:
 - a) The "building up" of others and
 - b) The well-being of all persons.

LOGIC MODEL:

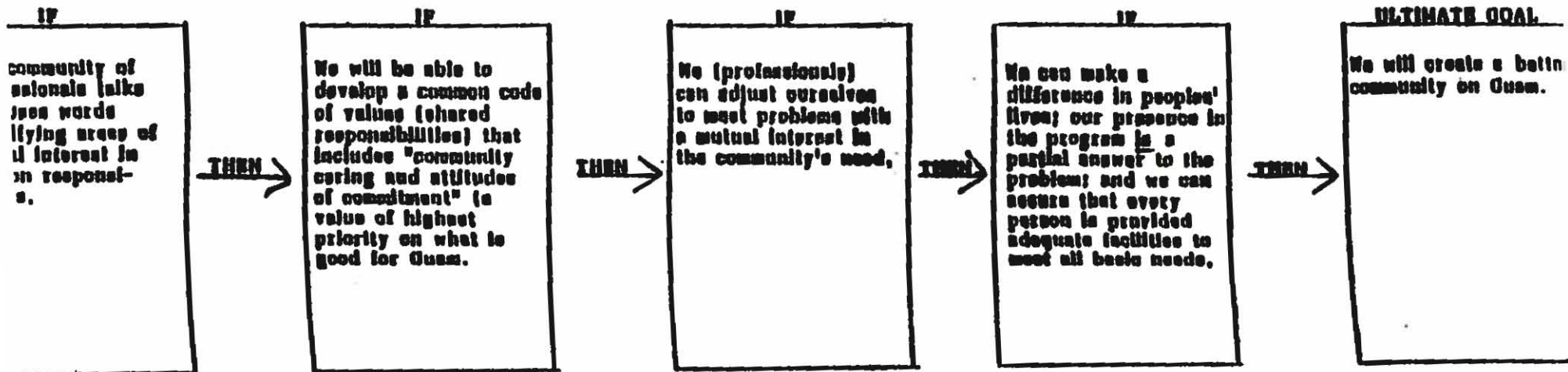


FIGURE 2

Logic Model to Achieve Goals 1A and 1B

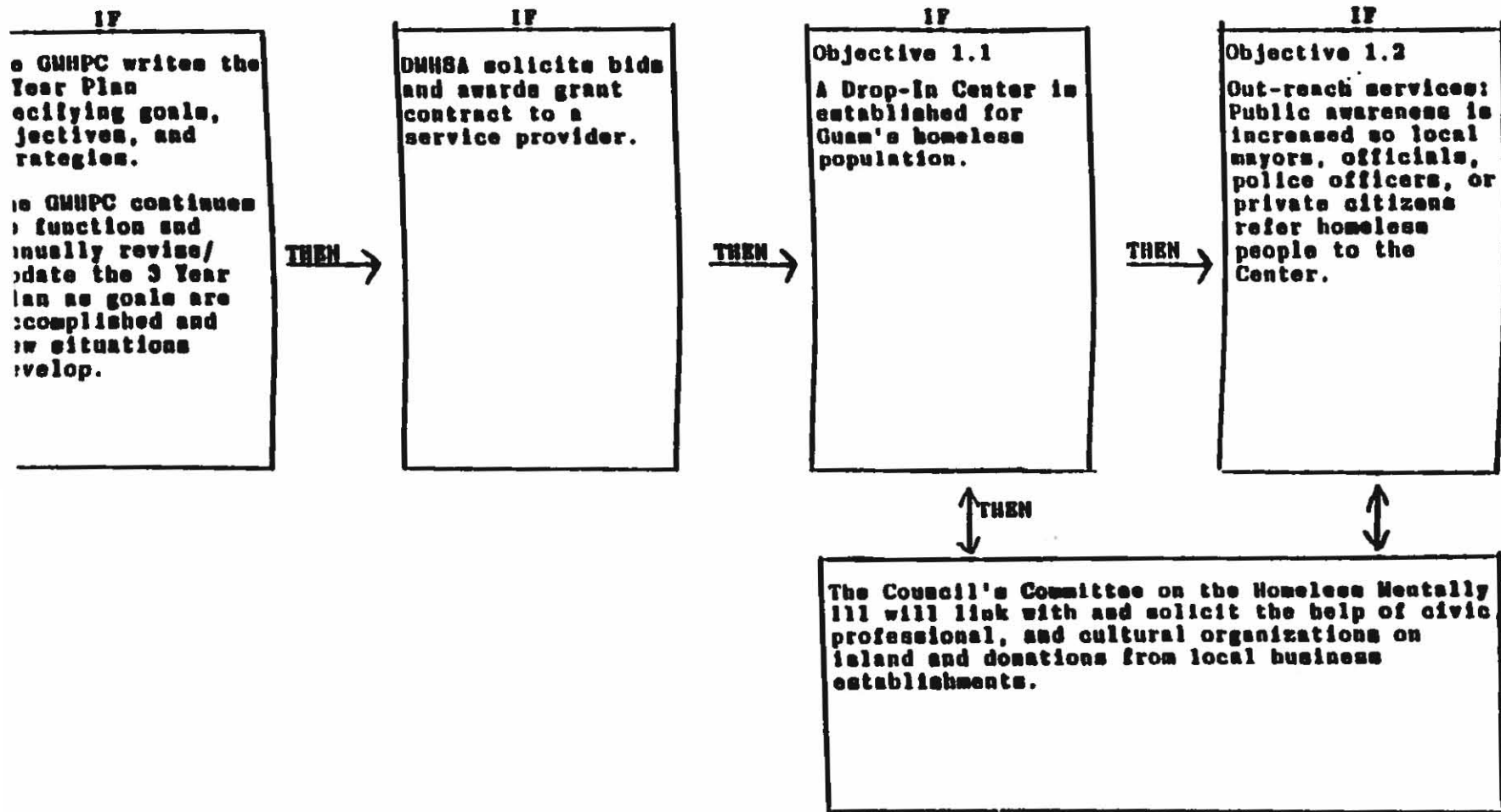


Figure 2 (Continued)

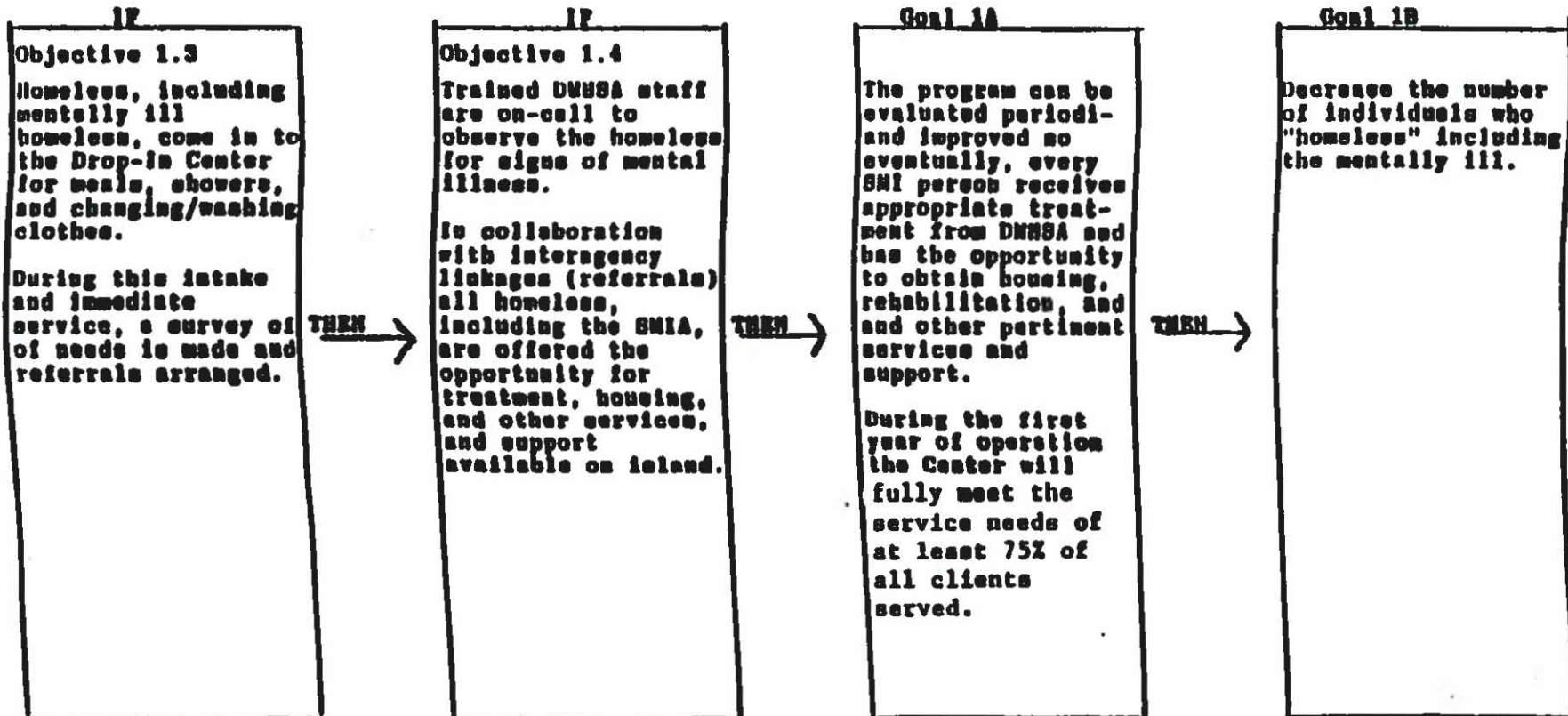


Figure 3
Actions for Implementing the Program Logic Model
(See Figure 2)

CONTENT: Objective 1.1 - Establish Drop-In Center

Actions Needed:

1. St. Vincent De Paul Society - Receives \$29,000 contract to provide services to the homeless.
2. The Maintenance and utility needs of the facility must be met. (Target is for an October 1 opening).
3. A system policy manual is written, and continues to be revised.
- 4a. Obtain equipment and supplies for daily operations.
- 4b. Obtain transportation vehicle(s) - 1 minimum / 2 optimum.
- 5a. Staffing plan is written; the Center will need a minimum of 8-9 volunteers who will rotate shifts through the week when it eventually remains open 24 hrs.; it's current hours of operation -- evenings and over-night until the next morning -- will need a minimum of 4-5 volunteers who will rotate shifts through the week.
- 5b. Obtain increased number of volunteers committed to help operations.
 - a) Need to achieve a pool of volunteers (minimum listing of 30) that can rotate service in 1-2 month blocks of time.
 - b) Contact college (UOG, GCC, Seminary) programs where students need practicums.
 - c) Contact court for assignment of "community service".
 - d) Contact village mayors, community organizations, etc.
- 6a. Conduct training workshops for volunteers and staff volunteers to learn First Aid, CPR, Intake interviewing skills, and how to handle aggressive or violent behavior (e.g. alcoholics, etc.). Contact GPD, Red Cross, DMHSA for the training.
- 6b. Develop the "Orientation Packet" for volunteers to include training materials.
- 6c. Establish Evaluation Plan.

- 7a. Establish a continuous support network (funding donations) among the private sector community.
- 7b. Need to seek support funding so some staff can be paid (managers/supervisors).
- 7c. Seek volunteers for different task needs (e.g. fundraising, volunteer recruitment and recognition committee) and delegate appropriately small job task-segments among several volunteers. Refer to "Tips for Working with Volunteers" Pp. 11-13 in Volunteers: Guam's People Helping People, Community Development Report No. 19, UOG.

EVENT: Objective 1.2 - Out-reach services: Public awareness is increased so local mayors, officials, police officers, or private citizens refer homeless people to the Center.

Actions Needed:

1. Set up publicity committee.
2. Write, print, and distribute flyers.
3. Draft, print, and distribute posters.
4. Media Blitz (talk shows).
5. Get listed in Service Directories, phone book.
6. Contact, and meet with agencies/mayor's council, and community organization meetings to conduct presentations.

EVENT: Objective 1.3 - Homeless, including mentally ill homeless, come in to the Drop-In Center for meals, showers, and changing/washing clothes. During this intake and immediate service, a survey of needs is made and referrals arranged.

Actions Needed:

1. Planning is started to expand hours of operations from the current limitation of evening hours and over-night stay.
2. Intake forms improved by distribution to agencies providing "referral services" to identify screening eligibility criteria and get editing suggestions. (Including liability forms). [Work with PHSS Medical Social Services].
3. Get literature from all service programs to include in a reference notebook binder available during intake.
4. Intake forms printed (as NCR duplication copies).
5. Volunteers trained for Intake skills.

6. Multi-lingual volunteers on-call .
7. If a solution for the client is not accomplished within 7 days (or client abuses services without accepting referral assistance as arranged), the Center will conduct a "staff review" that could restrict services.
8. There may be a need for legislation regarding Guam vagrancy laws to include appropriate legal action facilitating mental health program service for extreme cases refusing solutions. [Work with Guam Legal Services Corporation to ensure protection of people's Constitutional Rights].

ENT: Objective 1.4 - DMHSA -Mental Health Assessment conducted and other referral services provided.

tions Needed:

1. Currently, if client agrees to MHSA assessment, the Center must seek assistance for transportation. (Center's own car, GPD, Public Transit).
2. Arrange for volunteers willing to accompany clients to referral appointment.

Appendix G

Census figures set for Nov. release

By LIZ AVANAR
Daily News Staff

Official population figures for Guam are expected to be released by the U.S. Bureau of Census within the next few weeks, according to island census officials.

Peter Leon Guerrero, the director of the Bureau of Planning, said yesterday that he anticipates those figures will become available by early November. They will be released by the U.S. Department of Commerce's Bureau of Census in Washington, D.C.

Preliminary census figures were released by Guam Del Ben Blas earlier this month. But Leon Guerrero said the figure should not have been released

because it was not official.

"The federal government feels that this is their area of jurisdiction which they pay to have done," he said. "By waiting to release only official figures, (that) protects our interest."

Federal money for the island, Leon Guerrero said, usually is based on population figures.

An official category breakdown of Guam's resident profile is expected to take 18 months. In the past, official profile results took between five to six years, said Director Peter Barcinas at the Guam Department of Commerce.

The federal government provided about \$800,000 to conduct the census on Guam. An initial \$500,000 was granted

and an additional \$400,000 was released to increase about 400 census takers' salaries from \$6 to \$7 an hour and pay building rental costs, Barcinas said.

The salaries were raised as a measure to slow a high turnover rate among census takers and to attract new workers, he said.

When the census ended Sept. 1, some Guam residents said they never were contacted to be counted.

Sam Gillentine, the regional manager of the Inspector General at the Department of the Interior, said he never was contacted at his apartment building in Tamuning.

No one visited his home and no notices were left on his door, he said.

When census takers were unsuccessful in reaching residents, Barcinas explained, census supervisors were sent to the homes.

Barcinas, whose department performed the census operations on Guam, said supervisors, as a last resort, asked neighbors about how many people were living in the homes.

A short form, in place of the long profile form which had to be answered in person, was used to count the number of residents in those homes, Barcinas said.

Education board studies revisions UOG, GCC might change

By ZITA Y. TAITANO
Daily News Staff

Leaders in the island's post-secondary education system will weigh the idea of restructuring the roles of the University of Guam and Guam Community College at a meeting next week.

Lawrence Kasperbauer, the chairman of the Joint Board of Education, said board members will discuss organizational revisions that could result in GCC becoming a junior college and UOG becoming a senior college and graduate school.

Kasperbauer said he expects to receive a recommendation report from the structure-review committee that is handling the idea with the two post-secondary institutions.

The Territorial Board of Education, Guam Community College Board of Trustees, and the University of Guam Board of Regents make up the Joint Board of Education.

The joint board's meeting will be held at 6:30 p.m. at the Robert F. Kennedy library A-V

room 1 at the University of Guam on Tuesday.

The joint board meets twice a year to examine ways the three educational systems can meet the needs of the island's youth.

Other items to be considered at Tuesday's meeting include a presentation by the board's Teacher Certification Task Force committee. The presentation will focus on amending a law that would transfer teacher certification and licensing to the board. The Department of Education handles that role now.

Joint board members also plan to schedule a meeting with the legislature to propose the amendment. But for now, DOE will continue to handle such matters, Kasperbauer said.

Another agenda item calls for a look at the possible consolidation of some educational programs and the assessment of other existing programs and how the island's tight labor pool plays a role in those.

The board will meet again in January 1991.

Results of pay-scale study given next week

By MARSHALL SANTOS
Daily News Staff

Results of the Hay Group Comprehensive Classification and Compensation Study should be available to the Guam Legislature by next week, according to Felix Camacho, the executive director of the Civil Service Commission.

The Hay Group, a Washington D.C.-based management consulting firm, was given a \$477,000 contract by the CSC to study government jobs and make recommendations for fair compensation.

The study will bring pay scales up to date with two million similar jobs in the United States in comparable jurisdictions.

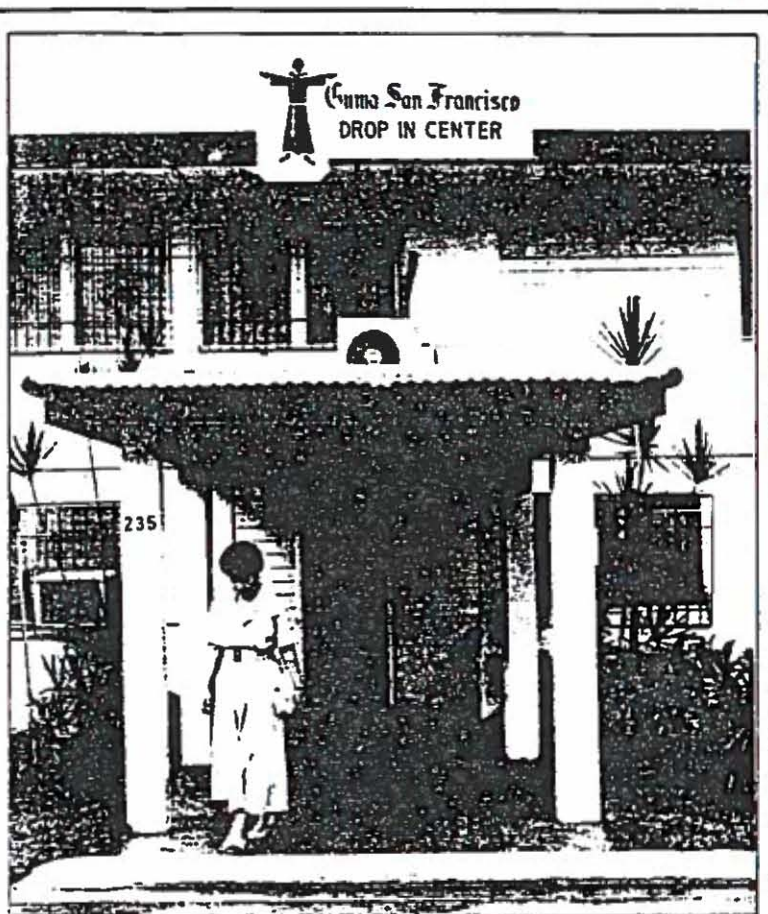
Camacho said the four-volume, 600-page report is complete and bounded, but has to

be reviewed by Manny Chagualaf, the last member of the seven-member CSC board to review the study. Camacho said yesterday that Chagualaf was on Saipan.

Vice Speaker Ted Nelson requested that the Committee on General Governmental Operations meet with the CSC and representatives from the Hay Group on Oct. 18, but Camacho said the commission was not given enough time to study the report and requested a postponement.

Nelson said yesterday that he will again request a public hearing with the CSC next week, "even if I have to issue a subpoena to drag them in here."

Camacho said that once the document meets with the approval of the Legislature, then it will become public.



HOMELESS CENTER OPENS — Juanita Ulloa of Tamuning leaves after visiting the Guma San Francisco Drop In Center for the homeless following an opening ceremony yesterday in Anigua.

Rape, murder retrial postponed again

By FRALE OYEN
Daily News Staff

The retrial of a man accused of participating in the attempted rape and murder of a nurse has again been postponed.

The retrial of Ramon A. Castro was scheduled to begin yesterday.

It now is scheduled to begin after Nov. 5, giving defense attorneys David Lujan and Michael Perez the chance to

argue that Superior Court Judge Janet Healy Weeks reconsider a decision issued yesterday afternoon.

Castro is being retried for his alleged participation in the March 2, 1986, murder and attempted rape of Patricia Best.

In 1987, Castro was convicted but his conviction was overturned after the 9th Circuit Court of Appeals found that the trial judge read incorrect jury

instructions.

In her decision, Weeks ruled that statements made by Rose Santos, Kenneth Charfauros, William Charfauros and William Iglesias would be excluded from the trial.

All four implicated Iglesias, not Castro, in the Best murder and may raise doubt to Castro's guilt, defense attorneys argued.

Castro's retrial has been continued for more than a month.

Appendix H



H O T L I N E

4 7 7 - 8 8 3 3 2 4 H O U R S

ONE CALL
CAN SAVE
A LIFE!

4 7 7 - 8 8 3 3

2 4 H O U R S

Anyone can Call

**Our dignity
is not in what we do,
but in what
we understand.**

**George Santayana
Winds of Doctrine
1913**