TERRITORY OF GUAM

MENTAL HEALTH
ALCOHOL AND DRUG ABUSE

FIVE YEAR STATE PLAN

1981 – 1986

TERRITORY OF GUAM
MENTAL HEALTH, ALCOHOL AND DRUG ABUSE
FIVE YEAR STATE PLAN

Mental Health and Substance Abuse Agency
Ada Plaza, Agana, Guam
P.O. Box 20999
Guam Main Facility, Guam 96921
Tel. No. 477-9704/5

GUAM

COMPREHENSIVE FIVE YEAR

STATE PLAN FOR

MENTAL HEALTH, ALCOHOL AND DRUG ABUSE

GOVERNMENT OF GUAM

MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY

POST OFFICE BOX 20999

GUAM MAIN FACILITY

GUAM 96921

PAUL M. CALVO

GOVERNOR

JOSEPH F. ADA

LIEUTENANT GOVERNOR

PETER A. SAN NICOLAS

ADMINISTRATOR

VICENTE B. CALVO

DEPUTY ADMINISTRATOR

PAUL M. CALVO
Governor

Territory of Guam

OFFICE OF THE GOVERNOR
AGANA, GUAM 96910
U.S.A.

OCT 07 1980

It is with confidence that I endorse the policies and programs contained in this Five-Year Plan for Alcohol and Drug Abuse developed by the Mental Health and Substance Abuse Agency, the Single State Agency for the Territory of Guam.

This plan represents the policy of the administration and sets forth realistic goals in a concise and efficient manner.

As we follow this plan into the 80's I am confident that it will lead us in a united direction towards reducing the many negative impacts of Alcohol and Drug Abuse.

Sincerely,

PAUL M. CALVO
Governor of Guam

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COMPREHENSIVE FIVE YEAR
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Sincerely,

PAUL M. CALVO
Governor of Guam

MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY
P. O. Box 20999 Main Facility Guam 96921 Tel: 477-9704/5

PAUL M. CALVO
Governor

PETER A. SAN N
Administra

July 31, 1980

The finalization of this Five-Year State Plan for Mental Health, Alcohol and Drug Abuse for the Territory of Guam represents the culmination of a year long effort by the staff of this Agency to produce a viable and effective planning document for future guidance. This plan considers the many unique aspects of Guam's culture and society and has promoted only those programs and activities which will best serve our community. To assure this responsiveness to the community, months were spent gathering community input and reviewing programs elsewhere. As we begin to implement the programs contained in this plan we will begin to see the fruition of our planning efforts and I feel confident that we do so with a job well done.

It is, therefore, with a sense of pride and optimism that I present this Five-Year Plan for Mental Health, Alcohol and Drug Abuse for the Territory of Guam.

Sincerely,

Peter A. Rivas

PETER A. SAN NICOLAS
Administrator

GOVERNMENT OF GUAM

OCT 07 1980

Memorandum

To: The Governor

From: Guam State Clearinghouse

Subject: Five-Year State Plan - Drug and Alcohol Services

The Clearinghouse Committee has initially deferred action on the subject State Plan because of various issues and concerns raised by the Bureau of Planning regarding the plan itself. These problems were subsequently discussed and settled to the satisfaction of the Committee.

The Five-Year State Plan for Drug and Alcohol Services is not an application for funding at this time, but simply a comprehensive document which outlines the objectives, policies and plans of action relative to drug and alcohol services proposed to be implemented on Guam during the next five years.

The Guam State Clearinghouse approves and recommends your concurrence.

Joseph F. Ada

JOSEPH F. ADA
Lt. Governor

Attachment

cc: FSHR
HHSAA ✓
SF Liaison Office

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Region IX
50 United Nations Plaza
San Francisco CA 94102

NOV 05 1980

Mr. Peter A. San Nicolas
Administrator, Guam Mental Health
and Substance Abuse Agency
P.O. Box 20999, Main Facility
Agana, Guam 96921

Dear Mr. San Nicolas:

Thank you for providing evidence of the State Health Coordinating Council and State Clearinghouse review of your Alcoholism Plan Update for fiscal year 1981.

The information submitted adequately satisfies condition number 1b as identified in our letter of September 11, 1980. However, condition number 1 will not be released at this time, it will remain in effect until such time as evidence is provided indicating that the State Health Coordinating Council is represented on the advisory council.

We would like to inform you that we have not received your response to condition number 2 regarding the assessment of your progress relating to the implementation of the State Plan and a plan of action for the next three years. Please submit this information at your earliest convenience.

If you have any questions concerning these matters, please contact Miss Dorine Loso, Director, Division of Alcohol, Drug Abuse and Mental Health Programs, Public Health Service, 50 United Nations Plaza, San Francisco, California 94102. Miss Loso's phone number is (415) 556-2215.

Sincerely,

Eric R Swanson for

Alan S. Harris
Chief
Office of Grants Management

cc:
Dorine Loso
Carlos Reyna

...MENT OF HEALTH & HUMAN SERVICES

DEC 04 1980

Mr. Peter A. San Nicolas, Administrator
Guam Mental Health and Substance
Abuse Agency
P.O. Box 20999, Main Facility
Agana, Guam 96921

Dear Mr. San Nicolas:

Thank you for responding to the conditions placed on your Alcoholism State Plan Update for Fiscal Year 1981.

The information submitted has been reviewed by the Regional Office and has been found to satisfactorily address condition 1a and 2. As a result, I am pleased to inform you that these conditions are hereby released.

Sincerely,

Sheridan L. Weinstein, M.D.
Assistant Surgeon General
Regional Health Administrator

cc:
Carlos Reyna

October 15, 1980

Sheridan Weinstein, M.D., M.P.H.
Regional Health Administrator
U.S. Public Health Service
Department of Health and Human Services
50 United Nations Plaza
San Francisco, California 94102

Dear Dr. Weinstein:

We wish to inform you that our Council has reviewed the State Plan on Alcohol and Drug Abuse submitted by Guam Mental Health and Substance Abuse Agency.

We found the State Plan in harmony with the Guam Health Plan.

Enclosed for your information are the results from a joint effort of our Plan Development and Project Review Committee.

Sincerely,

JUDITH P. GUTHERTZ
Chairperson, Guam Health
Coordinating Council

Enclosure

cc: MHSAA

November 3, 1980

Ms. Dorine Loso, Director
Division of Alcohol, Drug Abuse and
Mental Health Programs
Department of Health and Human Services
Region IX, Room 322
50 United Nations Plaza
San Francisco, California 94102

Dear Ms. Loso:

The Agency is an receipt (on October 6) of your letter dated Sept September 26, 1980 approving the Mental Health Five-Year Plan (1981-1985) with two conditions.

In an effort to satisfy both conditions the Agency herewith attached a listing of the Advisory Council membership and SHICC status report in their review of the plan. Subsequent actions regarding the SHICC's review will be directly forwarded to your office as soon as possible.

On behalf of the Agency and myself, I like to extend my sincere appreciation of the confidence bestowed upon this Agency and itis development of plans of the Mental Health services for the Territory of Guam.

Sincerely,

PETER A. SAN NICOLAS
Administrator

Attachments

LAFLAGUE:mgl
11-3-80

cc: Chrono - File
Directors Chrono - File
Larry Aflague

Guam Health Planning and
Development Agency
Suite 205, GCIC Building
414 West Soledad Avenue
Agana, Guam 96910
Phone: 472-6831/32

Guam Health Coordinating Council
c/o Suite 205, GCIC Building
414 West Soledad Avenue
Agana, Guam 96910
Phone: 472-6831/32

October 21, 1980

Memorandum

To: Administrator, Mental Health and Substance Abuse Agency

From: Administrator, Guam Health Planning and Development Agency

Subject: Mental Health Five Year Plan (1981 - 1985)

We are in receipt of Dr. Weinstein's September 26, 1980 letter indicating approval of the Plan with a stipulation that you provide evidence to the Regional Office that GHCC has approved or has not acted to disapprove said Plan.

As you know, the GHCC review process will terminate November 8, 1980. As of this date, the GHCC has not acted to disapprove the Plan.

My staff will continue to meet weekly with your planning staff to discuss ways to incorporate the Alcohol, Drug Abuse and Mental Health Plan into the Guam Health Plan. I am confident their efforts will lead to production of more articulate documents to guide development of Guam's health care system.

CERILA MATIAS RAPADAS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IX
Office of the Regional
Health Administrator
50 United Nations Plaza
San Francisco CA 94102

DEC 1 1980

12/5 SHKD

12/5 LLL

FRANK - MIKE
LARRY - FRED

Mr. Peter A. San Nicolas, Administrator
Mental Health and Substance Abuse Agency
P.O. Box 20999
Main Facility
Guam 96921

Dear Mr. San Nicolas:

The materials submitted in response to the two conditions for approval of the Mental Health Five-Year Plan (1981-1985) for the Territory of Guam have been reviewed.

I am pleased to inform you that, based upon this review, the conditions have been satisfied and are now removed.

Sincerely,

Sheridan L. Weinstein, M.D.
Assistant Surgeon General
Regional Health Administrator

PHONE (916) 457-3853

EDWARD RUDIN, M. D.
1410 BIRCHWOOD LANE
SACRAMENTO, CALIFORNIA 95822

9/30 9/29 Nick PRA 5e

September 23, 1980

Mr. Peter A. San Nicolas, Administrator
Mental Health and Substance Abuse Agency
P.O. Box 20999 Main Facility
Guam 96921

Dear Mr. San Nicolas:

Thank you for your time and your courtesies during my September return to Guam. As before, I very much appreciated my time with you and your staff.

Congratulations on your successful completion and submission of the Five Year Plans on Mental Health and Substance Abuse. You gathered valuable data on social indices, which should now be correlated and related to service needs.

Please let me know if you have not yet received the forms and guidelines I had requested for you from Region IX. Better yet, write Dorine Loso directly, with a copy to me.

My thanks again.

Hafa Adai,

Edward Rudin

cc: Lieutenant Governor Ada/Attention: Mr. Manny Cruz
DHHS, Region IX (3 copies)

TABLE OF CONTENTS

STAFF

Frank R. San Agustin - Chief, Administration Division
Michael B. Powell - Chief, Treatment Services Division
Carlos C. Diaz - Chief, Training and Prevention Division
Lawrence R. Aflague - Chief, Planning Division
Fred F. Ungacta - Chief, Quality Assurance and Evaluation Division
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Margaret G. Lara - Secretary I
Sabino A. Cruz - Building Custodian I
Maria P. Yamashita - Private Secretary
Phyllis R. Luminelli - State Plan Consultant
Gil H. Untalan - Consultant

A C K N O W L E D G M E N T

The Mental Health and Substance Abuse Agency gratefully acknowledges the following individuals and agencies for their assistance and input to this State Plan. In alphabetical order:

Andersen Air Force Base - Social Actions, Capt. Marty Teeter
Bishop Felixberto Flores - Diocese of Agana
Catholic Social Services - Father David Quitugua and Staff
Department of Education
Department of Public Safety
Department of Youth Affairs
Division of Mental Health - Drug and Alcohol, Saipan, Northern Mariana Islands - Frances Schwaninger-Morse, Ph. D.
Family Health Program - Dr. Peiter Huitema
Guam Community Mental Health Center
Guam Health Planning and Development Agency - Jose Mendiola
Guam Memorial Hospital - Leonard A. Ensminger, Administrator
Guam Telephone Authority - John San Agustin, Director, and Claudia Conroy
Human Services Corporation
Naval Hospital - Capt. Michael Carver
Office of Attorney General - Russell Weller, Chief Deputy Attorney General
Office of Highway Safety - Angelina Mummert
Participants of the Mental Health and Substance Abuse Agency Prevention Conference (February, 1980)
Department of Public Health and Social Services - Division of Social Services - John Guerrero
Special Assistant to the Governor - Lorenzo Aflague
Servicio Para I Manamko Association (SPIMA) - Tomas Santos
Teen Challenge - David and Joanne Hayes
Trust Territory Psychologist - Louis F. Morse, Ph. D.
Vietnam Veterans Committee Members
Village Commissioners' Council
Elsie Woodyard, Ph. D.

and to the respective Division Heads of the Mental Health and Substance Abuse Agency for their dedicated service.

Introduction

The continued and conscientious planning, development, revision, and provision of services relative to alcohol, drug abuse, and mental health problems to individuals in need is part of the Mental Health and Substance Abuse Agency's commitment to the people of Guam. The following combined Five Year Plan for Alcohol, Drug, and Mental Health is the culmination of months of effort by the Agency's staff to provide an effective planning document that will ensure the realization of its commitment to the people of this Territory.

The substance abuse problem is not an easy one to understand and effectively deal with unless its causes and, not just its effects, are dealt with realistically. Book One (Alcohol and Drug Abuse) represents the Agency's continued efforts to put together a current and realistic needs assessment through the careful collection and analysis of accurate and relevant data. MHSAA plans to expand its continued support and encourage active community outreach activities in order to guarantee maximum utilization of existing programs, as well as recognize, encourage, and develop specialized direct programs for special treatment populations. The impact of good, humanistic prevention programs plays a crucial role here. This, along with realistic program planning and effective and adequate treatment will undoubtedly prove to be a winning combination in the fight against substance abuse. With the combined efforts and cooperation of everyone involved in the human services field, and especially the key support of the family, the future can't help but hold many beautiful value-creating alternatives to substance abuse.

Book Two (Mental Health) is presented in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) format. It is written to conform with Book One (Alcohol and Drug Abuse) and in the context of a basic premise: that cooperation and consolidation of efforts in the areas of alcohol, drug abuse, and mental health will provide maximum impact, most economically, for the community of Guam.

Due to the unusual circumstances facing Guam, with the Guam Community Mental Health Center (CMHC) completing its last year of CMHC Operations Grant, the original intention of submitting one combined Five Year Plan

for alcohol, drug abuse and mental health was not feasible. With the understanding and consent of ADAMHA, Region IX, the Five Year State Plan deadline was extended to make it possible to incorporate key elements of the finalized Financial Distress Grant (FDG) application into this plan. With the urgency of the FDG application, inter-agency and community attention and concerns focused on this process. That is, the broadest based planning process, including important community decisions, took place within the context of the FDG application process. It is most appropriate for this plan to be centered in time and content on the results of that process.

It should be noted that, while the FDG application is now complete, the process initiated efforts and raised questions so that this Plan represents a beginning not an end. It is anticipated that the coming year will produce some significant changes of direction, based on efforts to gain information that have just begun and the reflection by many on the process just completed. This creates a unique challenge for composing a Five Year Plan. An unusual, but realistically necessary result, is that the Guam Mental Health and Substance Abuse Agency (MHSAA), as Single State Agency (SSA), has been forced to focus on that area of planning which is the genesis of directions for effort, on the goal setting process itself, rather than the usual emphasis on implementation. As we accepted the definition of our task, its rightness for a Five Year Plan became apparent. Rather than Guam being forced into an awkward task, Guam has been given an opportunity -- the opportunity to begin a five year planning sequence with an examination of basics.

It is worth mentioning that the CMHC is the only public institution offering mental health services on Guam. Pressures of various kinds have been felt to limit CMHC services to those defined under the CMHC Act. Such isolation of CMHC function is NOT appropriate for Guam, an insular community of limited size and resources. To the extent that specific funding for community mental health centers is available to Guam, the program can be fiscally isolated as with any other grant program.

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(Drug and Alcohol)

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(DRUG AND ALCOHOL)

INDEX OF APPENDICES
(DRUG AND ALCOHOL)

BOOK ONE

ALCOHOL & DRUG ABUSE

FIVE YEAR PLAN

PART 1. SYSTEM DESCRIPTION

A. Management System

1. Policy on alcohol and drug abuse.

The following are policies of the Mental Health and Substance Abuse Agency (MHSAA) as Single State Agency (SSA) for the Territory of Guam in the areas of alcohol and drug abuse.

a) That preservation of the dignity of the individual is of paramount importance in the prevention and treatment of alcoholism and drug abuse.

b) That the MHSAA will support and foster (the growth and development of) the provision of quality services to individuals in need, and that these services will be offered in the least restrictive setting possible.

c) That the following patterns of drug use are adopted by this agency:[1] 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 purposes. Drug abuse is the nontherapeutic use of any psychoactive drugs, including alcohol, in a manner that adversely affect some aspect of the user's life.

d) That treatment services will address the cultural issues germane to the residents of Guam including the Natural Provider* concept, cross-cultural program design, and special emphasis groups as appropriate such as women, youth, and the elderly.

e) That priority will be given to 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.

* Natural Provider - Clergy, Village Commissioners, Village elders, Suruhanus and others

[1] Report to the Congress of the United States HRD-80-32 April 14, 1980

f) That the MHSAA will promote legislation favorable to the provision and receipt of services by all in need in the areas within its responsibility.

The MHSAA has a commitment to the people of Guam for the continued and conscientious planning, development, revision, and provision of services to individuals in need. This commitment includes inacting cost effective measures in the areas of service provision, coordination of resources, technical assistance, data sharing, and grants management.

Since Guam is presently more advanced in some areas of services than in others, every effort will be made towards eliminating (and identifying) barriers to treatment where they exist and opening appropriate alternatives and opportunities for treatment which do not exist. This also includes the continuation of Methadone Maintenance and Detoxification services and Drug Free Residential Services (TC) which are recognized for their effectiveness in the area of drug treatment and rehabilitation. Diversion efforts with the Courts by both service providers in these areas have just recently begun. These efforts will be monitored, evaluated, and supported by the MHSAA as appropriate. The provision of counseling services to the inmates of the Department of Corrections was recently implemented by funding by the MHSAA, and will be continued, altered, or revised as appropriate based on evaluation and effectiveness.

The MHSAA recognizes the need for continued examination and alteration of services to assure quality of care in all areas within the jurisdiction of the agency. In some cases this requires legislation. An example of this is the continued efforts of this agency in support of the passage of Bill 59 before the 15th Guam Legislature. This bill, The Uniform Alcoholism Intoxication and Treatment Act is seen by this agency as a primary step in recognition of the scope and reality of dealing with alcoholism and alcohol abuse.

The Office of Highway Safety has recently solicited interest in a variety of driving programs development, including DWI, and efforts are underway with the Guam Court System to assure an effective DWI program germane to Guam.

The division chiefs are responsible for initial policy development in coordination with the Agency Administrator. Each division chief recommends legislation, policies, procedures, and program objectives within

the divisional area of responsibility. Joint staff meetings are held to finalize policy decisions. Major items, such as reorganization, and contracting, would require approval of the Governor of Guam. Authority for other areas specifically related to drug or alcohol related issues is vested in the MHSAA.

The MHSAA has a 13 member combined Advisory Council for drug and alcohol. The responsibility of the Council is to review and comment on activities and policies of the MHSAA. This Council meets monthly, or more often if needed, with the staff of the MHSAA (Administrator, Deputy Administrator, and Division Chiefs) to assure their active involvement and awareness of Agency activity. The Council has a broad base representation of women, youth, retirees, professionals and grassroot members, fulfilling Federal criteria.

2. The Single State Agency

The MHSAA was created by Executive Order 78-3 (Appendix A-Item 1) in February of 1978 and, as such, serves as the Single State Agency for mental health, drug and alcohol services within the Territory of Guam. (This Executive Order has recently undergone review by the Office of the Attorney General in order to develop an amendment to clarify the scope and authority of the MHSAA. This amendment is still being developed by the Office of the Attorney General.)

The Administrator of the MHSAA reports directly to the Governor of Guam as reflected in the Government of Guam Organizational Chart, (Appendix A-Item 2.) The Administrator also serves as a member of the Guam Health Coordinating Council and as administrative liaison to the MHSAA Advisory Council (Appendix A-Item 3) and the A-95 Clearinghouse. The Administrator and his staff serve as resource people to the Governor's Legislative Review Committee and to other agencies and organizations and, as appropriate, present testimonies on legislations relating to the areas within the purview of the MHSAA.

The MHSAA is organized into five major divisions: Planning (including Research and MIS); Direct Services (including treatment & technical assistance); Training and Prevention; Quality Assurance and Evaluation; and Administration (including contracts, grants, and budgeting). These divisions are represented on the MHSAA Organizational Chart (Appendix A-Item 4). In addition to the five major divisions the agency has a Medical Advisor on staff as indicated on the chart. Divisional support staff are

shown on this chart by respective division. Functional responsibilities are depicted on Appendix A-Items 5.

Each division, under a division chief, is responsible for inter and intra-agency coordination to assure maximal coordination of effort and resources. At present, all MHSAA staff carry inter-disciplinary functions on a combined function basis.

Presently, the staff of the SSA monitors, evaluates, and provides technical assistance to the two programs which provide services within the scope of the SSA authority and receive funding from the SSA or the local government. These programs are the Guam Community Mental Health Center and the Catholic Social Service, Inc. Technical assistance (TA) in the area of programming is provided by the Direct Services Division Chief; Budgeting by the Administrative Division Chief; and monitoring and evaluation by the Chief, Quality Assurance and Evaluation. Program development is assisted by coordinated efforts of division chiefs by approval of the Agency Administrator SSA, with final contract approval vested in the Governor of Guam after review by the Attorney General's Office, Department of Administration, and the Bureau of Budget. The Fiscal Officer of the MHSAA, in conjunction with Bureau of Budget determine the administrative costs based on federal guidelines and allowable charges.

Some functions of the SSA are performed as integrated functions across ADM disciplines. However, this only occurs with non-matching State funds. In all cases of federal funding, including State match funds, there is separate accounting by grant with distinct services (joint or combined) identifiable by ADM functions.

B. Planning

The MHSAA views coordinated planning as the basis for responsible program development. Since the MHSAA is not segregated by such categories as mental health, drug or alcohol, each division chief serves as the individual with ultimate divisional responsibility in all three categories for the Territory of Guam. Thus, the Chief Planner in conjunction with the agency consultant* for Guam in the MHSAA area is responsible for receiving and coordinating input to the State Plan by the public and private sector as well as from all other interested parties and government agencies. There are no formal sub-state planning entities on Guam. However, the MHSAA recognizes the importance of the government agencies; involvement as well as that of the village commissioners, clergy, elders, and the service providers. These groups play an important part in the acceptance and utilization of community services in Guam. The MHSAA Chief Planner is responsible for scheduling public meetings, conducting surveys, accumulating incidence and prevalence data and coordination with the Guam Health Planning and Development Agency, A-95 Clearinghouse, and Guam Health Coordinating Council for the review and approval of plans (Appendix B). The A-95 Clearinghouse has, as members, representatives from the Bureau of Planning, Bureau of Budget and Management Research, Guam Health Planning and Development Agency, Public Health and Social Services and other agencies as may be appropriate for specific issues. The State Plan is advertised for public input at the development stage, is presented to the Advisory Council for review and comment, and is also advertised as available for public review and comment upon completion (Appendix B).

The MHSAA is responsible for developing the mental health, drug and alcohol portion of the Guam State Health Plan. Joint meetings are held between staff of these respective agencies to assure coordination of effort as provided by inter-agency agreement (Appendix F).

In addition, the staff of the MHSAA enjoys a close working relationship with Guam Health Planning and Development Agency, Public Health and Social Services, Department of Education, Department of Public Safety, Community Mental Health Center, Catholic Social Services, Department of Youth Affairs, Guam Memorial Hospital, and Department of Corrections. Written agreements are made for specific formal purposes.

C. Support System

Technical assistance (TA) is provided to programs as well as to other government agencies and the private sector in any area within the authority of the MHSAA. Each division chief is responsible for determining the divison capabilities in the area of technical assistance to meet the needs (requests) for technical assistance and if the agency has the manpower and expertise on staff to deliver the specific technical assistance required. If the agency is unable to directly provide the assistance, alternatives are offered towards obtaining it and, where funding exists,

* Phyllis Luminelli; PRL Consultant Services: retained for preparation of the Five-Year Plan

the agency may partially or fully underwrite the cost of procuring the assistance of specialists (consultants) in the field to compliment the staff capabilities of the MHSAA.

Technical assistance is presently available in the areas of clinical supervision, program design/development, grants management, MIS development, internal monitoring and evaluation, and other areas of specialty such as clients rights, clients records, staff development and training, and media campaigns.

One of the main functions of the MHSAA is in the area of training and manpower development as will be addressed in later parts of this document. The Guam MHSAA recently provided technical assistance to Saipan, Northern Marianas Islands in the area of general program development and prevention and training.

D. Monitoring System

Presently the MHSAA conducts quarterly monitoring site visits to service providers and collects MIS data to determine utilization, quality of care, compliance with federal and local regulations, manpower needs, financial management, and service availability. It also collects data regularly from service providers as well as from Department of Public Safety, Public Health & Social Services, Guam Memorial Hospital and other agencies who acquire related data.

The MHSAA has, as part of the Planning Divison, responsibility for the development, integration, and implementation of a Management Information System for mental health, alcohol, and drug. Presently the system is functioning manually and incorporates such data as is obtained from NDATUS*, SAPIS*, CMER*, NIDA Quarterly Report on SWSG* and other indicator data from the related agencies named above.

* NDATUS - National Drug & Alcohol Treatment Utilization Survey
* CODAP - Client Oriented Data Acquisistion Process
* SAPIS - State Alcoholism Profile Information System
* CMER - Clinic Management by Exception Report
* SWSG - Statewide Services Grant

Preliminary steps have been taken to acquire computer capabilities which will formalize the Management Information System and expand the capability of the MHSAA to accumulate, analyze and retrieve data relevant to the mental health, drug, and alcohol fields in Guam. The MIS will incorporate and expand upon data available from the Guam Community Mental Health Center, Guam Health Planning and Development Agency, and other agencies and service providers.

Client data is maintained by primary substance of abuse regardless of joint or combined nature of service delivery. Other, non-fiscal, planning data, such as population characteristics data and crime statistics, are utilized as appropriate to the specific ADM task.

E. Budget Process

The MHSAA prepares an annual budget submission to the Office of the Governor of the Territory of Guam which includes the operational needs of the MHSAA as well as any funding required to maintain or expand program funding. In this budget federal formula dollars and funding under the NIDA Statewide Service Grant are identified and indication is made of how they are to be expended as well as which program will receive them for which services.

The MHSAA budget is prepared with input from each division chief and service providers and is based upon the goals and objectives of the MHSAA as they appear in the State Plan. The MHSAA directly administers those funds which are received and maintained by the agency and it monitors the expenditure of funds received by programs.

In the case of the Community Mental Health Center (CMHC) which is presently under the authority of the Guam Memorial Hospital, a submission for total funding is submitted to the legislature by the Guam Memorial Hospital including the Guam Community Mental Health Center. Funds received by legislature appropriation are administered by the Guam Memorial Hospital. Any federal funds received from the MHSAA are identified as such in the MHSAA budget request and subsequent appropriation. The MHSAA monitors program expenditures of the funds which are provided by the MHSAA to the CMHC and also of funds appropriated as matching by the legislature. Funds provided to the Community Mental Health Center under the Statewide Services Grant are released to the program upon receipt of expenditure report. Formula funds to MHSAA are received through Govern-

ment Division of Accounts, Department of Administration, in a lump sum appropriation with quarterly releases of funds to MHSAA. Catholic Social Services, Inc. (CSS), a newly formed, non-profit organization, received an initial contract from the MHSAA in June, 1979 to provide residential treatment for drug and alcohol abusers. CSS will submit a renewal request to the MHSAA for inclusion in the formal MHSAA budget request to the legislature for continuation of these services. Other programs of the Catholic Social Services organization would receive funding from other appropriate agencies and/or by direct legislature appropriation. The CSS was monitored for budget and program compliance by the MHSAA. Funds under CSS are administered by the CSS Director and Board.

Renewal of any contract or grant is based on a priority system which includes several factors such as utilization, cost effectiveness, community need, quality of service, and the ability of the contractor to provide the services and effectiveness of the modality(ies) involved.

All expenditures of local and federal dollars by MHSAA are monitored by the Government of Guam Department of Administration by the newly implemented and sophisticated Financial Management System.

At this time, MHSAA exerts no direct authority for ADM funds not administered by MHSAA. Our informal working relationships with Department of Education, Department of Public Safety and others have had significant programmatic impact, however. The previously discussed revision of the empowering Executive Order will clarify the MHSAA, role concerning fiscal, MIS and quality assurance issues for ADM funds not administered directly by MHSAA.

With funds administered by MHSAA which are not specific to particular ADM functions, decisions are made by the division chiefs meetings and discussions, needs assessment data, service delivery resources, resources for planning, including availability of resources and other ADM functions. This input is available to the Administrator who has final authority within MHSAA for input to the larger Territory of Guam budget process. Sub-contract providers are required to maintain accounts and report expenditures and revenues by specific ADM disciplines and clients by contract provision.

F. Grants Management System

The MHSAA awards all drug and alcohol contracts and grants based on the demonstrated ability of the contractor to provide quality services to those in need. All contracts and grants are subject to local or federal regulations depending upon the source of funding. The MHSAA employs the Government of Guam procurement regulations which requires competitive bid process unless there is a justification for sole source procurement. Following the bid process all contracts are reviewed and approved by the Administrator of the MHSAA, the Office of the Attorney General, Department of Administration, and the Office of the Governor with final authority resting with the Governor of Guam.

Contracts and grants are monitored on a quarterly basis for compliance with the terms of the contract, fiscal expenditures, and treatment issues. Any deficiencies are submitted to the contractor, in writing, with recommended action steps and target dates for compliance. Continued non-compliance can result in withholding of payment under the contract. Technical assistance is offered to assist programs to attain substantial compliance with applicable regulations.

The Department of Administration, using the recently implemented Financial Management System, has established separate accounts by specific grant programs and periods for all federal funds received by the government (excluding semi-autonomous agencies). Revenues generated by government operated programs are identified by program. Administration of revenues, however, is determined by the terms of legislative appropriation.

Under the Statewide Services Grant, funding is provided specifically for the provision of methadone treatment for heroin addicts. Utilization figures for the program are monitored as are expenditures for compliance with the SWSG provisions.

In the case of Catholic Social Services residential treatment for drug and alcohol abusers, funds are monitored by utilization figures by primary substance of abuse. Program expenditures are monitored on a quarterly basis for compliance with local and federal regulations.

Presently both the contracts are on a per-slot basis. Refer to Treatment and Rehabilitation Section for details.

In the case of the CMHC sub-contract under SWSG, only federal and state match expenditures are reported. The substantial State over-match (primarily for additional outpatient slots for drug abuse clients), the State appropriation to GMH for CMHC alcohol outpatient services and revenues generated by all service slots of CMHC, are not reported to MHSAA. The minimal revenues involved cannot be separately identified by the GMH fiscal system to date. This is expected to change in the coming months under the impetus of application for CMHC Financial Distress Grant funding.

The per-slot costing of the CSS residential program and identification of primary substance of abuse of clients, allow assignment of federal formula monies from NIDA and NIAAA to appropriate client costs with State monies absorbing the majority of costs without restriction per diagnosis. This can be fiscally tightened by ADM discipline as needed despite the increased pressure this places on a program such as CSS.

G. Service Delivery System

1. Presently there are two major service providers in the field of drug, alcohol, and mental health services which receive funds and are monitored and evaluated by the MHSAA. There are approximately* 30 methadone maintenance, 8 methadone detoxification, 8 drug-free and chemotherapy (detox) drug, and 25 alcohol counseling slots available at the Guam Community Mental Health Center, all outpatient. Catholic Social Service, ISA Program, offers 7 drug and 8 alcohol (drug free residential) treatment slots. Private D&A services providers on island are listed in Appendix D-Item 1. These providers are not required to report ADM capacities.

While there can be no treatment relationship with the Andersen AFB Social Action Office nor the Naval Air Station Counseling Assistance Center, these programs make civilian presentations, loan films and other materials from their libraries and generally cooperate in every possible way.

* CMHC capacities are approximated because CMHC is currently reducing staff center-wide in anticipation of funding cuts.

Both GCMHC and CSS have offered combined services in the area of Drug and Alcohol, though GCMHC recently reorganized as a joint service for Drug and Alcohol. The continued operation of these programs at the existing level is highly dependent on availability of funds. The CMHC, in particular, faces the potential loss of $ 517,000 in federal funds, all federal funds except SWSG and local match, based on the initial deferment of the CMHC Distress Grant application. Should funds not be made available under the distress grant mechanism, the CMHC will transfer the provision of D&A services to another agency by the beginning of FY 81. If one year funding is provided, D&A services will be transferred at the end of FY 81. The MHSAA is working closely with CMHC to assure smooth transition of these services to the most appropriate agency or service provider. Although it is not clear what the funding level for CSS will be next year, all indications are that those services will be funded at a level sufficient to continue this quality program. MHSAA is working closely with the staff of CSS to assure funding continuation.

The CMHC D&A program offers specific services geared towards the special needs of women and has made services available to persons under 18. CSS*, however, initiated the RTP*primarily geared towards men. Efforts have been made to secure funds to offer services to women but have not seen fruition. Although funding has not been available, CSS has provided some short term residential services to women at a location other than the RTP program.

The MHSAA recognizes the important of Prevention and those activities are identified in the Prevention Section. Treatment services geared toward youth are presently under study by the Chief of the Treatment and Rehabilitation Section.

2. Licensure and accreditation standards have not been developed specifically for ADM. To date, the two service providers have been contractually required to conform to all relevant federal standards. Both providers are monitored for compliance with NIDA standards, including services as rendered to alcohol clients as applicable. In addition, GMH-CMHC is licensed by FDA and DEA as required for methadone programs. GMH is accredited by JCAH and, as a part of the GMH system, CMHC is monitored for compliance with JCAH standards. Also,

* Catholic Social Service
* Residential Treatment Program

both providers must conform to Guam's laws and regulations involving fire and structural safety, food handling, etc. In lieu of formal licensure and accreditation, these standards assure quality services and client safety. As noted in the Quality Assurance and Evaluation Action Plan, formal licensure and accreditation standards will be developed and presented for review, comment and discussion by GHPDA, GHCC, MHSAA Advisory Council, service providers and the public prior to finalization and recommendation for authorizing legislation.

PART II: PERFORMANCE REPORT

A. General Procedures

The performance report is divided into six sections in order to facilitate the review of this plan. Each section report is based on the objectives set forth in the previous State Plan. Though last year's action plan and this "Performance Report" are presented in the NIDA format, all elements of the ADAMHA functional categories are covered. Each objective contains a section which explains the present status of that particular objective. Each status report was developed by the division chief responsible for completion of the referenced objective. General comments in response to the guidelines follow.

B. ADMINISTRATION

Objective a): By December 1979, the Executive Order which created the Mental Health and Substance Abuse Agency will have been revised to clarify the agency authority to enable it to effectively discharge its mission.

Status: A series of discussions have transpired between the Mental Health and Substance Abuse Agency and representatives of other Government agencies which included but was not limited to the Guam Health Planning and Development Agency, the Guam Clearinghouse, and the Office of the Attorney General. The Executive Order 78-3 was revised and forwarded to the Office of the Attorney General (AG) on March 17, 1980. As a result of the AG's review,it has been decided that a new Executive Order is not needed and instead 78-3 will be amended, as appropriate, to clarify the authority of the MHSAA. The wording has been finalized in consultation with the AG and submitted for processing. This objective is considered to be 100% completed.

Objective b): By June 1980, information relative to third-party payment will have been gathered and reviewed, and recommendations for action prepared in report form.

Status: Third party payment information is almost fully gathered. The MHSAA facilitated CSS-RTP[1] food stamp participation with the aid of PH&SS[2] and some self-pay from public assistance. Presently the MHSAA is working on Medicare eligibility with PH&SS. The MHSAA investigated the CMHC third-party payment status and was instrumental in gaining GMH commitment to separately identify third-party billings and collections beginning July 1, 1980. Preliminary discussions have been held with the Community Mental Health Center and other agencies regarding the inclusion of drug and alcohol services coverage to be included in the Government of Guam group health insurance coverage for 1981. We received a commitment from the Guam Memorial Hospital, Community Mental Health Center division, to compile an experience report on all third party income for completion by January 31, 1981. This objective is considered 95% complete and the MHSAA report is expected to be finalized by July 1980.

Objective c): By December 1979, the mechanism through which programs may obtain reimbursement from the Veteran's Affairs Office for services rendered to veterans will have been developed.

Status: Correspondence has been submitted to the V.A. Office in Hawaii for reimbursement of V.A. services rendered to Guam veterans - no reimbursement mechanism has been developed due to lack of response from the Hawaii VA office. MHSAA will continue pursuing this reimbursement mechanism.

Objective d): By October 1980, legislation enabling a tax to be levied on the sale of alcoholic beverages for the purpose of generating funds for alcohol related programs will be drafted and introduced to the Guam Legislature.

[1] Catholic Social Service - Residential Treatment Program

[2] Public Health and Social Services

Status: Tax legislation for alcoholic beverages is on suspended status pending submission and passage of a bill into law designating statutory ranking for the Mental Health and Substance Abuse Agency. This move would strengthen the position for passage of this type of legislation which would sepcifically earmark alcohol tax revenue for treatment of alcohol related problems.

Objective e): By September 1979, the Uniform Alcoholism and Intoxication Treatment Act will be revised and presented to the Governor's Legislative Review Committee.

Status: The Uniform Alcoholism and Intoxication Treatment Act was revised (9/79) and presented to the Governor's Legislative Review Committee. A revised draft copy of the Act was also submitted to Senator E.R. Duenas, Vice Chairperson of the Committee on Health, Welfare and Ecology. This objective is considered complete.

MANAGEMENT INFORMATION SYSTEM

Objective a): To develop a feasibility study on the pre-development design to the MIS.

Status: This objective did not contain specific target dates primarily because specific planning of the project required considerable preparatory work involving writing, systems translation, and programming of specific needs. Also, financial resources had not been prioritized for this project. The initial step taken was a request on October 1979 by the Chief Planner of the MHSAA for the appointment of an MIS task force and a systems advocate. The request is still pending. As of 3/80 form designs were in process of being drafted. Development of the feasibility study will not continue to be considered as an objective, instead, a redefining of this objective will be that, what has been accomplished will phase directly into a gross-design report which will constitute the pre-development design of the agency MIS. The purpose for this is twofold: first, the feasibility study

is nationally researched and the MIS is mandated by NIDA, and second; the agency is suffering from inadequate financial resources, limited time and staff.

Objective b): To refine existing enternal reporting requirements, e.g., CODAP, NDATUS, SAPIS.

Status: The refinement of the external reporting requirements was discussed with the Touche Ross Management Team on their recent visit to Guam to provide technical assistance. They met with the MHSAA division chiefs. This technical assistance provided the agency staff with necessary input ot proceed with the specific coding of needed data. Objective completed.

C. PLANNING AND COORDINATION

Objective a): By January 1980, the MHSAA will have, on a timely basis, information needed from other agencies for reports and planning.

Status: Basic information on program operations is being collected in an organized manner. CODAP is functioning well and monitoring is established. NDATUS and SAPIS reporting has progressed in a timely manner. The agency has made considerable progress on this objective and data are provided regularly by Public Health and Social Service, Department of Public Safety, Department of Education, and the service providers. MHSAA is closely monitoring the recent increase of DWI's and has met with representatives of the Court and office of Highway Safety to coordinate initial efforts at the development of a DWI program. Technical assistance has been provided the MHSAA to CSS-RTP and Saipan MHSAA.* A cooperative agreement has been signed between GHPDA and the MHSAA and an excellent working relationship exists between these and other government agencies. Objective completed.

Objective b): By May, 1980, the possibility of cooperative agreements with the Commonwealth of the Northern Mariana Islands

* Commonwealth of the Northern Mariana Islands

and the Trust Territory Govenrments will be explored and reported.

Status: A fact finding trip to Saipan was conducted in April 1980 and meetings were held with the Director of the Saipan Community Mental Health Center and also with the Psychologist for the Trust Territories. A report was written and forwarded to the Governor's office for consideration. Report is enclosed as Appendix C. Objective completed.

Objective c): By December 1979, MHSAA would have developed and implemented a State Plan milestone schedule to assure timely review and submission of FY 1981 State Plan.

Status: A Milestone schedule was developed in December 1979 and is located in the office of the Chief Planner, MHSAA. Objective completed.

D. TREATMENT AND REHABILITATION

Objective a): Design and implement a storefront program to provide central intake and emergency referral services.

Status: The design for the storefront program is in draft stage involving three distinct functions and is pending availability of funding. The functions are: 1) 24-hour crisis intervention services; 2) 24-hour information and referral service and directory; and 3) social detox (alcohol). The services directory is presently being revised, updated and designed for system implementation as a functional service tool. Funds have been identified: Uniform Alcoholism Act Funds avails 100% Federal funding to Guam for six years at $150,000 per year. This money should become available within a few months of application following the passage of the Uniform Alcoholism Intoxication and Treatment Act. Utilization of CETA workers is being explored. It is expected that this program can begin operation in 1981. This program will fill major portions of existing service gaps now existing for alcohol programming and also for general

life crisis situations. In addition it will provide the information and referral system many agencies have reported as a community need.

Objective b): Develop and implement an Employees' Assistance Program.

Status: Pilot project model was presented to the Agency Administrator in August 1979 - it is pending administrative direction and availability of local funds or submission for federal funding.

Objective c): Design and implement complimentary services for the special needs of addicted women.

Status: The MHSAA provided technical assistance to Catholic Social Services efforts to develop a proposal entitled "Comprehensive Program for Pacific Island Women With Alcohol Related Problems". This proposal was submitted to NIAAA. Funding was denied and Catholic Social Service is working on a re-submission for July 1, 1980.

Objective d): Provide technical assistance to the Community Mental Health Center Drug and Alcohol units in the development and implementation of a diversion program.

Status: This objective was met. The staff of MHSAA reviewed the CMHC proposal for a diversion program and found it to be defective in several areas. Constructive feedback was provided to the staff of the drug and alcohol units. The feedback was not incorporated and the program submitted to the Office of the Attorney General and the Courts. It has been pending further action since July, 1979.

Objective e): Develop alcohol treatment services germane to Guam.

Status: Social detox is seen as an ideal inclusion with the other 24-hour services in the storefront program under the Uniform Alcoholism Act. GMH would continue to provide medically required alcohol detox. Development of a DWI program is a prime concern and the Agency is coordinating efforts with the Court and Office of Highway

Safety. A short term residential alcohol program is seen as an appropriate component to the Employees' Assistance Program and is designed in draft form. Utilization of the natural provider system is discussed in further detail in the Action Plan for training and manpower development. The MHSAA is committed to supporting non-institutionalized counseling and community services geared to identifying and assessing individuals with alcohol related problems. Responsible provision of information, through community presentations and school programs, has been a part of MHSAA activities to add to the level of public awareness of alcohol use and abuse issues. AA is active and growing in membership and number of meetings, Alanon and Alateen are seen as important components in our treatment sector. (See Appendix D for schedule of AA meetings) The MHSAA is involved in efforts to begin groups capable of attracting and maintaining Chamorro and Filipino memberships.

I. RESEARCH AND EVALUATION

Objective a): Complete Guam Substance Abuse Needs Assessment by April, 1980. The description of this objective was too general in the use of the word "Substance Abuse". The objective needs to be more specific and was amended to read "complete Guam drug abuse Needs Assessment by April, 1980".

Status: Objective completed. Refer to Chapter III.

Objective b): Complete the CMHC D&A program evaluation by September 1979.

The evaluation of CMHC Drug program was completed on September 1979. The major program areas addressed in the evaluation are: organizational management, treatment process, personnel management and financial management. Site visits occurred in July 1979. A summary analysis and recommended action steps were finalized in August 1979. Follow-up evaluation and program monitor-

ing are presently being established with CMHC by the staff of MHSAA. Monitoring problems encountered in July and August, 1979, with the CMHC Alcohol Program, (that program was established in September as a separate service unit within CMHC and lacked NIAAA treatment funding for the program) resulted in the decision to defer evaluation at this time to other priorities. A copy of the report was sent to CMHC for their perusal. Objective completed.

Objective c): To develop and implement monitoring and evaluation procedures for all programs by December 1979.

Status: Meetings with D&A and Catholic Social Services Project Directors for purposes of establishing procedures for monitoring were initiated through meetings with CMHC's director in July 1979 and CSS's project director in January 1980. The effect of the meetings instituted the updating and improvement of reporting CODAP, NDATUS, and SAPIS requirements. Quarterly assessment and evaluation of the programs are scheduled regularly. Objective completed.

Objective d): Complete Needs Assessment section of 1981 State Plan by April 1980.

Status: Collection of data relevent to drugs and alcohol needs assessment were gathered by initiating verbal understanding with government departments to reserve, transmit, and submit copies of analyzed data to MHSAA relevant to surveys, population census, economic indicators, drug and alcohol arrests, morbility reports, mortality, ABC rules and regulations, drugs and DWI arrests, convictions, court referrals, juvenile justice referrals, etc. Reports and copies of these reports are made available to MHSAA staff. The data available include the following: Narcotics, caffeine, nicotine, inhalants/solvents, barbiturates, tranquilizers/sedatives, cocaine, marijuana, anorexants, betel nuts, hallucinogens, and alcohol.

TRAINING

Objective a): To assess training needs of key social service agencies.

Status: Training and Development (Government of Guam) is conducting a survey of Government of Guam agencies training needs. This data is being requested from them.

Additionally, staff development officers of key social service agencies on the island have been contacted and plans are underway to conduct such an assessment related to alcohol and drug abuse issues. This is expected to be completed by July 1980.

Objective b): To develop a course on counseling skills for one group of natural providers.

Status: This appears to be an objective Guam is not prepared to tackle as of yet. More local trainers have to be trained and experienced in delivering courses developed. It is expected that it will be another year before Guam is ready to design its own counselor-training courses that address the cultural and social issues unique to Guam and the Pacific.

In the interim, the emphasis has been on (1) adapting/revising NDAC/NIDA courses to meet local needs, and (2) developing a pool of local trainers through TOTs.

Objective c): To provide training to each member of MHSAA staff.

Status: A list of training and each member attending follows.

NAME	TRAINING/WORKSHOPS
1. Peter A. San Nicolas Administrator	1. PCP Workshop 2. Needs Assessment Prevention Workshop 3. Drug & Alcohol Program Workshop
2. Vicente B. Calvo Deputy Administrator	1. Drug & Alcohol Program Workshop
3. Frank San Agustin Chief, Administration Division	1. Indirect Cost Accounting

NAME	TRAINING/WORKSHOPS
4. Michael B. Powell Chief, Treatment Division	1. Clinical Supervision, NIDA/NDAC TOT 2. Drug In Perspective Update TOT 3. NIDA Regional Workshop 4. Grants Management Workshop 5. Program Management Workshop
5. Carl C. Diaz Chief, Training & Prevention Division	1. Community-Based Prevention Specialist TOT 2. Basic Management Skills, NDAC 3. State Training Support Program Staff Development Workshop 4. Short-Term Client Systems, NDAC
6. John C. Camacho	1. Community-Based Prevention Specialist, NDAC 2. Health Program Management Worksho
7. Aniceto S. Dignadice Medical Advisor	1. Senior Citizens Workshop 2. Supervisory Workshop
8. Larry Aflague	1. Program Management Workshop 2. Community-Based Prevention Specialist, NDAC 3. Health System Analysis 4. Grants Management Workshop
9. Fred Ungacta	1. Program Management Workshop 2. Community-Based Prevention Specialist, NDAC 3. Grants Management Workshop 4. Report and Technical Writing
10. Ernestina Cruz	1. Short-Term Client Systems, NDAC 2. Substance Abuse Prevention Workshop
11. Mike Nacar	1. Community-Based Prevention Specialist, NDAC 2. Short-Term Client Systems, NDAC 3. Techniques in Assessment of Clients 4. Substance Abuse Prevention Workshop 5. Senior Citizens Workshop
12. Don Ploke	1. Program Planning and Evaluation 2. Substance Abuse Prevention Workshop

NAME	TRAINING/WORKSHOPS
13. Bobbie Benavente	1. Short-Term Client Systems, NDAC 2. Community-Based Prevention Specialist, NDAC 3. State Prevention Coordinator Regional Workshop 4. Affective Education Curriculum Training
14. Sonny Taitano	1. Community-Based Prevention Specialist, NDAC
15. Paul Merfalen	1. Substance Abuse Prevention Workshop
16. Greta Llarenas	1. Community-Based Prevention Specialist, NDAC
17. Margaret Lara	1. Records Management 2. Substance Abuse Prevention Workshop
18. Laura B. Mandapat	1. Short-Term Client Systems, NDAC 2. Community-Based Prevention Specialist, NDAC 3. Substance Abuse Prevention Workshop
19. Carol Harris	1. Community-Based Prevention Workshop 2. Short-Term Client Systems, NDAC 3. Affective Education Curriculum Training
20. Esper Budano	1. Substance Abuse Prevention Workshop
21. Norma Pades	1. Substance Abuse Prevention Workshop

Objective d): Provide training to forty treatment personnel from key social services agencies.

Status: About 150 counselors, teachers and social workers from fifteen different social service agencies participated in MHSAA sponsored training as described below:

Course Title	Date(s)	No. of Participants	Sponsoring Agency
Community-Based Prevention Specialist	9/79	10	MHSAA
Group Facilitator	11/79	13	MHSAA

Course Title	Date(s)	No. of Participants	Sponsoring Agency
Short-Term Client Systems	3/80	8	MHSAA
Substance Abuse Prevention Workshop	2/80	98	MHSAA

Objective e): To train instructors in at least 2 additional NDAC or NCAE courses.

Status: Two persons from key social service agencies completed Phase III of a TOT course, Groups Facilitation. The course was conducted locally and the two are now certified trainers for this course, a training program which prepares counselors to be group leaders. A third person from a provider agency has undergone Phase I & II of the Group Facilitator Course and has only to deliver Phase III to become certified. In addition two of MHSAA staff have received trainer status for delivering Supervision and Community-Based Prevention Specialist Courses.

PREVENTION AND TRAINING

Prevention:

Objective a): Revise the pamphlet "Drug Abuse Prevention and the Guam Family".

Status: MHSAA is planning the development of a pictoral booklet entitled "Families on Guam - Ways of Being Together" It will depict how families spend their time on Guam and will function as a preventative tool in that it will demonstrate how the family in itself can serve as an alternative to substance abuse.

Community input has been sought via a photo contest and support has been solicited and received from the business sector. MHSAA will cover printing. The booklet will be distributed island wide and completion date is set for August 1980.

Objective b): Increase utilization of MHSAA library by teachers, counselors and students by 50%.

Status: Use of library has increased in excess of 50%, 1) An average of 100 people, most of whom are teachers and students use the services of the library monthly through film showing requests, using books, distribution of pamphlets on drugs and alcohol to schools and also to medical and dental clinic and law offices on island. 2) The MHSAA library has developed into the most comprehensive substance abuse library on island with over 700 volumes, worth over $7,800 including AV materials. 3) MHSAA announces books available monthly through the Agency Newsletter, COMPRENDE.

Objective c): Develop and implement an electronic mass media campaign focusing on alternatives to drugs.

Status: This was not accomplished; it was an unrealistic objective as no funds were available for a media campaign.

Objective d): Train forty teachers and counselors to use Magic Circle/ Innerchange kits as part of DOE's Substance Abuse Education curriculum.

Status: MHSAA planned to take advantage of the presence on Guam of a trainer from the Human Development Program in California. An agreement was reached to have the trainer for another 8 days for a Magic Circle TOT. Unfortunately a contract complication prevented DOE from bringing the trainer to Guam altogether.

In line with training teachers and counselors to use the Substance Abuse Education Curriculum, two Counselors attended a Training of Trainers course in Affective Education. MHSAA arranged for the two counselors to attend this workshop in Seattle Washington; with MHSAA funding travel and accomodations for one.

The same two counselors are presently conducting an Affective Education - Substance Abuse Education course for 30 people - counselors, teachers and 2 MHSAA staff members.

MHSAA assisted DOE in the application of a School Cluster Grant with Region 8 Training and Development Center. If awarded to DOE, teams within the elementary and secondary schools, the community and an MHSAA staff will be trained to design programs to prevent and reduce alcohol and drug abuse and other disruptive behavior in young people.

Objective e): Implement the Peer Counseling Program in two additional schools.

Status: The Peer Counseling Program presently exists in two schools. Continuation of the program in a third school failed when the trained instructor resigned to leave the Island. Because there hasn't been an expansion of the program in other schools MHSAA assumes there is a need to encourage and convince school administrators and personnel of the program's effectiveness. This can be accomplished through the Affective Education Workshops.

Objective f): Implement A Big Brother's Program.

Status: Talks are underway with the Kiwanis Club of Guam members who have expressed an interest in undertaking this as a club project.

Objective g): Provide P.E.T. to families of probationers.

Status: This objective has not been accomplished. Parent Effectiveness Training (P.E.T.) is in an experimental stage on Guam. A Guam P.E.T. Association has been formed through MHSAA's initiative. Two trainers will be piloting the course to test for relevance to and acceptance by the local cultures. At this point the 23 P.E.T. trainers are not prepared to put on the course for families of probationers.

Objective h): Produce a local film for use as a teaching aid with DOE Substance Abuse Education Curriculum.

Status: DOE Teachers and Substance Abuse Education Curriculum trainers advised against this plan explaining that the

need was to train teachers in the use of the curriculum, and that such a film at this stage of the program's development would be of minimal use.

G. CRIMINAL JUSTICE INTERFACE

Objective a): By September 1979, a formal mechanism by which joint state planning between the MHSAA and the GCJPA can occur will be developed.

Status: This objective has been deferred pending knowledge of GCJPA future status. Though various discussions took place, no clear results came from this activity. However, indirectly, these contacts assisted in the evolving relationship between DOC and MHSAA.

Objective b): Develop a letter of cooperation between MHSAA and the Department of Corrections to detail technical assistance to be provided DOC by MHSAA.

Status: Discussions between MHSAA and DOC Administration began in the fall. Technical assistance was provided to DOC staff concerning a proposal for LEAA funding for drug services to prisoners. This funding was not forthcoming and thus, in February, 1980, the MHSAA concluded a contract to provide DOC with $15,000.00 to purchase mental health services from the CMHC for incarcerated inmates. This service will include drug and alcohol counseling.

In addition to the above, the Direct Services Chief established a working relationship between CSS and the Superior Court of Guam and DOC which resulted in the first criminal justice client given early release from DOC on condition of successful treatment at the CSS Residential Treatment Program. Also, a presentation was made to a meeting of Adult Probation Staff by the MHSAA, Direct Services Chief, outlining the alternatives available for supplementing their rehabilitative efforts with formal treatment and the mechanisms involved. Although no formal letters of agreement are in effect at this

time the working relationship between the Criminal Justice system, the MHSAA and Service providers has developed in a positive and productive manner. The model written agreement format between MHSAA and GHPDA will be altered to accommodate the Criminal Justice system and efforts to finalize will be undertaken.

H. MENTAL HEALTH AND SUBSTANCE ABUSE ADVISORY COUNCIL

This section is in response to the ADAMHA Guidelines in reference to alcohol. However, as an integrated function with the minimal cost proportionately shared by ADM function, the discussion applies to drug abuse as well.

As previously stated, the Council was formed and first met on Sept. 20, 1979. The current membership representing a broad spectrum of the community and fulfilling federal criteria, is presented in Appendix A, Item 3.

In this, the Council's first year of existence, issues of the disciplines, substance issues and data for Guam, substantive issues of government related to substance abuse, have all been presented to the Council. A solid core of individuals is demonstrating consistent interest and attendance. Through review of several grant applications, the need for committee structure became apparent and was established on a functional basis. An early problem of obtaining quorum at the early evening meetings was studied and smoothly resolved by establishing luncheon meetings, a time with much fewer conflicts among the members. Appendix A, Item 6 provides the "Council Activity Report" to date, including the committees established.

I. GENERAL PERFORMANCE REVIEW COMMENTS

Each division chief experienced something less than 100% completion of all objectives, at least by the individuals' standards. Each has learned their own lessons regarding planning by the process of reviewing and reporting progress. In overview, the progress is actually quite satisfying and though each key staff/person is a bit frayed at the edges, a growing sense of pride of accomplishment and cooperative teamwork is developing, without as well as within the Agency. We can look together at the changes in the year and a half since most of us started with the fledgling MHSAA. We have and are surviving some significant obstacles, battles and challenges, some which have been very time consuming

without directly contributing to completion of state objectives. Classification of the Agency staff was a laborious and painful experience, absorbing considerable energy for months. Learning and establishing the various standard governmental procedures has been an unstated but substantial task. The CMHC distress funding situation, the uncertainties, pressures and work created for MHSAA was completely unplanned and out of MHSAA control. Current federal and local adverse economic and funding circumstances dictate much, while providing little data for important middle-term planning. Additional disappointment occurred with the denial of funds by both NIDA and NIAAA for treatment programs for alcohol and drug dependent women.

As we formulated objectives last year, we were aware of those for which we were significantly dependent upon events beyond our control. By limiting our objectives in some cases, we reduced unmet objectives. For the others, we have not been too disappointed by our degree of success. Our greatest disappointments are probably the deferment of development of the Government of Guam Employees Assistance Program, and lack of passage of the Uniform Alcoholism and Intoxication Act before now, and deferral of acquiring a terminal for computerized MIS.

In the area of cost effectiveness, we have come reasonably close to fulfilling our objectives, basically the same objectives as presented to each of our major sources of funding: the Guam Legislature, NIDA, and NIAAA. We are confident each recognizes our progress in developing our SSA functions and will demonstrate this recognition by appropriate funding within funding availability. With our efforts in response to needs not covered in the objectives, we feel we are more than minimally cost-effective. As our sophistication grows over the next couple of years, we hope to be able to easily compile economic as well social and subjective arguments for this cost-effectiveness.

PART III - NEEDS ASSESSMENT

A. INTRODUCTION

1. Purpose

This needs assessment presents an empirical analysis of drug and alcohol related problems on a territory-wide basis for Guam. This analysis provides the basis for the objectives and action strategies set forth in Section IV of this Five-Year Plan. The ongoing collection, update, and interpretation of relevant data from various sources will complement this base in future decision making processes relevant to drug and alcohol abuse and misuse on Guam.

2. Needs Assessment Strategy

The MHSAA recently completed a comprehensive drug and alcohol survey throughout the Island's public, and most of the private, secondary schools. The survey report is included as Appendix E-Item 1. This survey is seen as an important component to this Five-Year Plan for a number of reasons, as follows:

(1) The results provide a trend analysis of prevalence among youth when compared to the Chung[1] Survey conducted in 1974, Chart III-A, page 31 ,

(2) An excellent basis for comparing substance abuse on Guam and Stateside is provided, in Chart III-B, page 32 ,

(3) There is a very high percentage of individuals in Guam under the age of 15 (44.5%)[2] and this is expected to continue through 1990 per MHSAA Chart III-C, page 33 ,

(4) Prevention and Treatment activities, in order to be effective, must be geared towards the problems of this target group.

Additional analysis has been done with a variety of other data including Marden's Method[3], direct and indirect methods of estimating heroin use[4], interviews with the public and private sector as indi-

[1] R. Chung, Patterns of Drug Abuse among the youth of Guam, University of Guam, Social Science Institute, April 1975.

[2] Bureau of Labor Statistics, Government of Guam, Department of Labor, Sept. 1975

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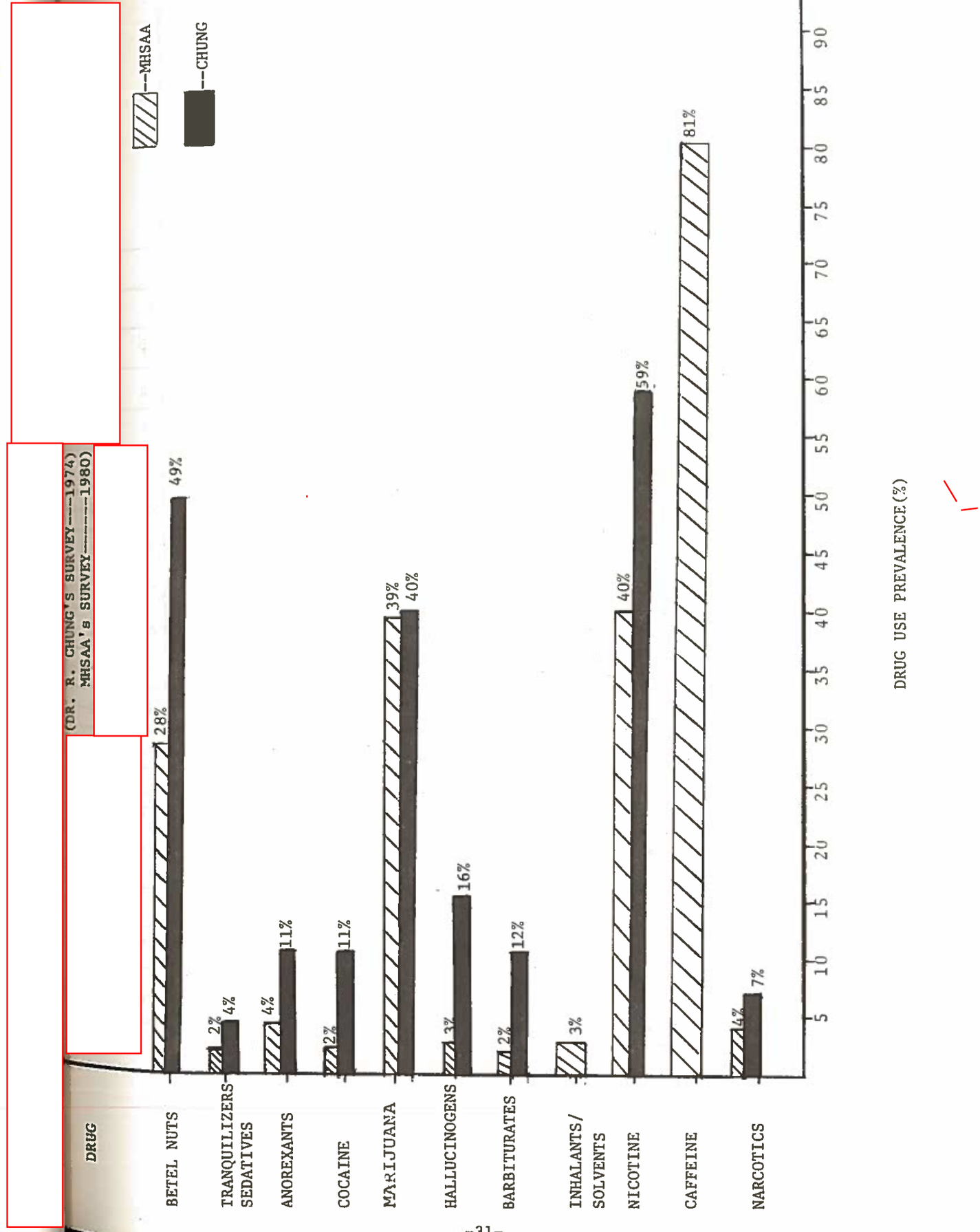

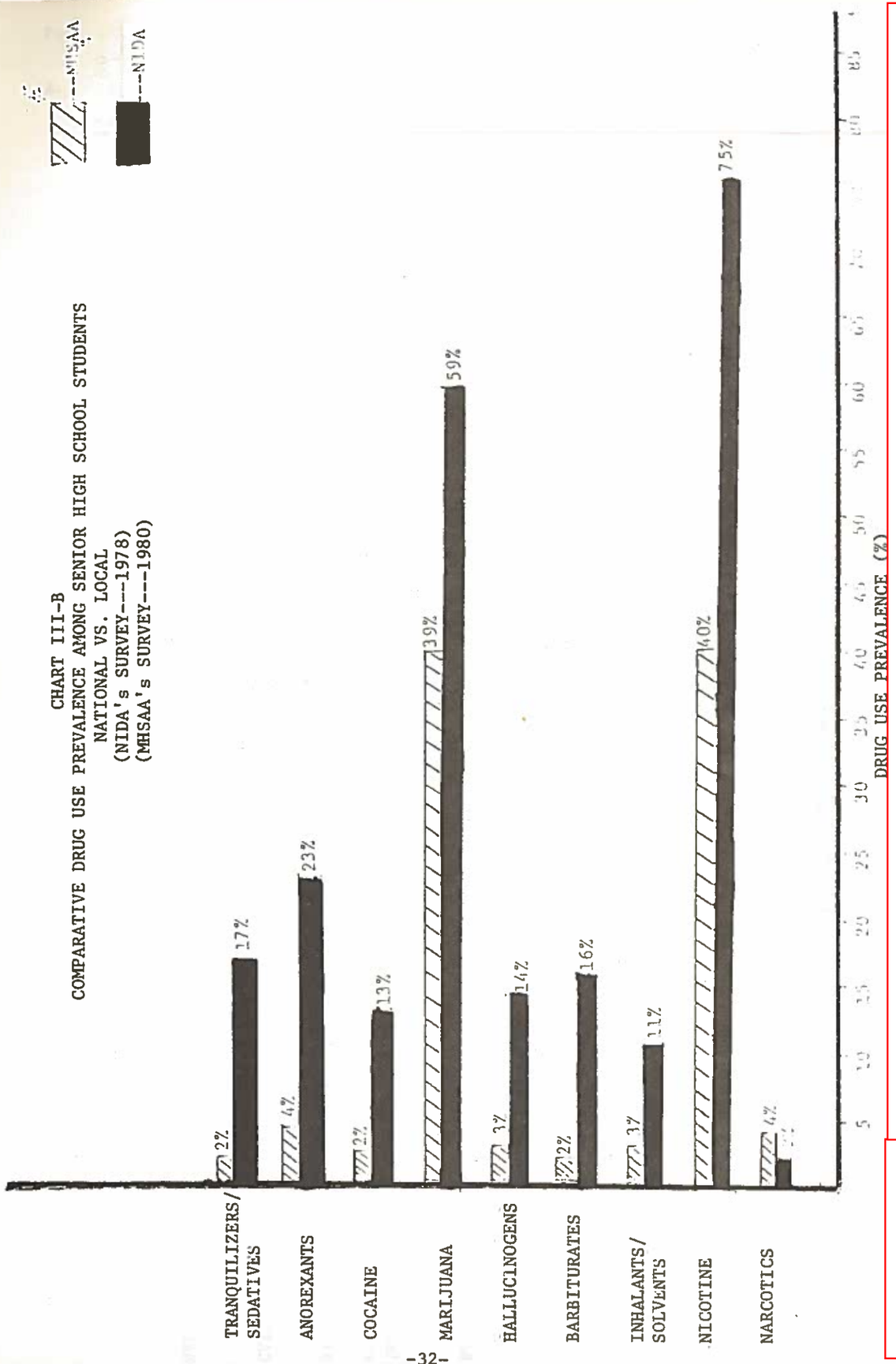

CHART III-C

PROJECTED POPULATION BY AGE GROUP AND PERCENTAGE DISRIBIUTION ON GUAM, 1975-1990

AGE GROUP	TOTAL CIVILIAN POPULATION				PERCENTAGE OF POPULATION			
	1975	1980	1985	1990	1975	1980	1985	1990
0-4	10,277	17,358	19,787	22,113	12.90	19.30	18.70	18.00
5-9	10,617	14,110	16,751	19,094	13.30	15.70	15.80	15.50
10-14	11,894	8,554	14,067	16,700	14.90	9.50	13.30	13.60
15-19	8,940	8,836	8,435	13,870	11.20	9.80	8.00	11.30
20-24	6,785	7,559	8,712	8,316	8.50	8.40	8.20	6.80
25 29	5,987	5,883	7,454	8,590	7.50	6.50	7.10	7.00
30 34	3,911	7,345	5,730	7,260	4.90	8.20	5.40	5.90
35 39	3,991	4,455	7,154	5,581	5.00	5.00	6.80	4.50
40-44	4,071	4,285	4,340	6,968	5.10	4.80	4.10	5.70
45-49	4,071	3,554	3,925	3,976	5.10	4.00	3.70	3.20
50-54	3,033	2,905	3,256	3,595	3.80	3.20	3.10	2.90
55-59	2,235	2,096	2,661	2,982	2.80	2.30	2.50	2.40
60-64	1,596	1,085	1,459	1,852	2.00	1.20	1.40	1.50
65-+	2,396	1,913	1,975	2,260	3.00	2.1	1.90	1.80
TOTAL	79,824	89,938	105,706	123,157	100.00	100.00	100.00	100.00

SOURCE: 1975, BUREAU OF LABOR STATISTICS, GOVERNMENT OF GUAM.
1980-99, QUINTON-BUDLONG.

cated in the Acknowledgment, and a variety of subjective factors relevant to drug and alcohol abuse and misuse. This comprehensive approach includes most current state of the art methods of estimating drug and alcohol abuse, incidence and prevalence, and allows planning and program development consistent with the determined needs.[1]

B. Alcohol data and analysis

The data which is set forth in this section emphasizes the seriousness of alcohol abuse and misuse in Guam.

Chart III-D page 35 plots the arrests for driving under the influence (DWI) for the period 1974 through 1980 (Jan.-March) including a projection of DWI's for 1980. The conservative projection of 972 for CY 80 based on 286 DWI's for the first quarter of 1980 represents a 1,030% increase from CY 78, 923% from CY 77, 324% from CY 76, 544% from CY 75, and 379% from CY 74. Charts III-E, III-F, and III-G; pages 36, 37 , and 38 present data on DWI by age, ethnicity, DWI and Public Drunkeness (PD), and number of annual offenses DWI and PD. Mean annual DWI offenses from 1977-79 revealed that 26% were Caucasian, 3% Black, 24% Filipino, 21% Guamanian, 14% Oriental, 13% all others. Mean public drunkeness offenses for this same period showed 33% were Caucasian, 11% Filipino, 17% Guamanian, 11% Oriental, 28% all others. When analyzing the DWI/PD data a number of interpretations are possible. The interpretation generally accepted by the staff of the MHSAA and confirmed by interviews with the representatives of the Courts, Office of Highway Safety, and DPS, is that police priorities and training in the identification and handling of DWI offenses accounts for the sharp increase in DWI arrests. With emphasis placed on DWI's the PD offenses have understandibly fallen off. Questions are raised regarding the negative correlation between the sex, age, and population distribution of Guam as presented on Chart III-H, page 39 , compared to the DWI/PD Charts III-E,F and G.

Further study of this negative correlation is recommended in future needs assessments.

The Guam Five-Year Health Plan (published Spring 1980) states "Department of Public Safety data showed that 15.3 percent of all traffic

1/ With needs assessment for both drug and alcohol performed by the same staff, data and mechanisms useful to both are not duplicated.

without directly contributing to completion of state objectives. Classification of the Agency staff was a laborious and painful experience, absorbing considerable energy for months. Learning and establishing the various standard governmental procedures has been an unstated but substantial task. The CMHC distress funding situation, the uncertainties, pressures and work created for MHSAA was completely unplanned and out of MHSAA control. Current federal and local adverse economic and funding circumstances dictate much, while providing little data for important middle-term planning. Additional disappointment occurred with the denial of funds by both NIDA and NIAAA for treatment programs for alcohol and drug dependent women.

As we formulated objectives last year, we were aware of those for which we were significantly dependent upon events beyond our control. By limiting our objectives in some cases, we reduced unmet objectives. For the others, we have not been too disappointed by our degree of success. Our greatest disappointments are probably the deferment of development of the Government of Guam Employees Assistance Program, and lack of passage of the Uniform Alcoholism and Intoxication Act before now, and deferral of acquiring a terminal for computerized MIS.

In the area of cost effectiveness, we have come reasonably close to fulfilling our objectives, basically the same objectives as presented to each of our major sources of funding: the Guam Legislature, NIDA, and NIAAA. We are confident each recognizes our progress in developing our SSA functions and will demonstrate this recognition by appropriate funding within funding availability. With our efforts in response to needs not covered in the objectives, we feel we are more than minimally cost-effective. As our sophistication grows over the next couple of years, we hope to be able to easily compile economic as well social and subjective arguments for this cost-effectiveness.

PART III - NEEDS ASSESSMENT

A. INTRODUCTION

1. Purpose

This needs assessment presents an empirical analysis of drug and alcohol related problems on a territory-wide basis for Guam. This analysis provides the basis for the objectives and action strategies set forth in Section IV of this Five-Year Plan. The ongoing collection, update, and interpretation of relevant data from various sources will complement this base in future decision making processes relevant to drug and alcohol abuse and misuse on Guam.

2. Needs Assessment Strategy

The MHSAA recently completed a comprehensive drug and alcohol survey throughout the Island's public, and most of the private, secondary schools. The survey report is included as Appendix E-Item 1. This survey is seen as an important component to this Five-Year Plan for a number of reasons, as follows:

(1) The results provide a trend analysis of prevalence among youth when compared to the Chung[1] Survey conducted in 1974, Chart III-A, page 31 ,

(2) An excellent basis for comparing substance abuse on Guam and Stateside is provided, in Chart III-B, page 32 ,

(3) There is a very high percentage of individuals in Guam under the age of 15 (44.5%)[2] and this is expected to continue through 1990 per MHSAA Chart III-C, page 33 ,

(4) Prevention and Treatment activities, in order to be effective, must be geared towards the problems of this target group.

Additional analysis has been done with a variety of other data including Marden's Method[3], direct and indirect methods of estimating heroin use[4], interviews with the public and private sector as indi-

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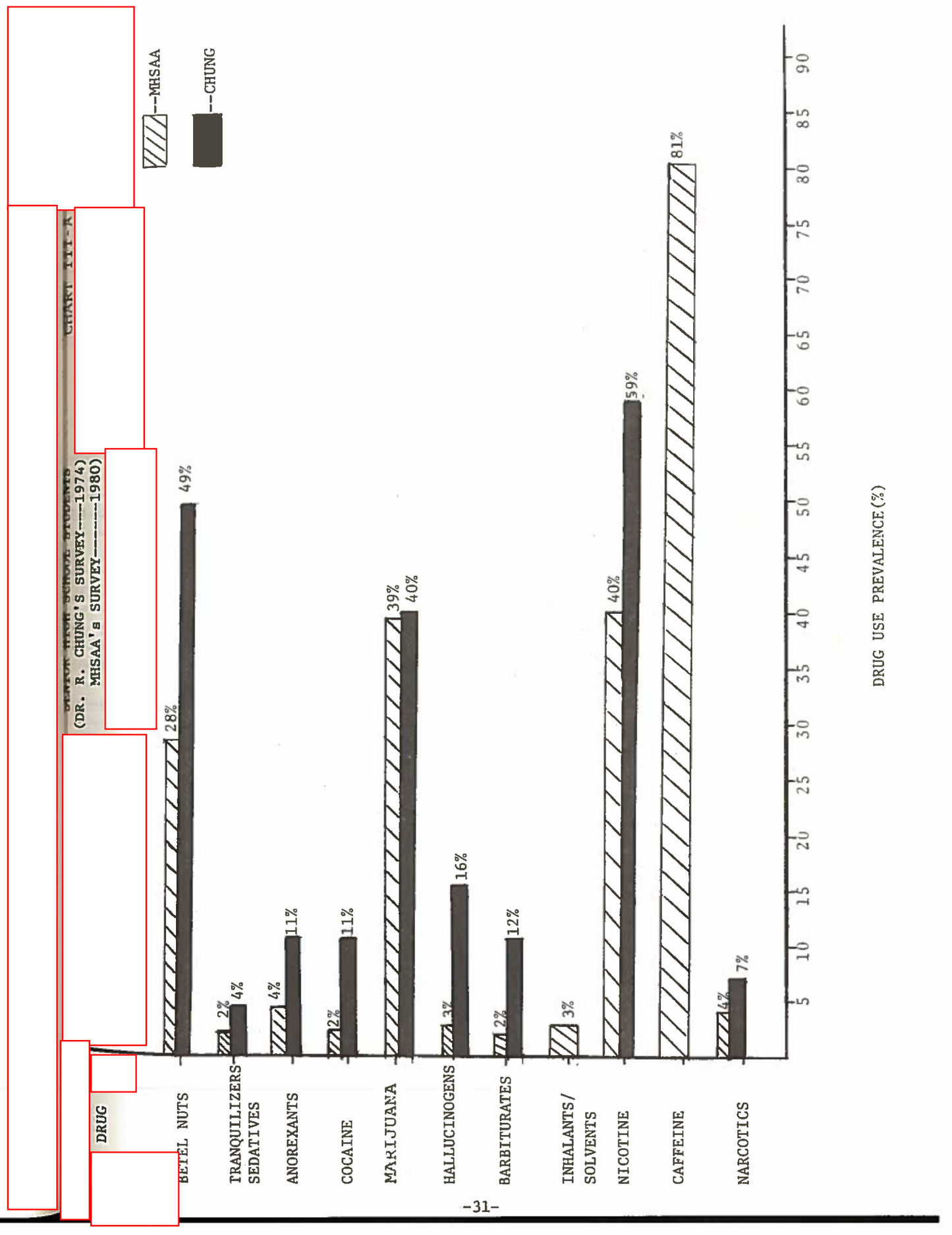
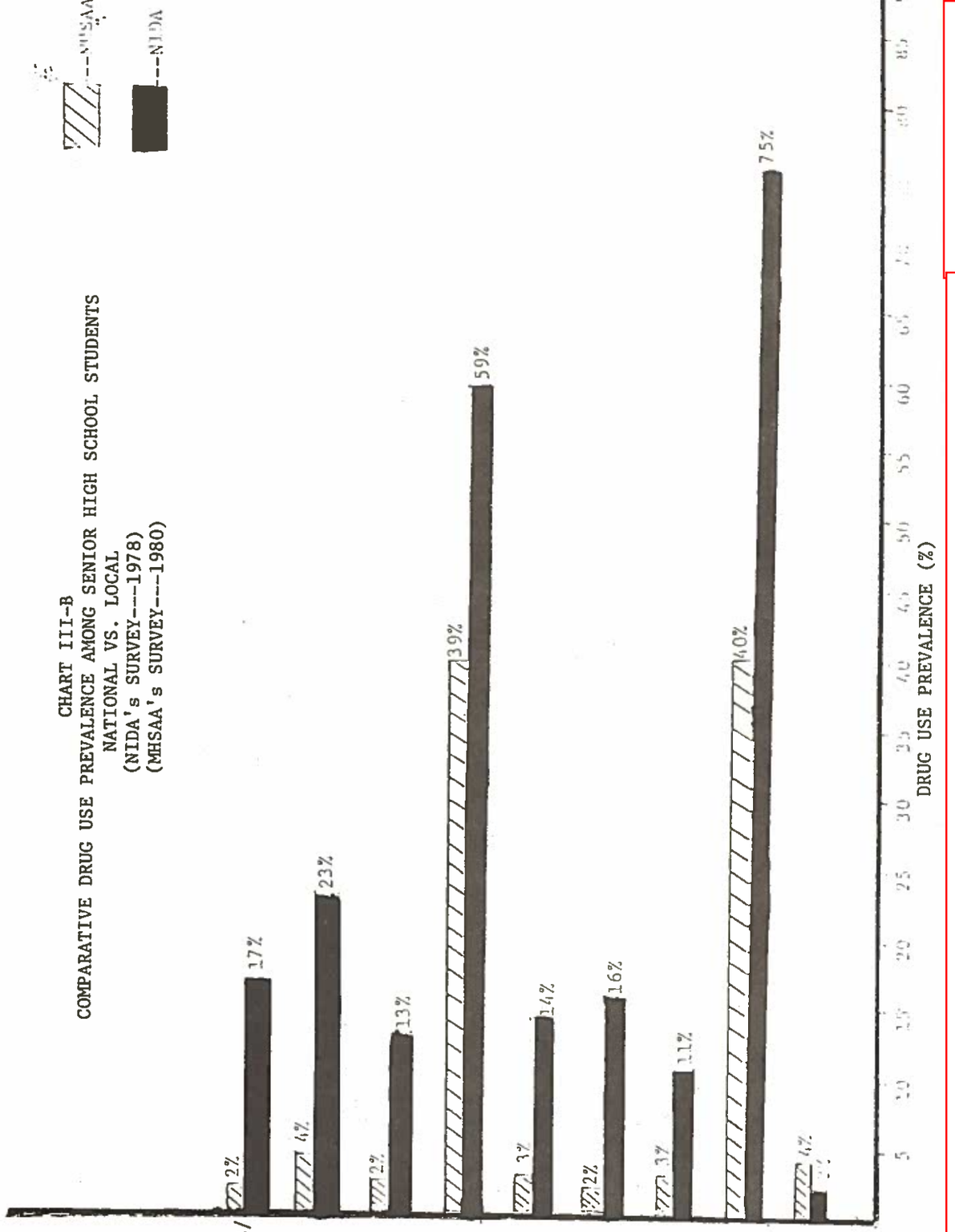


CHART III-B

COMPARATIVE DRUG USE PREVALENCE AMONG SENIOR HIGH SCHOOL STUDENTS
NATIONAL VS. LOCAL
(NIDA's SURVEY---1978)
(MHSAA's SURVEY---1980)



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SOURCE: 1975, BUREAU OF LABOR STATISTICS, GOVERNMENT OF GUAM.
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B. Alcohol data and analysis

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Chart III-D page 35 plots the arrests for driving under the influence (DWI) for the period 1974 through 1980 (Jan.-March) including a projection of DWI's for 1980. The conservative projection of 972 for CY 80 based on 286 DWI's for the first quarter of 1980 represents a 1,030% increase from CY 78, 923% from CY 77, 324% from CY 76, 544% from CY 75, and 379% from CY 74. Charts III-E, III-F, and III-G; pages 36, 37 , and 38 present data on DWI by age, ethnicity, DWI and Public Drunkeness (PD), and number of annual offenses DWI and PD. Mean annual DWI offenses from 1977-79 revealed that 26% were Caucasian, 3% Black, 24% Filipino, 21% Guamanian, 14% Oriental, 13% all others. Mean public drunkeness offenses for this same period showed 33% were Caucasian, 11% Filipino, 17% Guamanian, 11% Oriental, 28% all others. When analyzing the DWI/PD data a number of interpretations are possible. The interpretation generally accepted by the staff of the MHSAA and confirmed by interviews with the representatives of the Courts, Office of Highway Safety, and DPS, is that police priorities and training in the identification and handling of DWI offenses accounts for the sharp increase in DWI arrests. With emphasis placed on DWI's the PD offenses have understandibly fallen off. Questions are raised regarding the negative correlation between the sex, age, and population distribution of Guam as presented on Chart III-H, page 39 , compared to the DWI/PD Charts III-E,F and G.

Further study of this negative correlation is recommended in future needs assessments.

The Guam Five-Year Health Plan (published Spring 1980) states "Department of Public Safety data showed that 15.3 percent of all traffic

1/ With needs assessment for both drug and alcohol performed by the same staff, data and mechanisms useful to both are not duplicated.

CHART III-D

DRIVING WHILE INTOXICATED ARRESTS (1974-79)

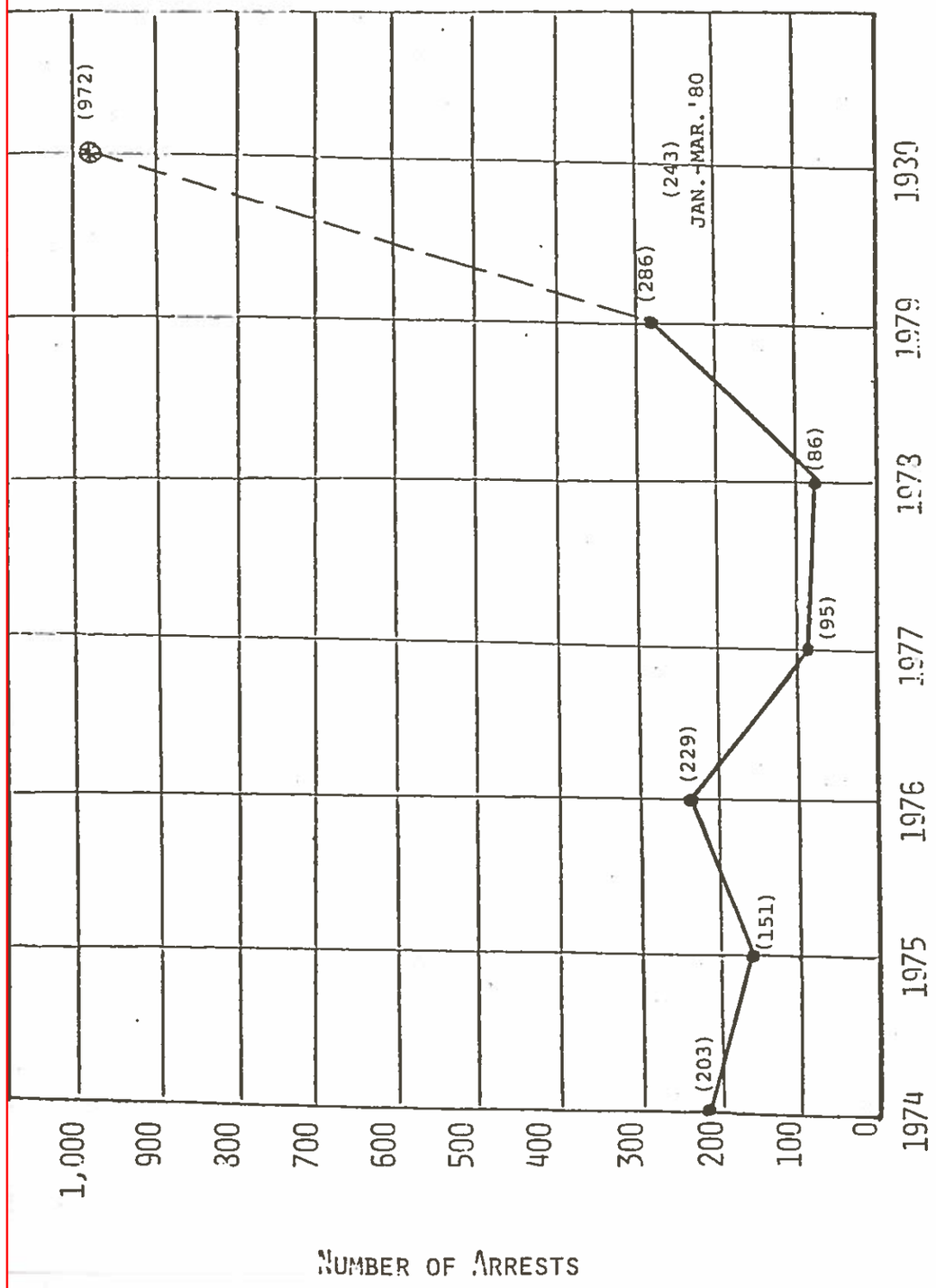


CHART III-E
DRIVING WHILE INTOXICATED (DWI)
BY AGE
MEAN ANNUAL OFFENSES (1977-79)

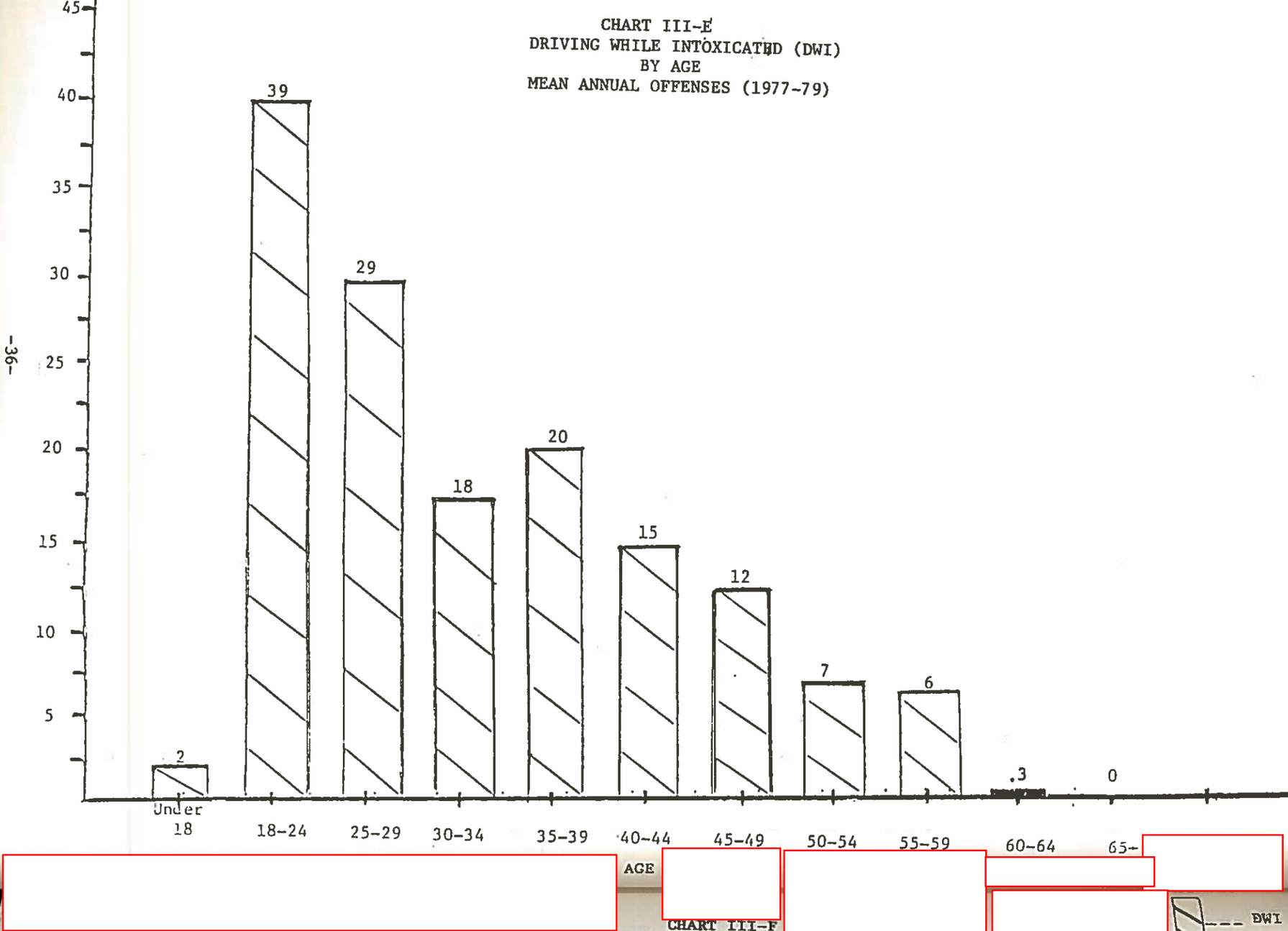
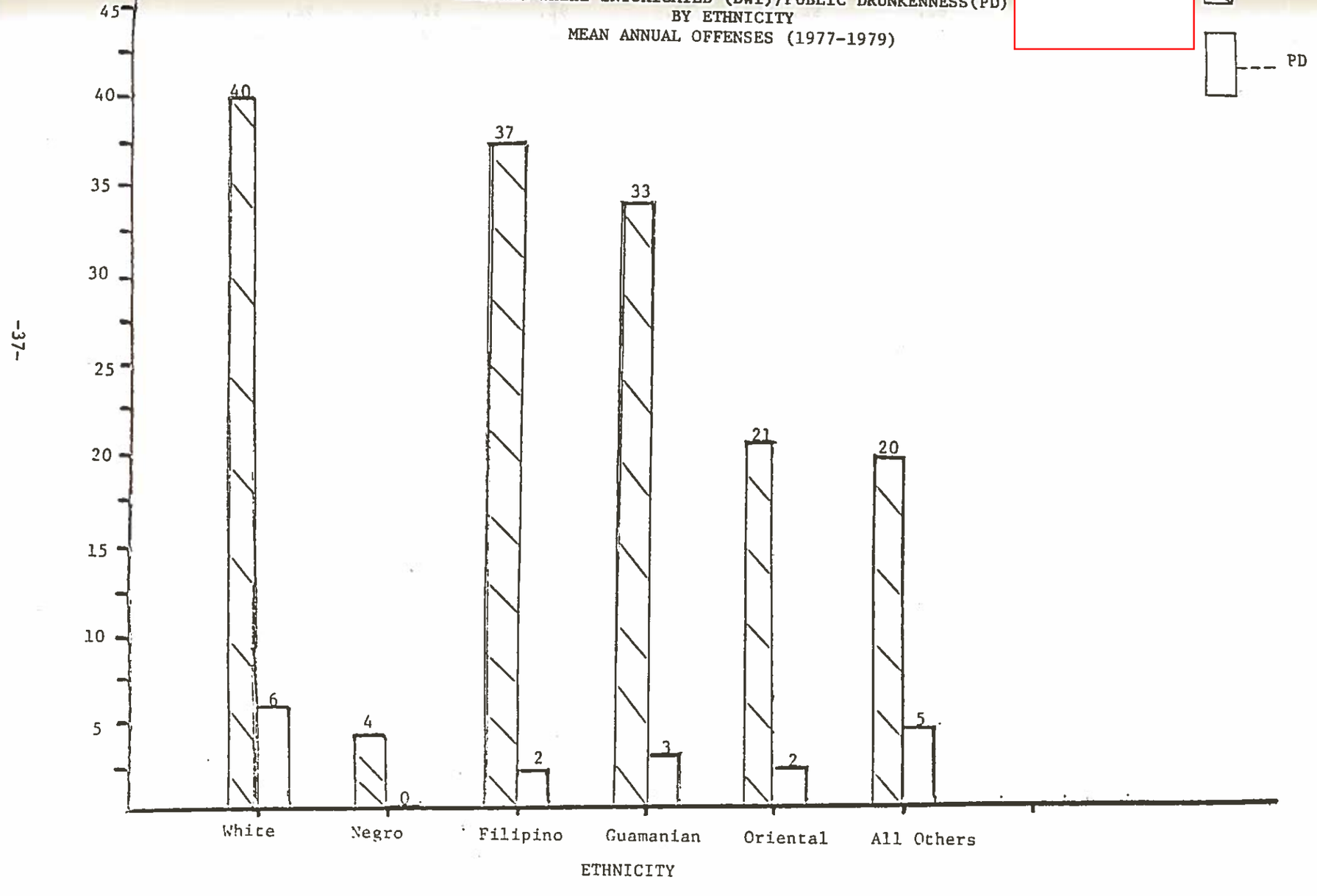


CHART III-F
DRIVING WHILE INTOXICATED (DWI)/PUBLIC DRUNKENNESS (PD)
BY ETHNICITY
MEAN ANNUAL OFFENSES (1977-1979)



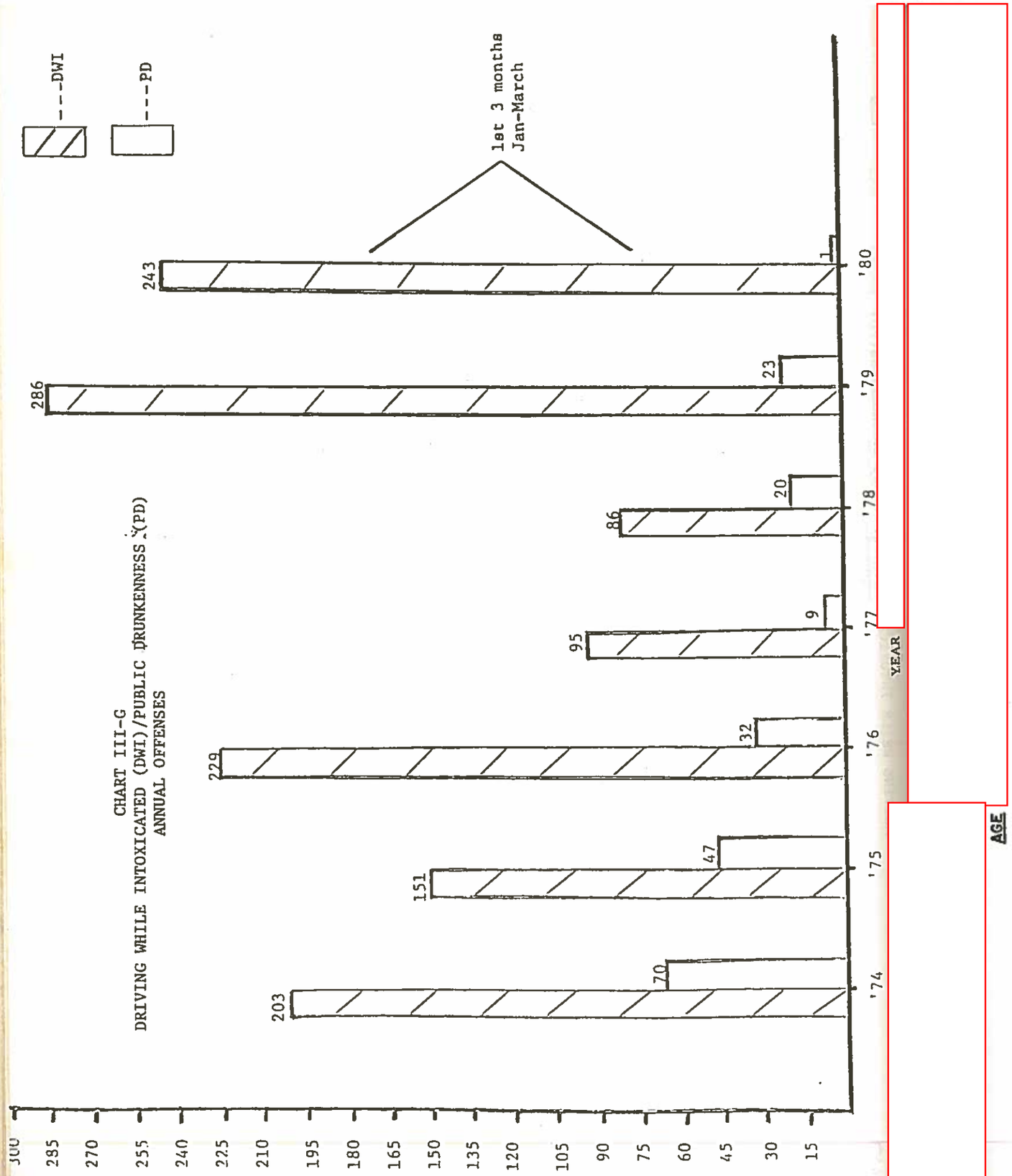
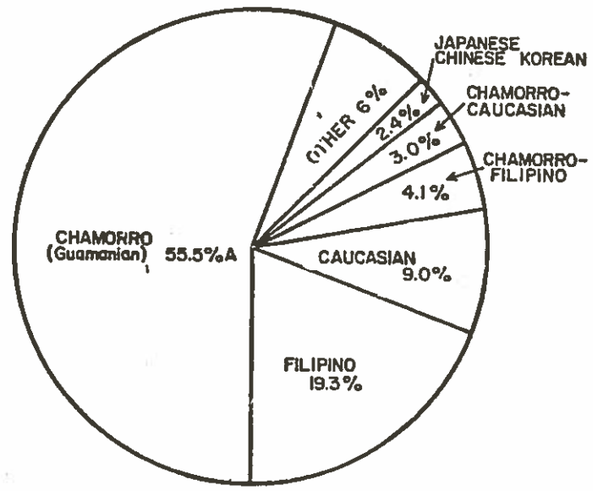
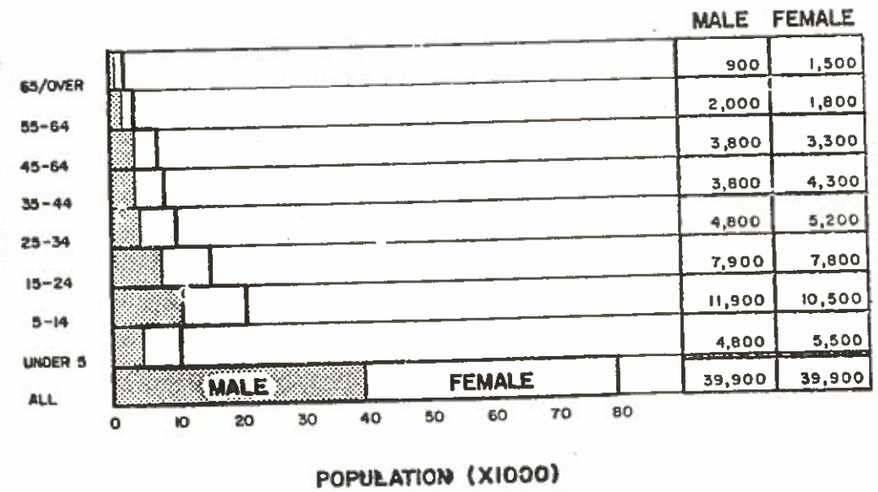


CHART III-H

Ethnic Composition of the Civilian Population of Guam, September 1975.



~~Figure 2.~~ Sex Composition of Population by Age Group



Source: Bureau of Labor Statistics

deaths for 1976 to 1978 were the direct result of drunken driving".

This appears to be generous underestimate of alcohol-related motor vehicle fatalities based on a variety of factors including empathy, and a lack of training in the identification and reporting of traffic related fatalities. This is supported, in part, by the fact that "drinking may be a factor in as many as 50% of the fatal motor vehicle accidents".[1] The 1978 "Task Panel Reports Submitted to The President's Commission on Mental Health" concluded "Literally a mass of evidence accumulated in over a score or more studies in this area demonstrates that drivers with blood alcohol levels of 0.10 percent or higher (the legal driving impairment level in many jurisdictions) are involved in from 35 percent to 59 percent of highway fatalities, depending on the particular methodology and population examined".[2] Subjective information including community interviews supports the contention that Guam should be closer in line with the 50% national estimate of traffic fatalities.[3] Additional health related data can be gained from cirrhosis of the liver mortality rates as presented on Chart III-I, page 41 . It is important to consider that cirrhosis of the liver, while a major cause of incapacitating illness and premature death in alcoholic persons, is only one mortality indicator relating to alcohol and mortality.

The severity of alcohol related problems on Guam is also supported by two recent attitudinal surveys: The Government of Guam Employees Survey, Chart III-J page 42 and the other being the alcohol section of the Secondary Public School Survey, Chart III-K, page 43.

The results of these two surveys are quite similar. 79% of students felt there is a drinking problem on Guam compared with 68% of adults. 3% of youth felt they had a drinking problem compared to 5% of adults, 52% of youth and 56% of adults knew someone with a drinking problem, and 28% of youth and 20% of adults felt someone in the family had a drinking problem.

[1] 1974 Edition of Accident Facts by the National Safety Council

[2] Volume IV, page 2084 (ALC 7)

[3] Guam's population based motor vehicle fatality rate, at 0.44/1000 for 1972-1976, is approximately double the national rate. This raises a question concerning alcohol's possible role in the high vehicle fatality rate.

CHART III-I
MORTALITY RATE
CIRRHOSIS OF THE LIVER
BY AGE (1976-1978)

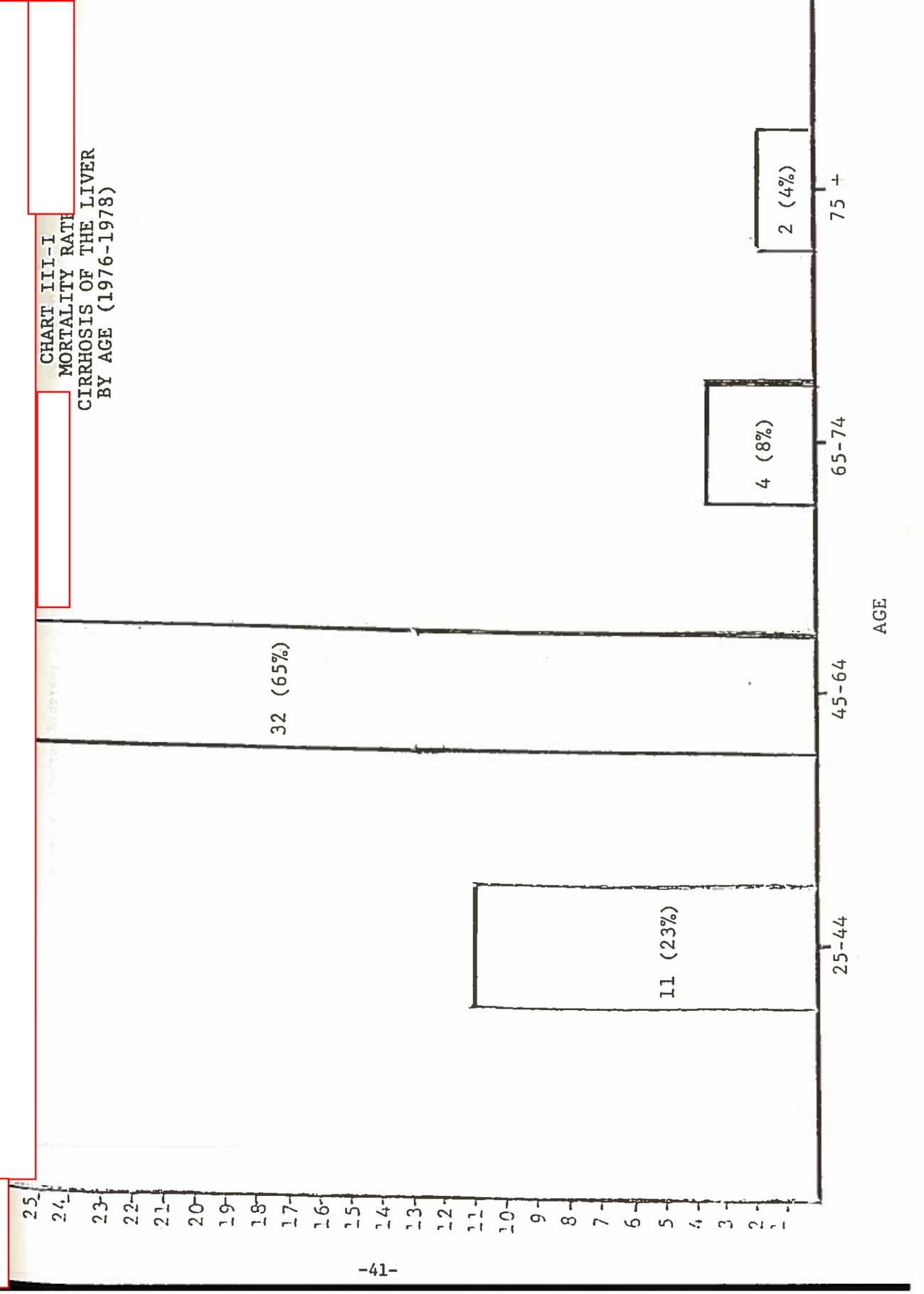
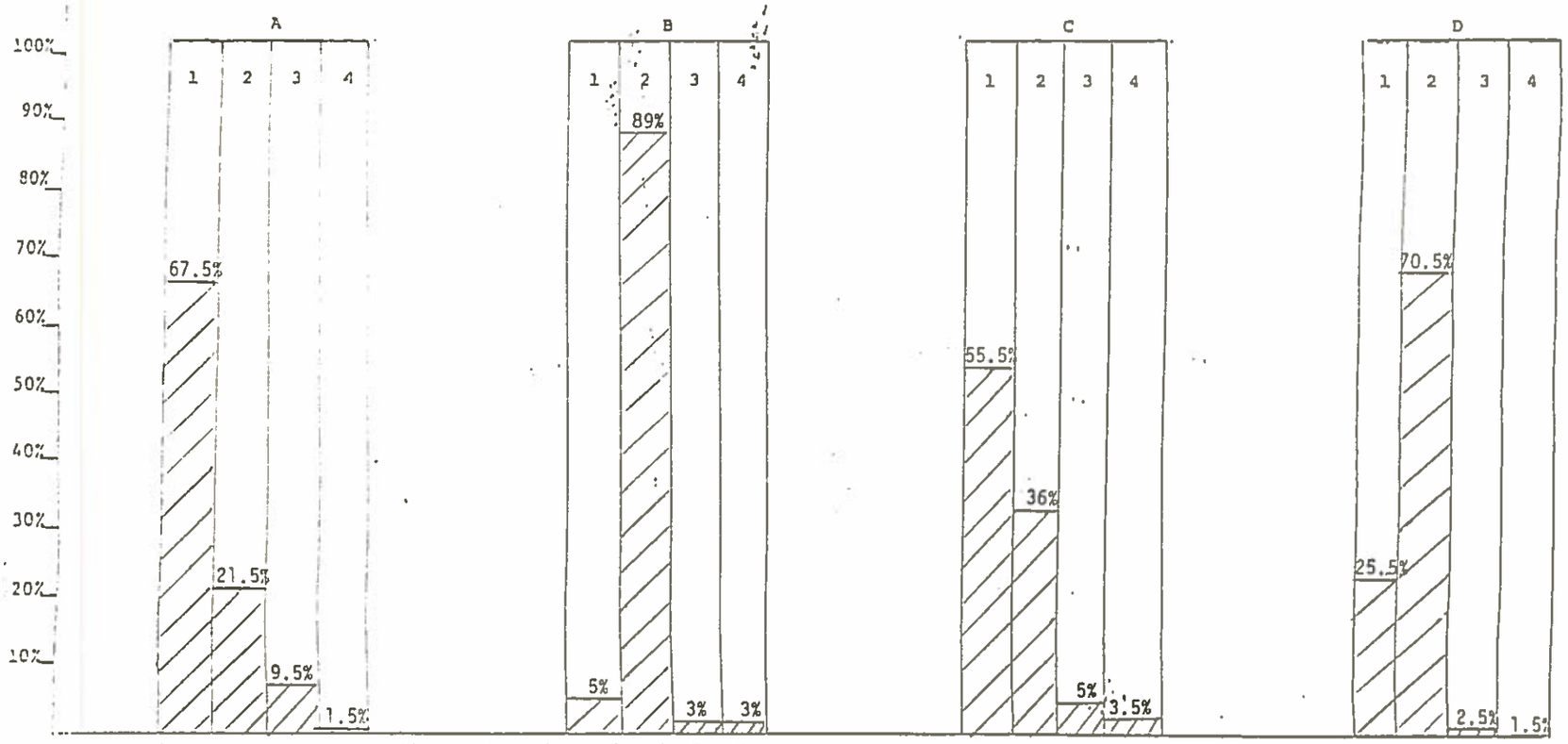


CHART III-J
ALL GOV/GUAM DEPARTMENTS (COMBINED)



LEGEND: A) Do you think there is an alcohol problem in Guam?
B) Do you feel you have a drinking problem?
C) Do you know someone who has a drinking problem?
D) Do you feel anyone in your family has a drinking problem?

LEGEND: 1) Yes
2) No
3) Don't Know
4) No Response

CHART III-
MHSAA ALCOHOL SURVEY

	Government of Guam Employees (1979)			Public Jr. & Sr. High Students (1980)		
	Yes	No	Don't know	Yes	No	Don't Know
1. Do you think there is an alcohol problem in Guam?	63%	22%	10%	79%	19%	2%
2. Do you feel you have a drinking problem?	5%	39%	6%	3%	95%	2%
3. Do you know someone with a drinking problem?	56%	36%	3%	52%	44%	4%
4. Do you feel anyone in your family has a drinking problem?	26%	71%	3%	28%	71 %	1%

The 3% of youth admitting to a drinking problem yields a prevalence of 522 youth aged 10-19, on Guam who admit to a self-perceived drinking problem.
DWI arrests of drivers age 18-24 comprised 26.2% of all DWI offenses for the period 1977-79. Mortality rates for alcohol related cirrhosis of those 25-44 was 23% of total number of cases.

Chart III-L presents the results from an alcohol consumption survey in 1978 conducted by the MHSAA. These results indicate that, based upon civilian liquor sales reported by licensed retailers, adults on Guam consumed alcohol equivalent to 9.79 12 oz. beers per day.

An interesting observation is the lack of evidence in support of alcohol related problems among women in Guam. However, the data available shows the following:

* 3% of women surveyed at DOE felt they had a drinking problem
* PHSS reported mean cirrhosis cases for women from 1976-79 was 19% of total
* Marden's method estimates 1,059 women on Guam as potential clientele for alcoholism treatment and 4,646 are men

According to Alcohol and Health, June 1974, "approximately 68% of U.S. adults are drinkers - 77 percent of men and 60 percent of women". According to NIAAA Fact Sheet 1975, "About 45% of adult women now drink once a month or more. Women aged 21 to 29 had the highest proportion of heavier drinkers. Appendix G-Item 1 addresses the issues of Drinking Practices of American Women.

The staff of the MHSAA is cognizant of special needs of women suffering from alcohol related problems and the barriers to treatment. Some of these are cultural in nature. Since all alcohol programming is at a developmental stage,programs will be designed with these issues in mind. Existing services of the D&A program of the GCMHC and the CSS program offer information and other services geared to the special needs of women. Special care is taken to avoid many of the problems addressed in literature[1] available on this subject. The agency also retains the con-

[1] State Responsibilities For The Well-Being Of Women In Alcohol, Drug Abuse, And Mental Health Programs, Jacquelyn H. Hall, Ph. D., NIMH
NIAAA - Cultural Groups, part b. Women & Alcohol Abusers; Women and Alcoholism, Edith S. Gomberg; Women in Therapy, The Needs Of The Female Drinker: Dependency, Power, or What? Sharon C. Wilsnack, Ph. D.
Women & Alcohol: A Guide for State & Local Decision Makers by Jonica D. Homiller

CHART III-L

GUAM ALCOHOL CONSUMPTION SURVEY

April 1979

341 Licensed Liquor Establishments on Guam

TYPES OF LIQUOR SURVEYED

1. Beer	60% of Total Consumption	
2. Distilled Spirits	25% "	
3. Wine (All kinds)	15% "	
TOTAL CONSUMPTION:		165,831,837

SURVEY RESULTS INDICATE (AVERAGE ESTIMATE OF BEER EQUIVALENCY)

** 31.74 - 12oz. cans of beer per day per household
** 5.35 - " " per person per day for every man, woman and child*
** $19.9 million - Annual Alcohol Beverage Sales
** 9.79 cans of beer per person (18 years and over) per day

* General Population: 84,999
Taken from Statistical Abstract
Guam Volume 7, 1976 Commerce

MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY
GOVERNMENT OF GUAM
POST OFFICE BOX 20999
MAIN FACILITY, GUAM 96921
LRAflague
6/80

sultant services of a woman experienced in the ADM fields for development of the Five-Year Plan and input to program development. As programs develop it is anticipated that women will have reasonable representation in the treatment sector. Efforts this year in data gathering did not produce useful information concerning alcohol related problems for the elderly on Guam. A specific strategy will need to be developed to get some indication of the scope of this problem area.

CSS has contracted for peer counseling services with the elderly and it is anticipated that additional data will be obtained through this program over the next year. MHSAA also anticipates surveying this target group during next year's needs assessment activity.

The MHSAA recognizes that alcoholism and alcohol abuse are among Guam's most serious social/economic and health problems and that alcoholism and alcohol abuse cross socio-economic strategy as well as age and sex. Sufficient comparative data exist to state confidently, if not happily, that Guam has as great or greater an alcohol problem as any SSA jurisdiction. This must be considered in light of very little resources to treat victims of alcohol abuse and those in some jeopardy. Conscientious efforts towards alleviating this problem must begin and resources must be identified in order to address this problem at all levels of potential impact.

C. Drug Data and Analysis

* The estimated heroin prevalence rate is 650 per 100,000 (Appendix I)

* Guam reports Serum B Hepatitis at .14 per 1,000 (Chart III-M page 48)
* MHSAA Drug and Alcohol Survey - Secondary Public Schools[1] present the following "ever-used" prevalence rates:

Drug Category	Grades 7-12	Grades 10-12
Narcotics	3.1	4.5%
Caffeine	77.3	81.0%
Nicotine	30.9	40.0%
Inhalant/Solvents	1.9	3.3%
Barbiturates	1.3	2.2%
Hallucinogens	1.9	2.7%
Marijuana	26.6	38.8%
Cocaine	1.4	2.0%
Anorexants	2.7	4.1%
Tranquilizers/Sedatives	1.5	2.0%
Betel Nut	24.4	27.8%

[1] Appendix E, Item 1

CHART III-M

SUMMARY OF REPORTED CASES OF SERUM B HEPATITIS

COMPARATIVE ANALYSIS

National vs. Local

National Summary of Reported Cases of Serum B Hepatitis for Guam and some of the highest ranking states show:

Guam	.14 per 1,000 *	
California	.13	"
Hawaii	.07	"
Illinois	.06	"
Massachusetts	.04	"
Michigan	.08	"
Nevada	.09	"
New York	.05	"
Ohio	.04	"
Pennsylvania	.07	"
Texas	.02	"

*1978 Figures 1/

GUAM - 1979 - .13 per 1,000
(No 1979 statistics available at present on the National level)

AS EVIDENCED BY THE ABOVE STATISTICS, GUAM RANKS HIGHEST AMONG THE NATION IN SERUM B HEPATITIS CASES.

Since 1975 Guam has dealt with a dynamic and volatile heroin abusing population. Since then, during 1978 and 1979 based on subjective data and drug indicators there appears to have been a stabilization of the dynamics of this population with apparent reduction in the prevalence and incidence of heroin abuse and use in Guam. Enforcement efforts[1] have successfully impacted some of the larger supplies on Guam. However, these dealers are replaced by others and we find that heroin remains available and reportedly the price has also stabilized.[2] Purity of confiscations was as low as 40% one year ago but are consistently 80-95% again.[2] When developing the prevalence estimate of heroin users a variety of data was reviewed using a number of methodologies. These included projections from heroin overdose deaths, The Indicator-Dilution Method, extrapolation from crime statistics, extrapolation from the school surveys, serum hepatitis (B), treatment records (CODAP) and heroin arrest data. Guam's downward trend in heroin abuse has closely followed the same national trends. However, with the increased supply of heroin now reaching the U.S. we must be careful not to assume a role of complacency. We must maintain our vigilance in efforts to address this problem. Also, Guam still seems to be among the highest heroin prevalence regions of the country.

Utilization figures of the GCMHC Drug and Alcohol program indicate a current 120% utilization of heroin treatment slots under the Statewide Services Grant. Though utilization has been dropping, outreach activity has been virtually absent, staff turnover suddenly high and staff morale low from the confusing CMHC situation. CSS utilization was low, again with poor outreach activity and significantly affected by the program's newness.

[1]Heroin Arrests 1976 - 37
1977 - 36
1978 - 60
1979 - 39

[2]DPS Narcotics Officers verbal report

CMHC D&A program annual report for five quarters (1/79 - 3/80), indicates that 71% (12 of 17) of the admissions are female. This is a much higher percentage than the 27% CODAP reported nationally for all modalities. Interviews with CMHC D&A counselors indicate that most women in the methadone program are lacking support services. Thus they are forced to maintain their dependency on their male addict counterparts a negative element in their recovery efforts. Additional issues for these women in the D&A program are health, job skills, child care, and identity problems. Efforts to deal with these needs are discussed in the section entitled Women and Alcohol, and also Section II, Performance Report.

MHSAA's and DPS' 1980 survey results of public senior high school students both indicate that one particular hard drug category, narcotics, has a local prevalence of 4%, twice the national average derived by NIDA in 1980. Though alarming as such it is encouraging that after 6 years this current 4% prevalence has fallen from the 7% figure reported in Chung's 1974 study (approximately 3,300 students) - a significant decrease. Interestingly enough, 7% of the actual number of narcotics users from the target population are still taking it daily (approximately 22 students.) Nationally, marijuana use prevalence in 1978 was 59% according to NIDA statistics. Locally, DPS' 1980 current follow-up survey results indicate a 48% prevalence, up 8% compared to Chung's 1974 findings of 40%, but still lower than the 1974 national average. MHSAA's present 1980 findings of 39% (3,900), however, show that there hasn't been much change in local marijuana use prevalence among senior high school students since 1974, but the results of all combined junior and senior high school students from MHSAA's survey indicate a significant prevalence of 27% (2,700), which reveals a much lower percentage of use among the junior high population.

The Agency's findings also indicate that the overall "ever-used" prevalence of all other major drug categories are significantly lower than the national figures. Use of inhalants/solvents has a 3% (300) local prevalence, lower than the national average of 11%; use of barbiturates at 2% (200) is down from Chung's findings of 12% and lower than the 16% national prevalence reported by NIDA; use of hallucinogens is 3% (300) locally, a decrease from Chung's results of 16% and the 14% national average; cocaine use prevalence is at 2% (200), down from Chung's findings of 11% and lower than the national average of 13%, anorexants use has a 4% (400) local prevalence, a decrease from Chung's 11% findings and much lower than the 23% national prevalence; use of tranquilizers/sedatives has a local prevalence of 2% (200), lower than Chung's findings of 4% and a considerable decrease from the 17% national average.

MHSAA also included four licit drug categories in its drug and alcohol survey. Each of these, caffeine, nicotine and alcohol are socially approved and betel nut, is an integral part of our island culture.

Comparatively, NIDA's findings on nicotine use prevalence was 75%, much higher than MHSAA's findings of 40% (4,000). This 40% local prevalence has decreased since 1974, when Chung's reported a 59% prevalence. There were no comparative figures on caffeine from NIDA, DPS, or Chung, but MHSAA agency's results indicated a local prevalence of 81%. Betel nut use among senior high students in 1974 was reported at 49% prevalence by Chung's, compared to MHSAA's findings of 28% (2,800) for both Junior and Senior High students.

In line with the school survey indications for Guam of high heroin problem, low other-drug (excluding alcohol) problem, is treatment data from CMHC Drug Program. According to CODAP admission reports from January 1979 through the first quarter of 1980 (January - March), 59% (34) of all clients (58) were admitted with a heroin primary problem. Alcohol primary use clients accounted for 26% (15) of the total admissions, followed by 3% (2) for non-Rx methadone, 2% (1) for barbiturates, 3% (2) for inhalants, 2% (1) for tranquilizers, 3% (2) other drugs, and 2% (1) for an unknown drug. Of these clients, 3 were diagnosed as having an alcohol secondary problem, 1 each for barbiturates, hallucinogens, over-the-counter drugs, and 2 for tranquilizers.

Elderly and Drugs

At present, data availability in this area is very limited, but as the Agency's ongoing needs assessment progresses, the evaluation of this issue will be developed.

Sex/Age/Ethnicity and Drugs

These socio-demographic variables were examined in the Agency's Drug and Alcohol survey with the following results from the combined Junior

and Senior high schools (10,000) students:

* of the total number of actual narcotics users, (310) 77% are male, 23% female 19% are between the ages of 12-15, 81% between 16-21; The two highest ethnic group users are (55%) Chamorros, (15%) Statesiders, roughly proportionate to population.
* of the total number of actual marijuana users, (2,260) 63% are male and 37% female; 38% are between the ages of 12-15, 62% between 16-21; highest are Chamorros (58%) and Statesiders (11%)
* of the total number of actual cocaine users, (140) all 100% are male; 29% are between the ages of 12-15, 11% between 16-21; highest users are Chamorros (64%) and Chamorro-statesiders (29%)
* of the total number of barbiturates users, (130) 85% are male, and 15% female (16-21): highest users are Chamorros (39%) and Chamorro-Statesiders (23%)
* of the total number of actual hallucinogen users (190), 74% are male and 26% female; 26% are between the ages of 12-15, 74% between 16-21; highest users are Chamorro (42%) and Statesiders (20%)
* of the total number of actual inhalant/solvent users (190), 68% are male and 32% female; 37% are between the ages of 12-15, 63% between 16-21; highest users are Chamorros (53%) and Chamorro-Filipino (21%)
* of the total number of actual anorexant users, (270) 59% are male and 41% female; 19% are between the ages of 12-15, 81% between 16-21; highest users are Chamorros (30%) and Chamorro-Filipino (26%)
* of the total number of actual tranquilizer/sedative users, (150) 67% are male and 33% female; 40% are between the ages of 12-15, 60% between 16-21; highest users are Chamorros (40%) and Statesiders (27%)

D. Discussion

The ADAMHA Guidelines call for defining that portion of the population that concerns the SSA as to their abuse of substance(s). For primary prevention, MHSAA sets the entire civilian population of Guam as its target group, with special emphasis on youth and their parents. However, the entire community

is involved. As should be apparent from the discussion thus far, MHSAA defines its treatment target population as those who are to some significant degree dysfunctional, wholly or significantly as a result of the misuse of one or more drugs, including alcohol. Dysfunction most commonly and importantly disrupts family relationships, the ability to maintain productive activity avoiding behavior dangerous to self or others and health. In this needs assessment, several sources of data most relied upon involve self-admission of use and self-admission of substance related problems. With the confidential format, common subjective wisdom suggest such self-admissions are somewhat conservative, particularly with alcohol. In treatment assessment, however, the workers seek confirming information.

Intervention efforts either involve crisis or are designed to impact problem use early in a progression of increasing problems. The less the dysfunction, the easier to be effective, the better the prognosis, the less damage done.

In this, criteria similar to those used by Marden and his predecessors, are used to define degree and kind of problems appropriate for treatment. Intervention properly encompasses a larger group, and those found, in a short assessment period, to be either not appropriate or not ready for treatment, are offered educational insights to better monitor their own substance use.

Poly-substance abusers present the special problem of identifying primary substance of abuse. In most instances, a favored, or most frequently used substance can be easily identified for any particular period of an individual's life. In some cases, individuals do seem to indiscriminately use various substances, where the intent focuses heavily on changing consciousness without much concern for the nature of the change. In these cases, the physically important determination of drug or alcohol as primary can usually still be made with confidence. In all cases, MHSAA accepts only the determination of a mental health professional experienced with drug and/or alcohol abuse clients or a physician.

MHSAA is very concerned about the high vulnerability to alcohol among recovered drug abuse clients. Of the first eight clients at CSS, four

were determined to alcohol primary clients. Three of these previously suffered from some other drug as primary problem. The seeming "innocence" of alcohol seems to lure many substance abusers who consider themselves recovered from physical and psychological addiction to less accepted drugs.

Alcohol and heroin emerge as drugs causing problems on Guam as great or greater than anyhwere else in the country. Self-admitted alcohol problems are much higher than national figures for both youth and adult populations. This year has marked many comments to MHSAA staff that alcohol has become a major problem in the schools over the last two years, which perhaps explains the decreases in other drugs since Chung's survey. This speaks to a rather sudden increase in alcohol incidence or, just as frightening, a sudden trend of incidence at a younger age. Heroin incidence appears to be down but, youth involvement is still higher, than national. And the three treatment clients at CMHC reporting 1979 incidence give one pause. With the two year expected lag time, 1979 portends a significant increase in incidence over 1978.

Again, despite lower than national prevalence, nicotine is widely used and known to be a dangerous drug.

With a low rate of prevalence reported, PCP is nonetheless of concern to us. It has recently appeared on the scene here. It is hoped that the lack of attractiveness of most drugs for the people of Guam will prevail. But this deserves careful attention.

The school surveys reveal patterns of drug use similar to Stateside. However, percentage of women in treatment, soemwhat higher in the past, has become significantly higher over the last year. Both women and youth then, comprise special populations of special significance. Among ethnic groups, school survey and treatment data reveal roughly proportionate numbers of the various ethnic groups and mixed categories with two notable exceptions: Caucasians are high in prevalence of most non-narcotic categories while Filipinos are low in most categores. It is noted that subjective opinion is that Caucasian youths are often unhappy on Guam and report feeling prejudice clearly. Filipinos note, with the fairly large proportion of Filipinos in the United States in a fairly short time, that the substantial , very close unit Filipino community on Guam watch out for

each other and set a high standard on acceptable social behavior.

Two issues of indirect but crucial importance must be stated:

1. Guam is expecting to suffer severe economic setbacks beginning in FY 1981 due to proposed federal cuts from DHEW alone amounting to 10% of the entire Government of Guam budget. This must be considered in light of Guam having no county, city, district or regional budgets to absorb the impact. Navy reductions will further reduce income and gross receipts tax revenues and income to local businesses. It is expected that Guam will follow the consistent pattern of increased alcohol and drug consumption with worsened social conditions.
2. Guam has been experiencing rapid cultural change. The rapidly increasing divorce rate on this strongly Catholic Island is just one of many indicators of the impact of this social change. Divorce increases problems among youth and negatively impacts the extended family structure attributed with counteracting many of the adverse effects of rapid change on Guam. It is reasonable to be concerned about Guam's next 5-20 years.

E. Summary

MHSAA will continue in its efforts to put together a current and realistic needs assessment study through the careful collection and analysis of accurate and relevant data. MHSAA plans to expand its continued support and encourage active community outreach activities in order to guarantee maximum utilization of existing programs, as well as recognize, encourage, and develop specialized direct services programs for special treatment populations. The recently formed Prevention Task Force, which resulted from MHSAA's last prevention workshop, will need the full support of the government and community to ensure its success.

The substance abuse problem is not an easy one to understand and effectively deal with unless we really understand its causes and not just its effects. The impact of good humanistic prevention programs really comes into play here, and this, coupled with adequate and effective treatment, will always be a winning combination in the fight against substance abuse. With the combined efforts and cooperation of everyone involved in the human services field, and especially the key support of the family, there's no doubt that the future will hold many beautiful value-creating alternatives to drug use.

A. Administration - Planning and Coordination and MIS

Resource Assessment: Efforts to provide the appropriate guidance, direction, and support for other program areas require reliable information upon which to make decisions and set directions, as well as an appropriate funding base with which to underwrite the costs. Information obtained from needs assessment activity combined with stable funding is seen as the solid base for this.

Presently, the MHSAA continues to work on agreements for exchange of ADM relevant data with other sources on Guam. We are cognizant of the fact that some data is just not readily available based on limited resources - either manpower or dollars. Manual analysis of surveys is a cumbersome and time consuming activity and the MHSAA has conducted two surveys within the past two years (see needs assessment). The time spent in analyzing the survey data manually could best be directed elsewhere.

Some data is received automatically by the MHSAA e.g., Serum B Hepatitis, Public Health and Social Service (monthly report) and other data is received on a request basis e.g., crime records, Department of Public Safety. All data received is considered in developing the State Plan.

Computer capability would allow computer analysis in a more comprehensive and cost efficient manner. The Needs Assessment capability of the MHSAA is limited by the lack of computer capability. While the Government of Guam does have a computer with the capacity to provide us with the analysis we require,lack of funding has not allowed the MHSAA to be in to this resource. The obvious value of this will be carefully considered as future funds are prioritized.

The potential loss of federal formula funds, and the possible loss of NIMH funds for the CMHC operations (Distress Grant) all have serious implications for all level of D&A programming in Guam. In addition the Local, Government of Guam fiscal austerity program adds an additional dimension to this. The timing is unfortunate for Guam. Having identified the needs and appropriate approaches within each of the

OBJECTIVES/ACTION STRATEGY

PLANNING - Five-Year Plan OBJECTIVE	MANPOWER	TIME FRAME	STATUS	METHODS/PROCEDURES-ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
III. To review and update each of the Five-Year State Plan annually for 5 consecutive years	Planning Divison's Staff: 1. Division Chief 2. Planner IV 3. Planner II	Semi-Annual Review	C	A. Evaluate the AIP each year semi-annually through completion dates, objectives, and action strategies of each functional area of the plan and its relationship to the Agency's practical application. 1) Identify and measure each objective of each functional area's proposed initiative versus outcome objective. 2) Monitor each program initiative by task and performances as stated in the work-plan.	1) $ 19,180 2) $ 17,457 3) $ 13,151	1) State 2) PAF 3) PAF
	PL - Staff	Mar. & Sept. of each year Dec, Mar, June Sept. FY 81' - FY 85'	C	B. Amend or revise specific areas of the plan as appropriate , semi-annually for five years beginning FY' 81 to FY 85'. 1) Schedule a quarterly meeting with each division to monitor performances and identify changes in work plan. 2) Add, delete or restructure objectives for each functional area consistent with State Plan Update and Agency recommendation.	1) AST 2) AST 3) AST	1) State 2) PAF 3) PAF
IV. To continue providing annual needs assessment studies on alcohol, drugs and mental health through program assessment, community input, survey mechanism, beginning FY 81 to FY 85	Division Chief 1) Program Coordinator 2) Research Analyst IV 3) Research Analyst III	March of each year beginning 1981-1985	C	A. Collect, tabulate and analyze data from Public Health, Department of Corrections, Criminal Justice, CMHC, Catholic Social Services, Department of Education, private educational institutions, military civilian employees, clinics, community, the public, etc. For purposes of updating existing data in concluding needs assessment study. This will be an annual initiative that is on-going each year for five years beginning Fy 85. B. Collect,analyze, and tabulate data on special emphasis groups including women and elderly.	1) $ 15,000 2) $ 15,214 3) $ 13,869	1) State 2) PAF 3) PAF

ST: Agency Staff Time - staff salaries plus administration

AF : Pending Availability of Funds
TATUS: - C - Continuing Service Activity N= New Service or Activity U = Unmet need

OBJECTIVES/ACTION STRATEGY

PLANNING - RESEARCH OBJECTIVE	MANPOWER	TIME FRAME	STATUS	METHODS/PROCEDURES-ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
	Division Chief 2) Program Coordinator 2) Research Staff IV & III	March of each year beginning FY 1981 - FY 1985	C C	1) Administer follow-up surveys to private and public junior and senior high school on drugs and alcohol updates. 2) Collect, tabulate and analyze statistical information to include updates on needs assessment study.	1) AST 2) AST 3) AST	STATE STATE STATE
	1) Chief Planner 2) Research Staff	March of each year beginning Fy 81 - FY 85	C	3) Gather data on (a) morbidity and mortality from public Health relevant to alcohol and drugs, (b) incarcerated clients on drug and alcohol information from Department of Corrections and Criminal Justice, (c) CODAP Statistical Drug & Alcohol information from CMHC and CSS. (d) Community input data from MHSAA's prevention program committee.	1) AST 2) AST	1) STATE 2) PAF
V Cont'd	Division Chief	Semi-Annual Mar, Sept., of FY 81 thru FY 85.	C	B) Assess each area of service, monitoring program impacts to service users. Relate the outcome of services to stated objective and establish program efficiency thru evaluation mechanisms provided by NIDA, NIMH, NIAAA and ADAMHA. Identify levels of disparity between provision of services and needed services. Submit recommendation to SSA Director for implementation and inclusion to updates and revision of Five-Year Plan.	1) AST 2) AST	STATE 1) PAF 2) PAF
V. C. complete Functional comprehensive data-base management system which will consider the inclusion of data updates, accessibility confidentiality, storagability, evaluation capa-	Division Chief MIS staff, systems spec, "	Jan. 1st, 1981 "	U	A) Support system of semi-automated efforts will be established between MHSAA and possibly University of Guam and/or Department of Administration by October, 1980. B) By Jan 1st, 1980, system model on semi-manual operations will be developed by Research staff in Planning Division.	1. AST 2. 28,000	STATE 1) PAF

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OBJECTIVES/ACTION STRATEGY

PLANNING - PROGRAM DESIGN OBJECTIVE	MANPOWER	TIME FRAME	STATUS	METHODS/PROCEDURES-ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
bility, correlation analysis and other features by October 1st, FY 1985.	Division Chief 2) Research Staff	Feb. 1st 1982	U	C) By February 1st, 1980 transitional efforts in programming filing system will be effectuated utilizing research staff in planning to coordinate the project.	2) AST	STATE 2) PAF
V. Cont'd	cont'd Division Chief 1) Program Coordinator 2) Research Staff	October of each year beginning 1980	C	D) Based on Needs Assessment study, the development of new programs, plans, improvement and expansion of existing programs in drugs, alcohol and mental health will be used to prioritize their relevancy as to need determined services in accordance to revisions and updates made from the 5-Year state plan by October of each year beginning with October 1st 1980 and ending October 1st 1984.	1) AST 2) AST	STATE 1) Local 2) PAF
	Division Chief	Dec., Mar., June, Sept., of Fy 81 thru FY 85	N	Sub/Action Strategy: 1) Proposed new programs such as Occupational Services Assistance program, Women Alcoholism program, Manpower Development program, DWI Educational diversion program, Alcohol Treatment Residential program, etc, will be established based on priorities determined by community needs analyzed thru statistical survey analysis, interviews, community input, manpower analysis (prevention training program), community-based prevention outcome analysis, of existing clients program services.	1) AST 2) AST	STATE 1) PAF 2) PAF
Cont'd	Chief Planner 1) MIS Staff Planner IV 2) Research Staff	Oct., 1982	N	2) By October, 1982 a data base management system for research will be a developed component of MHSAA's management information system.	1) 17,457 2) AST	STATE 1) PAF 2) PAF

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OBJECTIVES/ACTION STRATEGY

PLANNING - PROGRAM DESIGN AND MIS OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES-ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
	Chief Planner 1) Mis Staff 2) Research Staff	Jan. 1983	N	3) By Jan. 1983, Program/Clinic CODAP, SAPIS, and SSA regulation files from CMHC and programmed as parts of the Research Data Base System.	1) AST 2) AST	STATE 1) PAF 2) PAF
Cont'd	Chief Planner 1) MIS Staff 2) Research Staff	Oct, 1982	N	4) By October, 1982 a data base management system for research will be a developed component of MHSAA's management information system.	1) AST 2) AST	STATE 1) PAF 2) PAF
Cont'd	Chief Planner 1) MIS Staff 2) Research Staff	Jan. 1983	N	5) By Jan. 1983, program/clinic CODAP, SAPIS, and SSA Regulation files from CMHC and CSS will be instilled, coded and programmed as parts of the research data base system.	1) AST 2) AST	STATE 1) PAF 2) PAF
Cont'd	Chief Planner 1) MIS Staff 2) Research Staff	Oct. 1st 1983	N	6) By October 1st, 1983, program management policies and procedures from CMHC and CSS will be programmed into the data base and made parts of the system.	1) AST 2) AST	STATE 1) PAF 2) PAF
Cont'd	Chief Planner 1) MIS Staff 2) Research Staff	Oct. 1st 1984	N	7) Oct 1st, 1984, program files on organization management, treatment process, financial management and general management will have been programmed into the system and functionally operating.	1) AST 2) AST	STATE 1) PAF 2) PAF
Cont'd	Chief Planner 1) MIS Staff 2) Research Staff	Sept. 1985	N	8) By September 1985, comprehensive research and needs assessment study data-base system will be operational in a systematic, continuing process.	1) AST 2) AST	STATE 1) PAF 2) PAF

OBJECTIVES/ACTION STRATEGY

PLANNING - MIS OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES-ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
3) Develop MHSAA's management information system to a comprehensive detailed design stage to serve the mangager (administrator) - user (MIS - Service user) in a systematic manner in the decision-making process, by 1985.	Chief Planner 1) MIS Staff	Oct. 1st 1982	N	1) By October 1st 1981, the detailed deisgn model for the Agency's management information system will be completed.	1) AST	STATE 1) PAF
	Chief Planner 1) MIS Staff	Jan 1st 1982	N	2) By Jan 1st 1982, the MIS transitional phase of a semi-automated system will be completed	1) AST	STATE 1) PAF
	Chief Planner 1) MIS Staff	Oct. 1st 1982	N	3) By October 1st, 1982, the MIS and inclusion of one terminal and two modum units will be contracted between Department of Administration and MHSAA.	1) AST 2) unit lease quote from Dept of Admin. (approx $15,000 includes unit and computer time.)	STATE 1) PAF 2) Federal PAF
Cont'd	Chief Planner 1) MIS Staff	Oct. 1st 1983	N	4) By Oct. 1st, 1983 the use of MIS by the Agency will be servicing programs as well as other departments	1) AST	STATE 1) PAF
Cont'd	Chief Planner 1) MIS Staff	Oct. 1st 1985	N	5) By Oct 1st, 1985, all components of the MIS will be integrated within the system and shall not be limited to the following; FMS program/clinic data, research and statistical program data, Agency and program policies and procedures, Agency's divisional requirements.	1) AST	STATE 1) PAF

program areas we face the problem of needing to develop programs in the face of rapidly shrinking federal and Government of Guam money.

B. Treatment and Rehabilitation

Resource Assessment: In this "Resources Assessment section, alcohol and drug abuse will be considered together. Of interest to NIAAA and NIDA is our intent, if possible, that the Guam Five-Year Plan for Mental Health will integrate closely with this plan, with the major implication that planned services identified as combined alcohol and drug abuse services (per ADAMHA definition) would include the mental health discipline in the consolidated (combined) services. Neither details of funding mix, nor proportions of clients by discipline can be accurately predicted. However, based on a number of factors, including response to MHSAA and treatment personnel presentations and national experience, it is anticipated that the majority of clients will be for alcohol related problems, for the 24-hour services and employee assistance programs. Development of these two programs is dependent upon NIAAA funding. However, it is anticipated that from the other potential sources for funding mix, sufficient support can be identified to fully justify the "combined" sub-category of consolidated services.

While this narrative addresses both NIAAA and NIDA concerns, the action strategy clearly identifies the exact discipline status of each service element. The CMHC Alcohol Program and CSS Residential Treatment Program are both less than a year old. Both are functioning well but both face possible significant loss of funding; CMHC from eighth year termination of their Operations Grant (totaling about 40% of the CMHC budget) and CSS from MHSAA's probable loss of Drug and Alcohol formula funding. It is impossible to predict at this time what might happen with the funding situation of these programs. The Drug Program of CMHC is more secure due to the NIDA SWSG funding.

The "Needs Assessment" part of this Five-Year Plan presents the Agency's collection and analysis of data concerning the alcohol problem on Guam. In summary, there are strong indications that Guam faces a prevalance of alcohol problems as great or greater than the states with highest per capita problem levels. This includes youth as a special population and sufficient casue for concern considering the number of problem-drinking women. The Marden computations, substantially validated as minimal estimates, demonstrate a treatment need far surpassing current service capacities. To date, the only significant criticism of each of the programs is virtual absence of outreach activity. For this reason, and the newness of both programs, utilization cannot be considered as an indicator of need for services.

At present some outpatient counseling is avaiable and the alternative for somewhat flexible long-term residential treatment. CSS does have some loosely organized outpatient counseling capability, but lacking specific funding, it is limited. Existing program capacity is depicted on Chart IV-A page 64 .[1]

The two services now in some jeopardy, are seen as just the beginning for a viable alcohol services system. The action strategy details the other services felt to be minimally necessary for Guam. In summary, the pending proposal for "Comprehensive Program for Pacific Island Women with Alcohol Related Problems" would emphasize development of outreach education, intervention, counseling and residential services for women, dependent youth and significant others, affected by drinking problems whether the drinker is the women or someone close. Upon local passage of the Uniform Alcoholism Act, federal monies will be utilized as core funding to provide combined 24-hour services (crisis intervention, hotline, centralized services directory system emergency shelter and social detox). The Agency will propose and hopes to have federally funded, an employees assistance program, again of combined services with a funding mix, with the target being Government of Guam employees comprising half of Guam's total labor force which, through the strong extended family structure, has a potential of touching virtually all local residents. These services would include early intervention, counseling, referral and short-term intensive treatment. Highway Safety monies, locally available, are about to be used to initiate a professional DWI program with the Courts, a program which can become self-supporting through Court mandated fees. The need for this program is supported in the needs assessment section of this plan. Taken together, these programs, developed over the term of this Five-Year Plan, can provide Guam truly comprehensive services on a very efficient, and eventually self-and local-supported basis.

[1]The CMHC Methadone Maintenance services and the CSS-RTP both show better than average effectiveness on all five "Clinic Management by Exception Report" (NIDA's CMER). See Appendix H.

Chart IV-A
Existing Services Description
Treatment and Rehabilitation Division

Program	Discipline	Services	Capacity	Utilization Avg. Static	Utilization Dynamic	Client Characteristic	Out-comes
Guam Community Mental Health Center Drug Program(GCMHC)	D	a) Methadone Detox O/P		2.4	29	50% female	Slight-
		b) Methadone Mainte-nance O/P	36 static	31	47	50% 21-24 yrs. old	ly a-bove
		c) Drug Free O/P Coun-seling	(reduction anticipated)	1.5	18	50% 25-30 yrs. old	CMER nation
		d) Chemotherapy O/P		-0-	2	33% prior arrest	al a-verage on all five varia-bles
CMHC Alcohol Program	A Joint Services	a) Outpatient Counseling O/P	11/1/79-4/30/80				
		b) Referral & Services Assistance	35 static	21	44	Not Available	Not Avail-able
		c) Sig. Others Counseling O/P	(reduction anticipated)	91 sessions per month avg.			
		d) Crisis Intervention (opened 12/10/79)					
Catholic Social Services (CSS)	AD Combined Servs.	a) Residential Treatment Program (modified therapeutic community)	15 static	9/1/79 - 4/30/80 3.5	8	Male only All 22-29 yrs. old 29%-Criminal Justice	Signi-ficant-ly a-bove CMER nation-al a-reas o all 5 varia-bles

With Uniform Alcoholism Act funding to provide a crucial core fiscal base, the 24-hour services, combined across the three institutes and efficiently pooling resources across several functions, can demonstrate highly valued services at minimal cost to obtain eventual local funding. The employees assistance program, with easily demonstrated cost effectiveness, can with demonstration grant funding, quickly develop third-party funding supplemented by local dollars based on demonstrated savings, become self-sufficient locally. By pooling resources of the residential services and developing third-party payment, these essential services should be able to demonstrate sufficient utilization and effectiveness to justify local funding to pick up the slack. The Government of Guam survey provides useful information in the initial development (awareness and outreach) for this plan.

This provides an outline, a guide, for development of a services system on Guam. For Guam's insular, medium-sized population, this outline emphasizes services that have been shown to be key to effectiveness and/or fulfilling functions required to make a system work. It also emphasizes combining service functions across the institutes, integrating services, to minimize cost. It also emphasizes programs most able to achieve self-sufficiency, moving away from federal funding (except third-party) and minimizing the local appropriation in relation to revenues. Over the first year or two of the Five-Year Plan, substantial changes in details can be anticipated. This outline represents a treatment goal statement and the action plan presents the implied to provide guidance for action and not as restrictions towards approaching comprehensive alcohol services.

It should be noted here that youth as a special population (per the needs assessment of this plan), constitutes a target population of high priority for MHSAA. Some youth will be reached by each of the programs discussed, but none is designed specifically to target this population. However, as a apparent from Part IV, sections D and E, a heavy emphasis of both prevention and training efforts is to serve youth. Prevention is self-explanatory. For provision of counseling services, submission of a demonstration grant for a program in relation to the schools is being considered. However, the scope of need is so great, with 10,000 public school students and 2000 private

school students in grades 7-12, that an alternative is seen as more realistic. Identification and training of school counselors, nurses and teachers covering all schools, selected for level of interest in helping youth and popularity among the students, is viewed as the most economical and effective means of assuring services availability to the youth target group. The training would emphasize alcohol education, intervention counseling, general alcohol counseling principles, and resources and referral information.

Guam has established drug treatment priorities in direct conformity with NIDA. That is, the only substantive treatment efforts will be in the two modalities NIDA research has indicated as both effective and cost-effective: methadone maintenance outpatient (including the required methadone detox) and drug-free residential. Clinical evaluation will utilize the five criteria, recoverable from CODAP, which NIDA research has found to be most clearly correlated with treatment success as measured by post-treatment earnings, reduction of drug use and reduction of arrests compared with untreated or "less" treated groups. The only deviation is Guam's stance of encouraging reduced treatment durations from the long-term, traditional therapeutic communities. At this time, treatment duration is highly dependent upon individual treatment plans and client progress. However, minimum duration will almost always exceed the 120 days used as criterion for the "Clinic Management by Exception Report," (CMER). Our computations of the CMER are used for our evaluative purposes. See Appendix H.[1]

Guam is taking a firm stance in relation to diversion. The concept of decriminalizing alcohol abuse is outright accepted. Legal authorities on Guam are adopting firm positions regarding individual accountability for one's actions in relation to the law, however, MHSAA and those bodies constituted to provide citizen and public input to planning issues, take the position that, regardless of social issues, the law must be administered, faithful to the laws of Guam and the nation. For this reason, diversion programs which allow for avoidance of legal processes related to illegal behavior by participation treatment programs, are not supported. As a sentencing alternative or supplement, participation by offenders in DWI treatment programs, etc, is seen as a valid and fruitful process. Perhaps greater voluntary participation by those in need, prior to offense, will be encouraged.

[1] As mentioned earlier, both CMHC Methadone & CSS-RTP demonstrate better than average effectiveness on all five variables.

As stated in the "Progress Report" for "Criminal Justice Interface," efforts are focusing on establishing specific, new, practices. The continuation of this practical direction is reflected in the action strategy.

Technical ~~assist~~ance is available to the private sector as well. Approximately one half of Guam's work force work for the Government of Guam or its semi-autonomous agencies and only one large private employer exists on Guam (GORCO), but these issues affect all segments of the community and everyone can contribute with concerned awareness.

OBJECTIVES/ACTION STRATEGY

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES-ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
GOAL: TO PROVIDE COMPREHENSIVE, INTEGRATED ALCOHOL AND DRUG ABUSE SERVICES RELEVANT TO AND DESIGNED FOR THE PEOPLE OF GUAM.					1) 19,280 2) 13,476	1) STATE 2) STATE
1. Objective: Maintain the Methadone, outpatient program of the CMHC Drug Program and assure improvement in outreach efforts as measured by improved utilization (avg. static utilization of 30 for last 2 quarters of FY 1981)	1. Chief, Treatment and Rehabilitation Division (T&R) a. Chief, T & R Chief, Administration b. Chief, T & R c. Chief, T & R	FY 1981 3/15/80 and FY 1981 6/19/80 Aug. 1980 FY 1981	C	1a. Prepare and administer NIDA-SWSG b. Support the local appropriation required to maintain this program c. Provide T.A. to CMHC concerning outreach, emphasize importance.	1) AST 2) Program $ 32,825 17,675 23,500 35,000 $ 109,000	1) AST NIDA-SWSG StateMatch State (including) PAF PAF In-Direct and In-Kind by GMH (STATE)
2. Objective: Maintain the Residential Treatment Program of Catholic Social Services and assure improvement in outreach as measured by improved utilization (avg. static utilization of 12 clients for last 2 quarters of FY 1981).	2. Chief, T&R a. Chief, T&R b. Chief, T&R c. Chief, T&R d. Chief, T&R	FY 1981 3/15/80 and FY 1981 6/19/80 Aug. 1980 6/15/80 - 9/30/80 FY 1981	C	2a. Continue efforts for securing NIDA-SWSG funding. b. Support the local appropriation required to maintain the program. c. Assist CSS to establish a contract with VA for provision of 3 treatment slots. d. Provide T.A. to CSS concerning outreach, emphasize importance.	1) AST 2) $ 25,363 13,657 27,343 11,000 7,000 36,000 20,137 140,500 51,800 $ 192,300	STATE NIDA-SWSG PAF-FI State Match State Food Stamps Social Serv. V.A.- PAF Client Con- PAF tributions Other sources PAI

NOTE: AST: Agency staff time - staff salaries plus administration
PAF: Pending Availability of funds
STATUS: - C - Continuing Service Activity
- N - New Service or Activity
- U - Unmet need

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OBJECTIVES/ACTION STRATEGY

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES-ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
3. Improve the effectiveness of the drug programs by an aggregate increase of at least 15% for each program on the five CMER variables	3. a. Chief, T&R b. Chief, T&R	FY 1981 Quarterly Quarterly	C	3a. Compute and report to the programs, CMER variables from CODAP data each quarter b. Provide T.A. as indicated by CMER in areas where improvement is feasible.	AST	STATE
4. To support and encourage development of outpatient alcohol services program to yield a 10% increase in caseload.	4. Chief, T&R a. Chief, T&R b. Chief, T&R c. Chief, T&R	FY 1981 Every two months As requested FY 1981	C	4a. Maintain communication by conversation with program Supervisor at least once each two months. b. Provide T.A. as requested. c. Share information concerning federal and local alcohol issues and funding opportunities.	AST	STATE
5. If funded by NIAAA Demonstration Grant, establish SSA functions in relation to the CSS "Comprehensive Program for Pacific Island Women With Alcohol Related Problems" (education, outreach, outpatient counseling, collateral services, shelter and residential treatment)	5. Catholic Social Services a. CSS	FY 81	N	5a. Meet with program director to determine protocol. b. Draft SSA/CSS alcohol program protocol. c. Finalize and implement.	$ 620,000 60,000 17,940 23,000 12,000 45,000 38,000 10,000 $ 825,940	PAF NIAAA PAF In-Kind PAF Welfare PAF Self-Pay PAF Donations PAF Volunteer PAF Services PAF Resident PAF Income PAF Third Party PAI

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OBJECTIVES/ACTION STRATEGY

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES-ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
6. Develop and operate the Community Assistance Center, a complex of consolidated (combined) 24-hour services including hotline, information and referral, services directory system, emergency shelter, Uniform Alcoholism Act resource, social detox.	6. Chief, T&R a. Administrator b. Chief, Planning and Chief, T&R c. Chief, Planning Chief, T&R d. Chief, T&R	FY 1981 a. 10/1/80 b. 11/30/80 c. 2/20/81 d. 3/1/81	N	6a. Advocate passage of Uniform Alcoholism Act by October 1, 1980. b. Design program, prepare and submit proposal to NIAAA. c. Inter-Agency agreements between MHSAA and Department of Public Safety and Guam Memorial Hospital d. Implement per proposal	1) AST 2)$ 150,000 32,000 20,000 30,000 $ 212,000	STATE NIAAA(per yr. for 6 yrs.) P/ CETA P/ Volunteer Services P/
7. Develop and operate the Government of Guam Employees Assistance Program, including supervisor training, intervention counseling and short-term intensive treatment (residential or quasi-residential, approx. 3 weeks)	7. Chief, T&R a. Chief, Planning Chief, T&R b. Chief, Planning Chief, T&R c. Chief, T&R or other provider	7/1/81 - 6/30/84 a. 12/1/80 b. 8/1/81 c. Thru FY 1981 and on	N	7a. Design program, prepare and submit proposal to NIAAA b. Negotiate with one or more Gov.Guam departments to begin implementation. c. Continue and expand implementation of program	1) AST 2) $ 905,000 275,000 20,000 20,000 $ 820,000	STATE NIAAA PAI Third-Party (increasing each year) PAI Self-pay PAI State (Third year) PAF
8. Develop Guam relevant self-help alcohol (and drug) group for intervention, self-help and after-care.	8. Chief, Planning Chief, T&R	Thru FY 1981	U	8. Work with other providers, A.A. and especially clinically discharged clients towards developing a strong core group.	AST	STATE PAF

OBJECTIVES/ACTION STRATEGY

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES-ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
9. Develop program elements and programs for the elderly who have problems with drugs and/or alcohol.	9. Chief, Planning Chief, T&R	FY 1981	U	9a. Assess needs of elderly b. Determine most economical means of satisfying identified needs.	1) AST 2) Unknown	STATE Existing Resources P Unknown P
10. Support and assure provision of a DWI program centered with the Courts	10. Chief, Planning Chief, T&R Supreme Court a. Chief, Planning Chief, T&R b. Chief, T&R c. Chief, Planning Chief, T&R	FY 1981 7/1/80 FY 1981 9/1/80	N	10a. Review, critique and after TA to those working to develop a DWI program and select a program to support. b. Provide TA as requested or needed. c. Assure operating program by working with the Courts.	$ 10,000 As needed	Federal Hwy Safety Self-Pay
11. Support inclusion of appropriate services for women and youth in existing programs and new ones, but especially in the CSS Residential Treatment Program.	11. Chief, Planning Chief, T&R	FY 1981	C	11. a. By pointing out identified needs and offering TA. b. By inclusion of services to women in renewal contract with CSS.	AST Existing Resources	STATE PAF
12. Support and work with the Training and Prevention Division efforts to provide secondary Prevention services to the youth of Guam through the schools	12. Chief, Planning Chief, T&R	FY 1981	N	a. Maintain close communication, share in assessing needs and preparing any proposals, and assist in providing TA and training.	AST	STATE

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES - ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
13. Prepare and propose legislation for establishing authority for credentialing of selected categories of mental health, drug and alcohol counselors.	Chief, T & R	5/1/82	N			
	Chief, T & R	9/30/81		13a. Prepare "Draft Guidelines for Credentialing Standards of Mental Health, Drug and Alcohol Standards" including consideration of experimental training and emphasizing knowledge and skills. (These are not intended as the standards themselves but rather a general framework for inclusion in authorizing legislation)	AST	STATE
	Chief, T & R	10/15/81		b. Submit the "Draft Guidelines..." to GHPDA, service providers, GASW, GHCC, MHSAA Advisory Council and in a public meeting for review and comment.	AST	STATE
	Chief, T & R	4/30/82		c. Incorporate comments in draft legislation.	AST	STATE
	Administrator	5/1/82		d. Submit proposed legislation to the Legislative Review Committee of the Governor's Office.	AST	STATE
14. Achieve inter-agency agreements as concerns mental health, alcohol and drug abuse with GMH, DPS, PH&SS, AG, Superior Court, DOE, GCC, DOC, Parole Board and UOG	Administrator Chief, T&R Chief, Planning Chief, Q.A.&E Chief, T&P	6/30/82	N		AST	STATE
	Administrator and appropriate other(s) from above	2/15/81		14a. Meet with agency and department heads, or their representatives, of GMH, DPS, PH&SS and DOE to discuss inter-agency agreement.	AST	STATE
	Chief, T&R Chief, Planning Chief, Q.A.&E Chief, T&P	4/15/81		b. Draft proposed agreements with GMH, DPS, PH&SS and DOE.	AST	STATE
	Administrator and appropriate other(s) from above	11/15/81		c. Meet with agency and department heads, or their representatives, of AG, Superior Court (Presiding Judge), GCC, DOC and Parole Board.	AST	STATE

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES - ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
	Chief, T&R Chief, Planning Chief, Q.A.&E Chief, T&P	2/15/82		14d. Draft proposed agreements with AG, Superior Court, GCC, DOC, Parole Board and UOG	AST	STATE
	Administrator	9/30/81		e. Finalize and sign agreements with GMH, DPS, PH&SS and DOE	AST	STATE
	Administrator	6/30/82		f. Finalize and sign agreements with AG, Superior Court, GCC, DOC, Parole Board and UOG	AST	STATE

C. Quality Assurance and Evaluation

Resource Assessment - The Quality Assurance/Evaluation section has received annual technical assistance from Touche Ross Co. relevant to the development and implementation of monitoring and evaluation tools and methods. Division Chiefs of Treatment/Rehabilitation, Quality Assurance, Evaluation and Planning joint quarterly site monitoring visits which yield a variety of information for evaluation purposes i.e., compliance with local and federal regulation and law, client/staff ratio, client records, confidentiality, administration including fiscal and personnel, primary substance of abuse, aftercare activities, outreach and intake. All site visit reports are submitted to the individual programs for review and if necessary, action. No alcohol formula dollars presently go into alcohol treatment and rehabilitation. Programs within the purview of the MHSAA are judged on quality of services based on information gathered at the site visit. Various reports SAPIS, CODAP, etc., and information are gathered, as required, and reviewed and forwarded to the appropriate agency.

Guam is just beginning to consider the issue of licensure, accreditation, and certification. Presently, the Division Chiefs of Treatment/Rehabilitation, Prevention/Training, and Quality Assurance/Evaluation are all jointly considering this issue. Licensure and certification standards from other states are being reviewed and considered. Discussions are underway with the Guam Community College regarding credits for national courses. We are very concerned with developing criteria that will assure quality of care while not being bureaucratically cumbersome.

Internal SSA evaluation activities are conducted by joint meetings between the Administrator, Deputy Administrator, and Division Chiefs with input from the ADM Consultant. Planning activities receive input from the GHPDA. Fiscal and administrative monitoring is handled by other government agencies.

All programs contracted by MHSAA have established clear measures of functioning. Site visits also gather effectiveness data for analysis and feedback. Judgment as to degree of effectiveness is in large part within the responsibility of the Chief,Treatment and Rehabilitation.

OBJECTIVES/ACTION STRATEGY

QUALITY ASSURANCE AND EVALUATION DIVISON

QUALITY ASSURANCE OBJECTIVE	MANPOWER	TIME FRAME	Status	METHODS/PROCEDURES/ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
To provide a comprehensive systematic process for discovering new operating capacity potential for alcohol, drug and mental health services annually.	1)Chief Division of Quality Assurance and Evaluation 2) Program Planning Evaluation and Research Sepcialists	FY 81 thru FY 85	C	1) Each year starting FY 81 thru FY 85, the Quality Assurance Section will continue to systematically inquire, observe and study each phase of all factors affecting functional capacities of alcohol, drug and mental health services.	1) $19,080 2) $17,457 3) $14,000	STATE PAF PAF
				a) Quality Assurance Section of SSA will implement quarterly Quality Assurance relevant to drug, alcohol, and mental health methodologies by utilizing quality assurance staff. It will monitor the status & changes in factors affecting: client needs, service utilization program infrastructure target population served, their age, sex, ethnicity, geographic origin, opinions and attitudes of clients, program personality factors, modality, discipline, treatment process, organizational structure, program management, general management. These data will be gathered through the use of methodologies in various survey instrumentalities and currently established external reporting requirements i.e. CODAP, NDATUS, SAPIS, CARL. In addition, SSA will continue to conduct program interviews and quarterly site visits	1) AST 2) AST	STATE PAF
Cont'd	Same	Cont'd	U		1) AST 2) AST 3) AST	STATE PAF PAF

NOTE: AST - Agency staff time - staff salaries plus administration
PAF: Pending Availability of funds
STATUS: - C - Continuing Service Activity N = New Service or Activity U = Unmet

OBJECTIVES/ACTION STRATEGY

OBJECTIVE	MANPOWER	TIME FRAME	Status	METHODS/PROCEDURES-ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
Cont'd	Same	Cont'd	U	b) Quality Assurance Division will implement appropriate practical application of inductive or deductive findings to each program/clinic/center. This is manifested by the discovery of new facts in treatment process, patient rights, program funding policies etc. Enforcement procedures will be conducted under controlled conditions to test or discover alternative functional capacities of each service modality for alcohol, drug and mental health program.	1) AST 2) AST	STATE PAF
Cont'd	Same	Cont'd	C		1) AST 2) AST	STATE PAF
Cont'd	Same	FY 81 to FY 85		c) Quality Assurance Project Proposals and progress reports will be submitted by Q.A. Dir. to SSA director on a quarterly basis to sanction its feasability, certification and/or implementation. This initiative will be done thru program coordination on a systematic submission of timely reports by program recipients.	1) AST 2) AST	STATE PAF
Develop appropriate licensing standards for A&D programs by October 1983.			N	a. Review standards of other states by April 1981 b. Report on review June 1981 c. Select licensing criteria by Oct. 1981 d. Present to public for comment by Dec. 1981 e. Incorporate/revise as appropriate April 1982 f. Acquire appropriate legislation 82-83 g. Final - Oct. 1983	1) AST	STATE

OBJECTIVES/ACTION STRATEGY

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES - ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
SSA will implement a systematic process of determining the effectiveness and efficiency of existing functional capacities to meet total needs and stated objectives from program recipients and service users by 1981.	1) Chief, Quality Assurance & Evaluation 2) Program Planner/ Evaluation and Research Specialist	Between FY 81 thru FY 85	U	The Evaluation Division of SSA will implement the following process: - Establish a quarterly updating evaluative criteria and required or desired levels of performance by service area and applicable SSA program structural guidelines for alcohol, drug, and mental health programs. - Sensing and recording system performance and environmental condition study from Division of Planning, SSA. Information input thru survey mechanism will also support findings. - Comparing program performance records, environmental requirements, and performance standards acceptable to NIDA's, SWSG, NIAAA, and NIMH program review manuals. - Data deductions, tabulations, and transmissions to validate, quantify, and qualify findings as evidenced by reporting mechanism required by SSA, NIDA's, CODAP, SAPIS, NDATUS	1) AST 2) AST	1) STATE 2) PAF

D. Prevention/Training/and Manpower

Resource Assessment - The Guam Mental Health and Substance Abuse Agency has adapted the definition of the National Association of Prevention Professionals (NAPP) of prevention as being a proactive process, utilizing an interdisciplinary and multi-cultural approach designed to empower people with resources necessary to constructively confront stressful life conditions.

It is proactive in that it spans the deliberate activity before the onset of a problem. It is interdisciplinary in that it spans the traditional human service delivery systems (social services, juvenile delinquency, education, etc.) The approach is multi-cultural as it recognizes the diversity of values and customs of the multi-ethnic population of this and neighboring Pacific Islands. In empowering people, it enhances their natural support system or, when this support is absent, provides a means of enabling them to help themselves, moving them from dependency toward personal autonomy in ways that are acceptable to them.

The definition of prevention encompasses many activities that establishes a positive approach as opposed to the scare tactic approaches used in the past. Prevention is different from treatment in that it addresses the needs of a section of the population either not involved or else minimally involved in drugs. Prevention activities, those that promote personal growth toward full human potential, are broken down into four parts:

Information - centers on the function of providing accurate and up-to-date information on the nature of drugs, prevention strategies and resource announcements to the general public. The aim is to heighten awareness of drug abuse and its prevention.

Education - The function involves promoting a deeper knowledge of drug abuse and its inherent problems. It differs from public information since it focuses on specific populations like youth, parents, service providers, etc. Some education mechanisms include the substance abuse education curriculum written for grades K-12.

The unrevised Substance Abuse Education Curriculum lacks alcohol specific prevention activities, of which is needed, based on informal reports from teachers and counselors who indicate an increase in student problem drinking particularly among junior and senior high school students. The Mental Health and Substance Abuse Agency completed a comprehensive drug and alcohol survey in April 1980 throughout the island's eight, secondary schools to approximately 7,072 students, or one-fourth of the 27,000 students the Department of Education serves. Survey results indicate that 79% of the respondents think there is an alcohol problem on the island, with 2.5% or 300 students admitting that they feel they have a drinking problem.

Through a coordinated effort with the Department of Education, the Mental Health and Substance Abuse Agency thinks that alcohol prevention literature, films and resource material, can be made available and more accessible to DOE teachers and counselors, and the two departments can combine efforts to revise the present substance abuse education curriculum to include specific prevention/intervention strategies.

Intervention - These activities will provide services to those individuals who are at risk, i.e., those that are likely to participate in substance abuse. MHSAA will continue to support the Peer Counseling training as an intervention strategy for teenage students. Peer Counseling programs qualifies as an intervention strategy as it works with individuals who are not yet deeply involved with drugs to require treatment, but whose needs are not being met by the formal institutions.

Alternatives - Drug abuse prevention operates on a basic assumption that if individuals are provided fulfilling and rewarding experiences, they will be less prone to engage in substance abusing activities. The positive and rewarding experiences must be provided to the public. MHSAA has discussed with Prudential Insurance Agency the feasibility of applying for Channel One, an alternatives programming project, which offers opportunities for youth to demonstrate skills, ideas and cooperative planning. This direction in drug abuse prevention which provides rewarding experiences through which people can achieve growth will actively be pursued by MHSAA.

It is the responsibility of MHSAA to develop and maintain prevention programs that abides by the definitions stated above.

MHSAA will focus upon building local trainer capacity so that a self-sufficient internal capability may be achieved. This capability will

enable trainers to design and implement culturally relevant training programs. This is important in that most training courses are designed towards mainland needs and although MHSAA thinks that similarities between Guam and U.S. abound, the past practice of transplanting social service programs and practices to Guam on the assumption that what is good for the mainland will benefit Guam also has sometimes proven disastrous in terms of utilization and effectiveness. Training courses, films and literature developed on the mainland must be modified and where appropriate developed locally to suit unique local needs.

Key individuals from social service agencies will be identified and trained through a phasing system. The aim is to develop a cadre of local trainers using the generic approach as much as possible. These trainers will subsequently train others from within their own agencies and select potential persons whom they will train through all phases. This training cycle would continue until each agency develops their own cadre of trainers. We will have totally developed our own training resources, that dependence on bringing in off-island trainers would be significantly reduced and eventually become unnecessary.

Another group upon which MHSAA intends to focus training needs are the "natural providers". These are leaders within the community such as the family, village commissioners, priests, folk practitioners and civic leaders who have always been throughout Guam's history the caregivers and advisors for those who seek help with their problems. Interviews with priests and commissioners have evidenced their desire to enhance their effectiveness in counseling substance abusers and in general helping families cope with today's problems. The "natural providers" concept underscores further the need for modifying training courses or even the development of new ones.

Regional - MHSAA has responded to a request from the Saipan government to provide technical assistance to a service provider agency by conducting a training workshop on Facts About Drug Abuse. They have also inquired into the possibility of MHSAA sponsoring another workshop in the future. The Northern Marianas and Trust Territory government looks toward Guam SSA as a vital source of technical assistance in the area of mental health and drug abuse. Previous studies have shown that there is a high incidence of alcohol abuse in the more po-

pulated Trust Territory islands. To date we know of no one being trained in mental health and/or substance abuse fields. By enhancing our own training capability, we will be better able to provide them with training assistance when requested. Formal agreements with Northern Mariana Islands and Trust Territory (NMI and TT) will be explored to facilitate this.

Implications of performance reports regarding training: In the course of providing training in the past, several problems have arisen.

(1) Training needs have not been properly assessed. Training is often provided in response to what is accessible or available versus what the employees actually need. MHSAA needs to develop a needs assessment instrument which would measure the nature and extent of other agencies' training needs and base its delivery from there.

(2) Participants sent to training are not necessarily those of whom the course was intended. In the future, it would be required that employees selected should meet a minimum criteria, e.g., that trainee be engaged in a counseling role or work in the area of treatment, etc.

OBJECTIVES/ACTION STRATEGY — PREVENTION

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES - ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
1. Maintain funding for the State Prevention Coordination program	Prevention Staff	On-going	C	a. Obtain SPC grant application kit b. Complete and submit proposal to NIDA	$19,180	STATE
2. Organize and provide the annual Prevention Workshop for direct service providers	Prevention Staff	Yearly	C	a. Identify and obtain funds for Workshop b. Create organizing committee c. Develop workshop agenda and format d. Invite appropriate direct services providers e. Implement workshop, to include evaluation and follow-up mechanisms	1) AST 2) $ 1,800	1) STATE STATE-PAF
3. Provide information on hazards of cigarette smoking and alcohol abuse to 500 students from public schools in grades K-8	Prevention Staff	By Dec. '81	N	a. Develop presentation format appropriate to age level b. Coordinate school presentation schedule with DOE c. Obtain handouts for presentation d. Conduct presentation to 45 students monthly e. Evaluate each presentation	1) AST 2) $ 1,500	STATE Federal-PAF
4. Expand MHSAA Prevention Newsletter to include all school and health counselors, all libraries on island and 100 additional teachers	Prevention Staff	By Dec. '81	C	a. Increase funding for newsletter b. Increase publication by 200 more issues	1) AST $ 150	STATE STATE Local
5. Arrange for an adult education course for parents on substance abuse prevention to be taught at Guam Community College	Prevention Staff	Sept. 1982	N	a. Develop a course for parents on substance abuse b. Pilot course twice with 40 parents c. Contact GCC regarding incorporation of course into existing adult education programs d. Train GCC personnel in instructing the course	1) AST 2) $ 3,500	STATE STSP SPC-PAF

NOTE: AST: Agency staff time - staff salaries plus administration
PAF: Pending availability of funds
STATUS: C - Continuing service activity N= New Service activity U= Unmet Need

OBJECTIVES/ACTION STRATEGY — PREVENTION

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES - ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
6. Continue prevention coordination efforts with other agencies and groups on island	Prevention Staff	on-going	C	a. Maintain Prevention Task Force's representative membership	1) AST	1) STATE
7. Provide training specific to basic counseling skills to teachers, bus drivers, counselors and other personnel who have daily contact with youth	Prevention Staff	April '82	N	a. Train 4 instructors in SHORT-TERM CLIENT SYSTEMS course, NIDA b. Implement pilot course to 15 teachers, bus drivers, counselors, etc. c. Provide training to an additional 40 teachers, bus drivers, etc.	1) AST 2) $3,000	1) STATE 2) Federal PAF
8. Assist DOE in developing Health Education curriculum for grades K-12	Prevention Staff	On-going	C	a. Meet with DOE Drug Coordinator to identify assistance b. Provide technical assistance as indicated	1) AST	1) STATE
9. Recruit and hire a permanent Agency Librarian	Training and Prevention Supervisor	By Sept. 1981	C	Request (1) one additional employee slot for MHSAA Librarian from Legislature Recruit according to standard Government of Guam hiring procedures	1) AST 2) $12,000	1) STATE 2) STATE - PAF
10. Develop library into mental health/substance abuse Clearinghouse for the island.	Training and Prevention Supervisor	By Sept. 1983	C	a. Continue to obtain all available literature on mental health and substance abuse prevention, treatment, research, training, etc.	1) $8,000	1) STATE
11. Increase utilization of MHSAA library by teachers, counselors, students, and other "providers" by 50%.	Prevention Staff	By 1981	C	a. Continue inserts in the Agency's Newsletter on reading materials available in the MHSAA library b. Identify informational needs of teachers, counselors students, and other "providers". c. Establish liaison with Main Library (Nieves Flores) for the purpose of increased utilization of MHSAA library by students, teachers, counselors, and the public. d. Utilize the Nieves Library van to disseminate pamphlets and brochures on substance abuse.	1) AST 2) $500	1) STATE 2) STATE

OBJECTIVES/ACTION STRATEGY — TRAINING

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES - ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
1. Obtain funding for State Training Support program	Training staff	Feb. 1981	N	a. Acquire STSP grant application kit b. Complete and submit proposal to NIDA	1) AST	1) STATE
2. Obtain funding for NIAAA State Manpower Development program	Training staff	Feb. 1981	N	a. Acquire NIAAA SMDP grant application kit b. Complete and submit proposal to NIAAA	1) AST	1) STATE
3. Continue development of pool of local trainers qualified to instruct in NDAC/NIDA courses	Training and Prevention Supervisor	On-going	C	a. Train 5 instructors annually in 3 separate NDAC/NIDA TOT courses b. Each instructor will provide two training events annually.	1) AST 2) $15,000	1) STATE 2) STSP/SPC and STATE
4. Train the 19 village commissioners and parish priests in basic counseling skills	Training staff	By Dec. 1983	N	a. Train 2 instructors in Short-Term Client Systems NDAC/NIDA course b. Pilot STCS course with 10 clergy and commissioners c. Modify and revise course as indicated d. Provide two STCS training events to the 19 commissioners and 19 parish priests	1) AST 2) $5,000	1) STATE 2) STSP/SPC and STATE
5. Assess the training needs of direct service providers in all the human services agencies annually	Training staff	On-going	C	a. Create committee composed of staff development officers of all key social service agencies b. Develop needs assessment instrument with committee c. Conduct assessment via committee members d. Identify training priorities and strategies from assessment e. Provide training as appropriate	1) AST 2) $300	1) STATE 2) STATE

OBJECTIVES/ACTION STRATEGY — TRAINING

OBJECTIVE	MANPOWER	TIME FRAME		METHODS/PROCEDURES - ACTION STRATEGY	ANNUAL COSTS	SOURCES OF FUNDING
6. Arrange for UOG credits to be given for MHSAA sponsored training	Training and Prevention Supervisor	By Oct. 1981	N	a. Meet with UOG extension services b. Determine criteria to be met and arrangements necessary c. Arrange crediting for each training event as indicated.	1) AST	1) STATE-PAF
7. Lay groundwork for credentialing of counselors involved in substance abuse counseling	Training staff	By Feb. 1981	U	a. Disseminate information on credentialing to all personnel involved b. Provide workshop on credentialing to clarify issues and receive feedback from counselors c. Designate an agency/group as the credentialing authority d. Create credentialing committee to study and develop credentialing system	1) AST 2) $5,000	1) STATE 2) STSP
8. Arrange for inclusion of a substance abuse prevention course in UOG Social work curriculum	Training staff	1982	N	a. Meet with UOG personnel b. Provide training to appropriate personnel c. Provide assistance as indicated	1) AST 2) $3,000	1) STATE 2) STATE

E. Summary of Financial Support - The largest source of funds for the operation of MHSAA is still from the State Appropriation derived from taxes and appropriated annually by the Guam Legislature.

The second largest source of funds is the State Formula Funds for Drug (409-NIDA) and Alcohol Abuse Prevention. These funds are awarded annually by HEW through NIDA and NIAAA offices and carry a three year grant period.

The Statewide Services Grant which provides partial funding for methadone treatment is an annual grant award which the MHSAA receives upon submission of grant award application.

The MHSAA also submits applications for discretionary grants as proposals are received from the granting agencies and for which MHSAA is eligible to apply. Presently, we have a grant award of $24,436 under the State Drug Abuse Prevention Coordination Grant Program and an application for FY 1981 was submitted on July 15, 1980 for $25,651.00.

No collection and deposit mechanism has been established for third party payment or additional sources of income since local laws and procedures governing disposition of revenue generated income do not encourage positive activities geared toward subsidizing the State Appropriation and Federal funds received year after year.

Because of the uncertainty of the budget process and the inability of MHSAA to produce revenue generated income, programs are basically implemented on an annual basis as funds are available and can conceivably be discontinued as funds are exhausted or are not reappropriated for the existing programs.

Presently, the State Budget Appropriation for MHSAA which went from $425,969 in FY 1979 to $336,782 in FY 1980 and took a further dip to an established budget ceiling of $312,636 for FY 1981 does not present an optimistic condition for program expansion. The maintenance budget ceiling of #312,636 for FY 1981 is sufficient to continue the Agency's planning, coordinating and evaluation effort, but only to the extent of existing programs.

Federal funds, in particular the formula funds, are being used to supplement and increase the level of funds available for drug and alcohol services and activities.

If at any fiscal year, the State Appropriation gets below $300,000 the Agency shall be forced to merge with another agency in order to exist functionally or face a sudden economic death. At this point, the efficiency of planning, monitoring and evaluation would have to be compromised with the paradox approach of "consolidation of effort". Thus efficiency would still be jeopardized in as much as the staff's planning, monitoring and evaluation efforts would be overtaxed and would produce only less than satisfactory results.

Form I

Item I.	FY 1980		
A.	State Revenue funds:		$ 336,872
B.	Federal Funds received (actual)		
	1) Statewide Services Grant (410-NIDA)	$ 35,350	
	2) State Drug Abuse Prevention Coordinator Demonstration Program	$ 24,436	59,786
C.	Federal Funds anticipated (estimate)		
	1) Drug Abuse Prevention Formula Grant (409-NIDA)	$212,856	
	2) Alcohol Formula Grant	$ 32,271	245,127
Federal Funds:	All sources Sub-total		304,913
	Total		$641,695

NOTE:
1. The approved FY 1980 budget per P.L. 15-66 appropriated $507,372 of which $336,782 derived from State revenue funds and $170,590 represented the federal portion of the budget which was reported as an estimate in the Agency's total budget submission.
2. The estimate amount of $245,127 for the Drug Abuse Prevention Formula Grant and the Alcohol Abuse Formula Grant was received from NASADAD and appeared at this time to be a reliable estimate. The proposed budget cut as recommended by President Carter may produce a reduction of 6% and 10% for the Alcohol and Drug Formula Grant respectively.

Item 2.

A. State Revenue funds:		$ 312,636
B. Federal Funds: All sources (estimate)		
1) Statewide Services Grant (410-NIDA)	$ 32,825	
2) Drug Abuse Prevention Formula Grant (409-NIDA)	191,673	
3) Alcohol Abuse Formula Grant	29,546	254,044
Total		$ 566,680

PART V: GENERAL CONSIDERATIONS

A. Accounting Procedures - As an added information we do maintain separate accounts for all federal grant awards based on the grant award period. All records are available for audit and are being kept at Division of Account, Department of Administration. This is described on page 90 .

Presently we have no funds available to be awarded to other public or private non-profit agencies and we do not foresee the Agency awarding funds in the immediate future. If however the time comes where the Agency is in a position to award funds, item (1) through (4) of the ADAMHA Guidelines, page 29-30 will be incorporated in one (1) Agency's policies and procedures.

B. Reports and Records - All reports are submitted as requested on forms provided in a timely manner. Records of Advisory Council meetings as well as fiscal and other official records of the Mental Health and Substance Abuse Agency are maintained and access afforded to authorized federal authorities.

GOVERNMENT OF GUAM
AGANA, GUAM 96910

FINANCIAL MANAGEMENT SYSTEM

DEPARTMENT OF ADMINISTRATION

FMS - MANUAL

FORWARD

This publication is issued for information, guidelines and compliance of all personnel administering or accounting for Financial Resource in the Annual Operating Budget, Continuing Appropriation, Federal Grant-in-Aids, General Funds, Special and Trust and Agency Funds and Revenue Accounts.

The System is an integrated system, fully automated, handling a financial transaction once and automatically updating their respective accounts and files. This is a Uniform Budget and Accounting Information System (BACIS) which affects all departments and agencies whose accounts are accounted for and maintained by the Department of Administration. Accordingly, all are enjoined to comply to the Procedures and Accounting Methods Outlined in the Financial Management System Manual.

The System is effective 1 October 1979, commencement of Fiscal Year 1980. For further information or clarification, please call the Accounting Division on 472-6230/6240/6508. Each department and agency is assigned a Section Leader who maintains the accounting records and are to provide continuing assistance to their assigned departments and agencies. We encourage the department and agency Directors to avail themselves to this additional service.

FRANK G. BLAZ
Director of Administration

SUBJECT TITLE: INTRODUCTION

The Financial Management System Manual documents the fiscal policies, accounting principles, internal controls, operating procedures and reporting requirements comprising the Financial Management System of the Government of Guam. This system is designed to:

1. Establish adequate financial control to ensure compliance with statutory requirements;
2. provide organizational units of the Government with accurate and timely financial information for effective management of the financial affairs under their jurisdiction;
3. control the detail financial records maintained in approved departmental sub-systems; and
4. integrate data requirements of the many governmental functions into a single comprehensive system.

The Financial Management System manual is intended to be a working guide for all levels of personnel to use in accomplishing their financial responsibilities. The manual will be of particular value in assuring continuity of operations in the event of personnel turnover, as well as aiding in the training of new employees. This manual encompasses the entire central government accounting operation through the inclusion of many separate, but integrated procedures. The employees assigned the responsibility for performing their tasks should be the most qualified to recommend changes and improvements in data processing methods; consequently, it is anticipated that they will propose additions

and revisions to this manual.

Manual Format to facilitate their, the employees and other users of the manual, participation in the maintenance of the manual, it is important that the structure of the manual be thoroughly understood. Also familiarity with the contents of each section encourages those concerned to use the manual to its maximum potential. The manual consists of twenty-two (22) major sections & four (4) appendixes in addition to the bale of contents:

Each section begins with an introductory paragraph explaining the contents and, ordinarily, presents the more general information before progressing to specific and detailed procedures. Supporting exhibits and attachments are provided, when necessary and where applicable, and follow the narrative of the section. Sections are numbered with Roman numerals and alphabets. The page numbers commence on the first page of each section and reflect both the section and page number of the section, respectively. Exhibits accompanying the procedures are identified by the section number and a numeric code identifying the exhibit. For example:

(a) Page "A-10" would be the tenth page of Section A.
(b) Exhibit "A-1" would be the first exhibit of Section A.

A page number is also assigned the exhibit according to its page location within the section.

Manual Maintenance - The Systems and Standards Office, Division of Accounts, Department of Administration is the organization responsible for coordinating, reviewing and distributing all revisions to the Financial Management System Manual.

All requests for changes will be directed to this organization. Upon receipt of change request, a schedule for review will be made and concerned organization's supervisor will be notified of the date and time when review is to be made, and what related date and information will be required to adequately perform the review on the change request. The review findings and recommendations will be fully documented for review and approval by the Director of Administration. Budgeting changes are identified and addressed in the review. The requestor will be notified if and when the requested changes have been approved or disapproved and the effective date of approved changes.

Copies of the manual will be maintained in loose-leaf form to facilitate the insertion and removal of pages. All new and revised pages will be numbered to properly conform with the remainder of the manual. Revision and additions are to be incorporated into the manual immediately upon receipt and superseded pages removed and destroyed.

All revisions will be sequentially numbered beginning with "1" and will be distributed under a letter of transmittal (see

Exhibit I"1). Introduction for making the manual changes is outline on the transmittal form Exhibit I"1.

STATE APPROPRIATIONS AND FINANCIAL SUMMARY
(Completion of this form is mandatory)

ANNUAL PERFORMANCE REPORT
EXPENDITURE SUMMARY FOR YEAR COMPLETED 1980

STATE REVENUE FUNDS	$ 336,782
FEDERAL FUNDS: ALL SOURCES	$ 304,913

ANNUAL UPDATE OF STATE PLAN
EXPENDITURE SUMMARY FOR PROGRAM YEAR 1981

STATE REVENUE FUNDS	$ 312,636
FEDERAL FUNDS: ALL SOURCES	$ 254,044

STATE APPROPRIATION REPORT
FOR PROGRAM YEAR 1981

NAME OF CONTRIBUTING AGENCY (Enter name of each Dept. in blank space)	SINGLE STATE AUTHORITY	DOE _____	CMHC _____	DPS _____	_____	_____	
TOTAL FUNDS ALLOCATED FOR DRUG ABUSE	312,636	19,205	80,000	310,000			

TOTAL STATE DRUG ABUSE APPROPRIATION: $ 721,841
STATE Guam

C E R T I F I C A T I O N

C. Assurances

LEGISLATIVE APPROPRIATION for

A. Mental Health and Substance Abuse Agency

B. Community Mental Health Center

C. Department of Education

D. Department of Public Safety

cannot be certified at this time since the Budget Act for Fiscal Year 1981 has not been passed. Upon passage of the Budget Act for Fiscal Year 1981 certification of Legislative Appropriation will be completed and forwarded in the form of an "Addendum" to the State Plan submitted. Additionally, a revised State Appropriation and Financial Summary will be forwarded.

C

ASSURANCES

1. All services provided under the Plan will be made available without discrimination on account of race, color, national origin, sex, creed, duration of residence, or ability or inability to pay for such services.

2. Drug and alcohol abusers and alcoholics who are suffering from medical conditions shall not be discriminated against in admission or treatment solely because of their drug or alcohol abuse or alcoholism by any private or public general hospital or outpatient facility which receives support in any form from federal funds available to the State for services provided under the Plan.

3. All services provided under the Plan shall be publicized as to be generally known to the population to be served and shall be so located as to be readily accessible, available and responsive to the needs of the population to be served.

4. The Mental Health and Substance Abuse Agency has developed and will maintain, to the extent feasible, a current and complete inventory of all public and private resources available in the State, including but not limited to programs funded under State laws, occupational programs, voluntary organizations, education programs, military and Veteran's Administration resources, and available public and private third party payment plans.

5. The Mental Health and Substance Abuse Agency will coordinate its planning efforts with other State planning agencies.

6. Federal funds received for services under the Plan will be used to supplement State and other non-federal funds, but will not be used to supplant such funds.

7. Equal Employment Opportunity is assured by the State Merit System. Discrimination in any aspect of personnel administration because of political or religious opinions or affiliations, or discrimination because of age, sex, race, national origin or physical disability will be prohibited except where age, sex or physical requirements constitutes a bona fide occupational qualification. All personnel employed by the Mental Health and Substance Abuse Agency who have authority for supervising the development and administration of the State Plan, must and do conform to the rules

and regulations of the Government of Guam Merit System. In addition, the Mental Health and Substance Abuse Agency has developed a tailored Affirmative Action Plan and will take positive action to implement that plan and take any action consistent with merit to assure equal employment opportunity.

8. The Mental Health and Substance Abuse Agency established policies and procedures to ensure that treatment or rehabilitation projects or programs supported by formula grant funds will provide to the the Agency a proposed program performance standard, or standards to measure, or research protocol to determine, the effectiveness of such treatment or rehabilitation programs or projects.

9. State certification, accreditation and licensure requirements applicable to alcohol abuse and alcoholism treatment facilities and personnel take into account the special nature of such programs and personnel, including the need to acknowledge previous experience when assessing the adequacy of treatment personnel.

10. The Mental Health and Substance Abuse Agency has assessed the need for prevention and treatment of alcohol abuse and alcoholism by women, by individuals under the age of eighteen and by the elderly; prevention and treatment programs within the State will be designed to meet such need.

11. In addition, all requirements as presented and/or referenced in the "ADAMHA COMBINED STATE PLAN GUIDELINES" of the Office of Program Coordination, July 1978 presented in Part V, Section C, are followed by the Mental Health and Substance Abuse Agency including the following areas of compliance: 1. Nondiscrimination, 2. Accessibility, 3. Maintenance of Effort, the Administrative Requirements, 4. Merit System Personnel, 5. Performance Standards, 6. Specific Needs, 7. Review and Approval issues and 8. Funds for Administration.

I do hereby certify that these assurances are made in good faith and will be maintained by the Mental Health and Substance Abuse Agency as a condition of continuing funding.

Peter A. San Nicolas

PETER A. SAN NICOLAS, Administrator
Mental Health and Substance Abuse Agency
Government of Guam

7-14-80
Date

FORM APPROVED
OMB NO. 68-R1222

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

STATE PLANS:
Under Section 505 of the Social Security Act, as amended
Under Section 1615 of the Social Security Act, as amended
Under Section 303 of the Comprehensive Alcohol Abuse and Alcholism Prevention, Treatment, and Rehabilitation Act, as amended
Under Section 409 of the Drug Abuse Office and Treatment Act, as amended
Under Section 237 of the Community Mental Health Centers Act, as amended
Under Section 1603 of the Public Health Service Act, as amended

APPLICATION FOR FUNDS:
Under Section 314(d) of the Public Health Service Act, as amended

CERTIFICATION

1. I hereby certify that Mental Health and Substance Abuse Agency (State Agency) of the State of Guam has been designated to administer or supervise the administration of, (check each applicable item) the:

- ☐ State Plan for Maternal and Child Health and Crippled Children's Services (strike out one if administered separately) under Section 505, Social Security Act, as amended. Regulations: 42 CFR Part 51a, Subpart A.
- ☐ State Plan for the SSI Disabled Children's Program under Section 1615(b), Social Security Act, as amended. Regulations: 42 CRF Part 51a, Subpart C.
- ☒ State Plan for Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Services under Section 303(a), Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, as amended. Regulations: 42 CFR Part 54a, Subpart B.
- ☒ State Plan for Drug Abuse Prevention under Section 409, Drug Abuse Office and Treatment Act, as amended. Regulations: 42 CFR Part 54b, Subpart B.
- ☐ Funds made available for Public Health Services under Section 314(d), Public Health Service Act, as amended. Regulations: 42 CFR Part 51, Subpart B.
- ☐ Funds made available for Hypertension Programs under Section 314(d), Public Health Service Act, as amended. Regulations: 42 CFR Part 51, Subpart B.
- ☐ Funds made available for Mental Health Services under Section 314(d), Public Health Service Act, as amended. Regulations: 42 CFR Part 51, Subpart B.
- ☐ State Plan for Community Mental Health Services and Facilities under Section 237, Community Mental Health Centers Act, as amended. Regulations:
- ☐ State Plan for Medical Facilities Assistance under Section 1603, Public Health Service Act, as amended. Regulations:

2. I further certify that each State Plan or application for funds (identified above) consists of the following mat rials which, in form and content, are those which are or will be utilized for the conduct of State health programs under the State Plan or application, and all of which are hereby incorporated by reference and made a part of such State Plan or application:

   (a) Those pertinent State laws, codes, regulations, administrative rules, surveys of need, published standards and criteria, and planning, organizational, information, reporting, and evaluating manuals and documents, contracts and interagency agreements which have been identified by authorized representatives of the Secretary and which they have stated, in writing, are acceptable as part of the State Plan or application, in accordance with the applicable Federal regulations. All documents so identified and the written statements of acceptance are on file in the office of the (State Agency)

   (b) The annual budget, which represents the best current estimate of financial resources available to support activities by each State Plan or application indicated above.

3. I further certify that all State Plans and applications covered by Section 1524(c)(6) of the Public Health Service Act, as amended, have been made available to the Statewide Health Coordinating Council (SHCC), in such detail as the SHCC may require, and have been approved by the SHCC in accordance with such Section 1524(c)(6).

4. I further certify that I am authorized to submit each such Certification and Budget on behalf of the above listed agency and to submit statement of needs, objectives, and resources, performance reports, and expenditure reports as may be required from time to time pursuant to the applicable regulations and policies and in accepting the responsibility for such program do hereby give each of the assurances required by the applicable Federal regulations.

Joseph F. Ada
JOSEPH F. ADA (Signature)

7/14/80 (Date)

ACTING GOVERNOR OF GUAM (Title)

PHS-5153-1
(REV. 2-78)

FORM APPROVED
OMB NO. 68-R1222

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE

STATE HEALTH PLAN OR APPLICATION BUDGET

STATE Guam
FISCAL YEAR 1981
AGENCY Mental Health and Substance Abuse Agency
X INITIAL
REVISION NO.

FUND SOURCE	SEC 303 of ALCOHOL	SEC 409 DRUG	SEC 237 FACILITIES	SEC 1603 FACILITIES
	G	H	I	J
1. STATE PUBLIC	60,000	29,546	1	1
2. LOCAL PUBLIC				
3. PRIVATE NON-PROFIT				
4. SUB-TOTALS				
5. FEDERAL FUNDS A		191,048		
FINANCIAL ASSISTANCE FUNDS B	40,653	114,663[2]		
DIRECT ASSISTANCE				
6. PREVIOUS FISCAL YEAR (1) CARRYOVER				
7. TOTALS				
8. LESS ESTIMATED EMPLOYEE EFFORT				
9. TRANSFERENCE EFFORT				
10. AMOUNT OF MATCHING PROPOSED BY STATE				
11. DIRECT COMMUNITY SERVICES				
12. TOTAL HEALTH FUNDS BUDGETED				

FUNDS BUDGETED TO OTHER AGENCIES

PURPOSE	STATE PUBLIC AGENCIES	LOCAL PUBLIC AGENCIES	NON-PROFIT
PUBLIC HEALTH			
MENTAL HEALTH			
REMARKS			

PROGRAM DIRECTOR (Name and Title)
PETER A. SAN NICOLAS, Administrator
AGENCY HEAD (Signature) Peter A. San Nicolas DATE 7-14-80
TITLE

OFFICE OF GOVERNOR
JOSEPH F. ADA Joseph F. Ada DATE 7/14/80
TITLE
ACTING GOVERNOR OF GUAM

9-30-80.

[1]Estimated formula grant award.
[2]FY 1980 ends Sept. 30, 1980 - figure is an estimate of expended amount by

PHS-5153-2
(REV. 2-78)

GOVERNMENT OF GUAM
OFFICE OF THE GOVERNOR
AGANA, GUAM

EXECUTIVE ORDER NO. 78-3

REDESIGNATION OF THE GUAM MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY

WHEREAS, the infusion of federal and local resources for the support of mental health and substance abuse care services on Guam has not appreciably changed the mental health and substance abuse status of the people of the Territory and such resources are limited; and

WHEREAS, there is no regulatory authority to oversee and coordinate all operations and services relative to mental health and substance abuse program delivery systems; and

WHEREAS, the need for a single state agency of mental health and substance abuse is recognized by Congress and the President of the United States and emphatically stipulated in the Public Health Services Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Acts, are Title XX of Social Security Act; and

WHEREAS, Public Laws 94-63 and 91-616, as amended, authorize the establishing of a State Mental Health and Substance Abuse Agency to perform comprehensive planning, implementation, monitoring, and other regulatory functions and activities relative to mental health and substance abuse; and

WHEREAS, the effective implementation of Mental Health and Substance Abuse plans and projects must gain the support of the community; and

WHEREAS, decisions relative to the allocation of Mental Health and Substance Abuse resources on the island must be arrived at as objectively as possible and further, decisions relative to the planning, implementation and regulation of Mental Health and Substance Abuse resources and services

must also be made in the most forthright and objective manner; and

WHEREAS, the plans, recommendations and decisions made by the State Mental Health and Substance Abuse Agency involve large amounts of federal and local funds; and

WHEREAS, the effective implementation and regulation of Mental Health and Substance Abuse resources is the responsibility of the Executive Branch of the Government of Guam;

NOW, THEREFORE, I, RICARDO J. BORDALLO, Governor of Guam, by virtue of the authority vested in me by the Organic Act of Guam, as amended, do hereby order as follows:

1. Executive Orders 70-37, 71-7, and 73-12 are hereby repealed.

2. The Guam Mental Health and Substance Abuse Agency is hereby established as an Agency of the Executive Branch of the Government of Guam. This Agency shall be operated in accordance with applicable territorial statutes, policies, regulations, and procedures.

3. The Agency shall be administered by an Administrator who shall be appointed by the Governor. The annual salary of the Administrator position shall be Twenty Seven Thousand Dollars ($27,000).

4. The Administrator shall submit annually a plan to the Governor indicating which positions shall be unclassified and which shall be classified. The salary levels of the unclassified positions shall require the approval of the Governor. The approved unclassifed positions shall be filled by appointment of the Administrator. The employment of personnel in the classified positions shall be executed within the regular hiring procedures of the Government of Guam.

Agency Purpose:

For the purpose of improving the Mental Health of the residents of Guam;

increasing the accessibility, acceptability, continuity, and quality of Mental Health and Substance Abuse services for the residents, restraining increases in the cost of providing residents' Mental Health and Substance Abuse services, and preventing the unnecessary duplication of Mental Health and Substance Abuse resources, the Agency shall have as its primary responsibility, the provision of effective Mental Health and Substance Abuse planning for the island, and the promotion of the development within the area of Mental Health and Substance Abuse services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the Guam Mental Health and Substance Abuse Five-Year Plan. To meet its primary responsibility, the Agency shall carry out the following functions:

a. The Authority is authorized to undertake special projects within its administration, one of which shall be the Guam Treatment Alternatives to Street Crime (TASC), a program designed to serve as a referral agency through which drug dependent offenders may be diverted from the criminal justice system into treatment and rehabilitation programs.

b. The Agency shall assemble and analyze data concerning:

(1) the status (and its determinents) of the Mental Health of the residents of Guam;

(2) the status of the Mental Health and Substance Abuse care delivery system in Guam and the use of that system by the island's residents;

(3) the effect the island's Mental Health and Substance Abuse care delivery system has on the mental health of the residents of Guam;

(4) the number, type, and location of the island's Mental Health and Substance Abuse resources, including Mental Health and Substance Abuse services, manpower and facilities,

(5) the patterns of utilization of the island's Mental Health and Substance Abuse resources, and

(6) the environmental and occupational exposure factors affecting immediate and long-term conditions.

c. Establish, annually review, and amend as necessary the Guam Mental Health and Substance Abuse Five-Year Plan which shall be a detailed statement of goals.

(1) Describing a mentally healthful environment and Mental Health and Substance Abuse systems on the island which when developed will assure that quality Mental Health and Substance Abuse services will be available and accessible in a manner which assures continuity of care at a reasonable cost for all the residents of Guam;

(2) which are responsive to the unique needs and resources of the area; and

(3) which take into account and are consistent where applicable with the national guidelines for Mental Health and Substance Abuse planning policies issued by the Secretary of the Department of Health, Education and Welfare.

d. The Agency shall annually review, and amend as necessary an Annual update to the Five-Year Plan which describes objectives which will achieve the goals of the Guam Mental Health and Substance Abuse Five-Year Plan and priorities among the objectives.

e. The Agency shall develop and publish specific plans and projects for achieving the objectives established in the Annual update to the Five-Year Plan.

f. The Guam Mental Health and Substance Abuse Agency shall implement the Guam Mental Health and Substance Abuse Five-Year Plan and Annual update to the Five-Year Plan which when submitted through the State Health Planning and Development Agency to the Secretary of HEW, shall be the health policy documents of the Government of Guam. In implementing such plans, the Agency shall perform at least the following functions:

(1) the Agency shall seek, to the extent practicable, to implement its Mental Health and Substance Abuse Five-Year Plan and Annual update to the Five-Year Plan with the assistance of individuals and public and private entities on the island;

(2) the Agency may provide, in accordance with the priorities established in the Annual update to the Five-Year Plan technical assistance to individuals and public and private entities for the development of projects and programs which the Agency determines are necessary to achieve the Mental Health and Substance Abuse systems described in the Guam Mental Health and Substance Abuse Five-Year Plan.

(3) the Agency shall, in accordance with the priorities established in the Annual update to the Five-Year Plan, make grants to public and non-profit private entities and enter into contracts, subject to the Governor's approval, with individuals and public and non-profit private entities to assist them in planning and developing projects and programs which the Agency determines are necessary for the achievement of the Mental Health and Substance Abuse systems described in the Guam Mental Health and Substance Abuse Five-Year Plan. Such grants shall be made from funds received under Public Laws 91-616, 92-255, 94-63, and other Public Laws that may become applicable.

g. The Agency shall coordinate its activities with all appropriate governmental and private agencies and for this purpose shall enter into written coordination agreements, the content of which will depend upon the nature and extent of coordination. The Agency shall seek to enter into agreements with the following:

(1) the Guam Medical Society (relative to its relationship with a Professeional standards Review Organization),

(2) the Guam Memorial Health Plan,

(3) the Family Health Program,

(4) the Health Maintenance Life Program,

(5) Health Insurance Providers,

(6) the Social Security Administration; and any other private group or agency which the Agency determines appropriate.

h. The Agency shall review and approve or disapprove each proposed use on Guam of federal funds for Mental Health and Substance Abuse Services

(1) appropriated under the Public Health Services Act, or

(2) the Community Mental Health Center; or

(3) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act; and the Comprehensive Drug Abuse Prevention, Treatment and Rehabilitation Act for grants, contracts, loans or loan guarantees for the development expansion, or support of Mental Health and Substance Abuse resources; or funds made available by the Government of Guam for support of any of the above, subject to review and approval per Executive Order 77-20 and P.L. 93-641.

5. The Agency shall be advised by the Guam Mental Health and Substance Abuse Advisory Council. The Governor shall appoint two members to serve for a period of one year and three for two years. The Council shall be composed of one representative from the Medical Society, one representative from the Bar Association, one from a private organization dealing with mental health and drug abuse, one from an employers council, and one from the general public. The Chairperson shall be elected by majority vote of the membership and shall serve in that capacity for two years each term. The Council shall advise the Agency generally in the performance of its functions. This advisory capacity shall include but not be limited to:

a. review of the Guam Mental Health and Substance Abuse Five-Year Plan;

b. review and comment on the annual update to the Five-Year Plan based upon its consistency with the Guam Mental Health and Substance Abuse Five-Year Plan;

c. review and comment on applications made for grants from the Guam Mental Health Service Development Fund;

d. review annually and comment on any State Plan any application and any revision of a State Plan or application developed as a condition for receipt of any funds under allotments to States described in Section 4 of this Executive Order;

e. review and comment on the Annual Work Program of the Agency, its Annual Grant Applications, and Policies and Procedures.

6. The Department of Administration shall provide administrative support for the Agency's accounting and purchasing requirements.

7. The Agency shall have cabinet ranking and shall have all the authority, privileges, and responsibilities in the administration of its duties.

8. The Agency shall perform its functions in accordance with federal Public Laws 91-616, 92-255, 94-63 and 93-641 and any amendments thereto, and all applicable laws, rules, regulations, policies of the territory and Executive Order 77-20.

9. The current 100% federal funds, supplies, equipment, and records being used by the Guam Memorial Hospital Authority for support of the Guam Mental Health and Substance Abuse Agency shall be transferred to the Agency upon the signing of this Order.

10. The Administrator, upon appointment by the Governor, shall be responsible for the transfer of all other funds, supplies, equipment and records, and for the recruitment of needed personnel.

This Order shall take effect upon the date of my signature.

Signed at Agana, Guam, this 18th day of February, 1978.

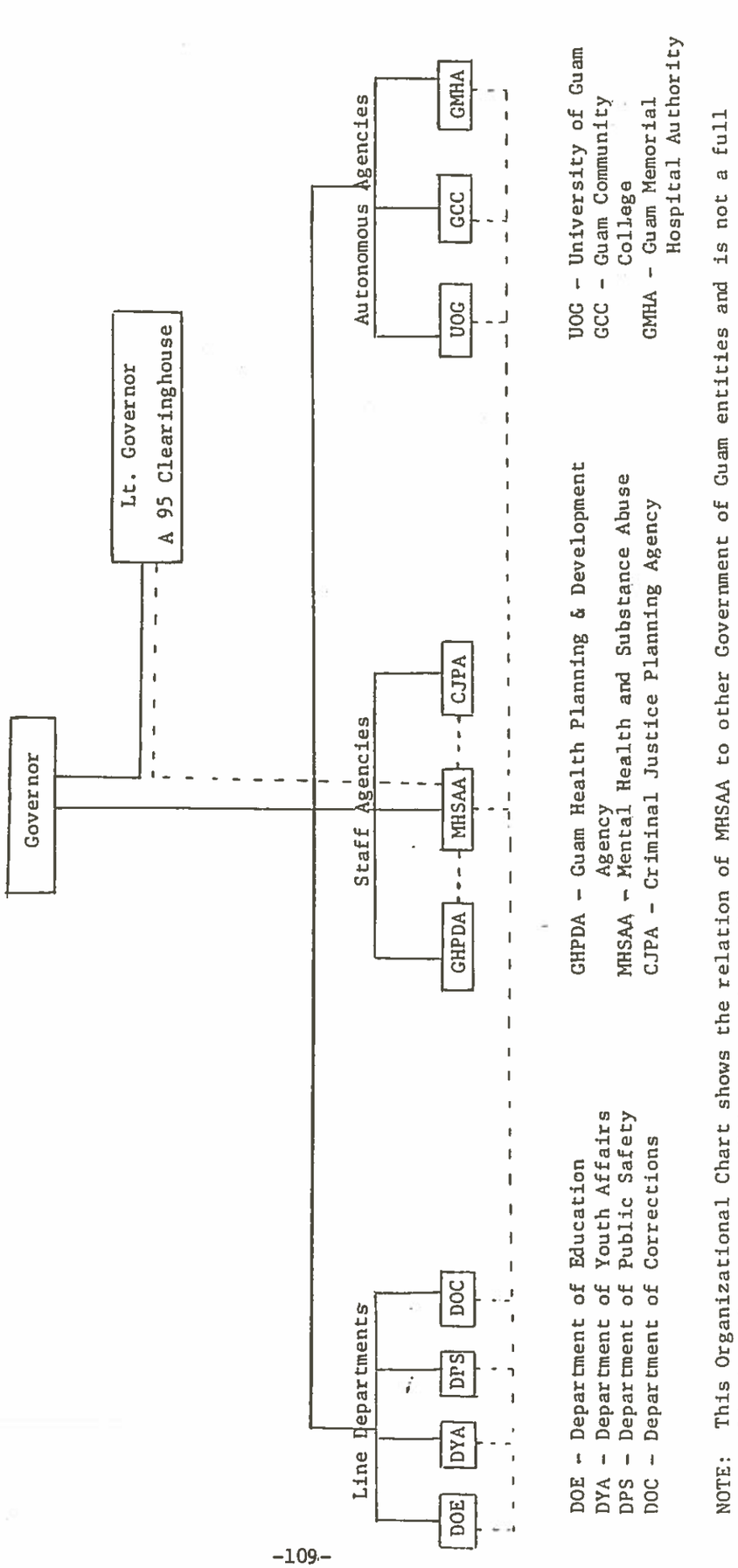
RICARDO J. BORDALLO
Governor of Guam

COUNTERSIGNED:

RUDOLPH G. SABLAN
Lieutenant Governor

APPENDIX A-ITEM 2

GOVERNMENT OF GUAM ORGANIZATIONAL CHART



NOTE: This Organizational Chart shows the relation of MHSAA to other Government of Guam entities and is not a full listing of Government of Guam agencies and departments.

APPENDIX A-ITEM 3

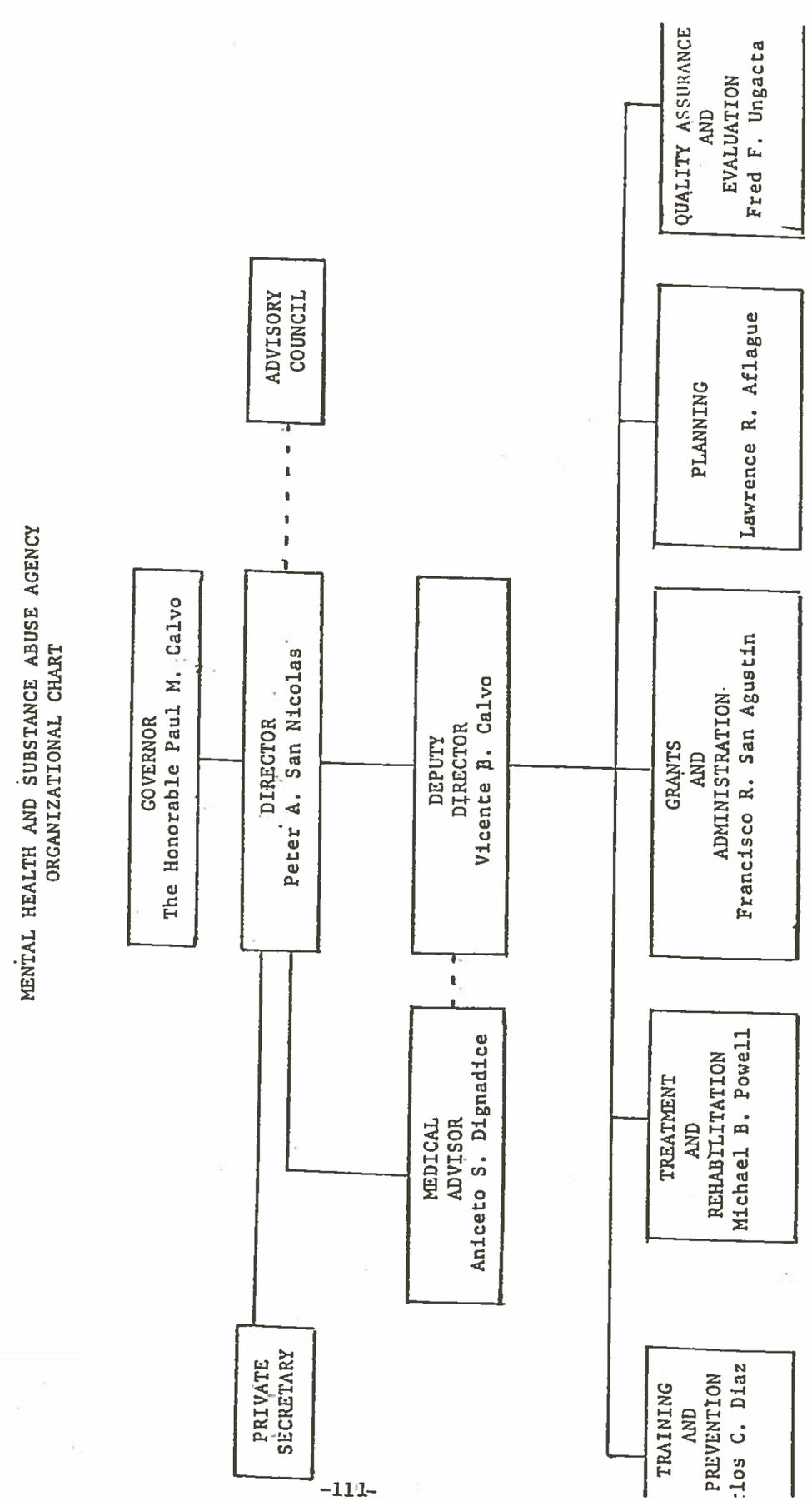
Mental Health and Substance Abuse Agency
Advisory Council Members
1981

NAME	TITLE	DATE OF APPT.	*
Claudia Conroy	Chairperson	Nov. 6, 1980	C
Vince Pereda	Vice-Chairperson	Nov. 6, 1980	P
Peter Carlos	Member	Nov. 6, 1980	C
Eduardo R. Chanco	Member	Nov. 6, 1980	C
Antonio M. Eustaquio	Member	Nov. 6, 1980	P
Lourdes Flores	Member	Nov. 6, 1980	C
Jackie Fields	Member	Nov. 6, 1980	P
Juan E. Garcia	Member	Nov. 6, 1980	C
Phyllis Luminelli	Member	Nov. 6, 1980	P
Mary Medina	Member	Nov. 6, 1980	P
Gregorio Calvo, Jr.	Member	Nov. 6, 1980	C
Jose Pangelinan	Member	Nov. 6, 1980	C
Lynn San Nicolas	Member	Nov. 6, 1980	C

* C = Consumer
P = Provider
NOTE: All members now serve for one year term. Pending legislation would establish staggered two year terms.

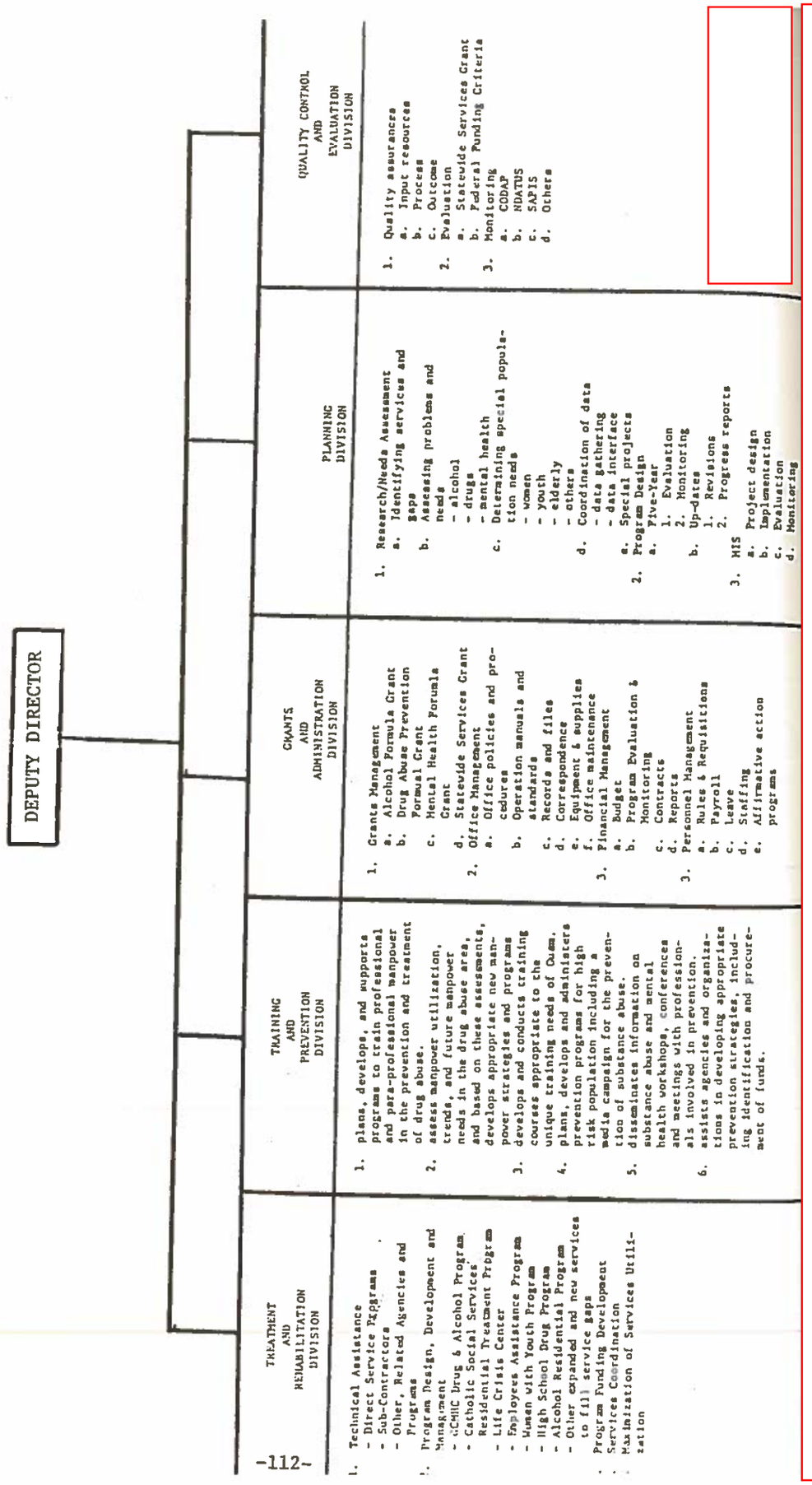
APPENDIX A-ITEM 4

MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY
ORGANIZATIONAL CHART



MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY APPENDIX A-ITEM 5

DIVISION FUNCTIONAL CHART



APPENDIX A-ITEM 6

MENTAL HEALTH AND SUBSTANCE ABUSE ADVISORY COUNCIL
1980

Meeting Dates within the past year

Sept. 20, 1979 at 6:00 PM at the MHSAA Conference Room
Oct. 18, 1979 at 6:00 PM at the MHSAA Conference Room
Nov. 21, 1979 at 6:00 PM at the MHSAA Conference Room
Dec. 20, 1979 at 6:00 PM at the MHSAA Conference Room
Feb. 5, 1980 at 6:00 PM at the MHSAA Conference Room
Mar. 26, 1980 at 12:00 Noon at Joe & Flo's Restaurant
May 29, 1980 at 12:00 Noon at Joe & Flo's Restaurant

Officers

Anthony Santos, Chairperson
Claudia Conroy, Vice-Chairperson
Maria P. Yamashita, Secretary

Committees and their Members

Task Force	Review	Budget
Eduardo Chanco*	Claudia Conroy*	Jesus Herrera*
Jackie Fields	Joe San Nicolas	Ronald Taitague
Juan Garcia	Antonio Eustaquio	Peter Carlos
Vicente Untalan	D.Lewis Kanaiaupuni	Catalina Ferrante

*Committee Chairperson

Summary of Accomplishments

Adopted Council By-Laws

Approved Creation of Committees

Reviewed and Commented On - Application of Catholic Social Service for Women's Alcohol Program

MHSAA 1980 Substance Abuse Prevention State Plan Update

Community Mental Health Center Financial Distress Grant

Participated in the MHSAA 1980 Substance Abuse Prevention Workshop

The difference between the sexes

PACIFIC DAILY NEWS, Thursday, February 14, 1980

Uncommon conversations

By PHILIP NOBILE

Where does the battle of the sexes originate? Feminists argue that social conditioning explains why boys are boys and girls act like girls. It is true that society rewards men who lust after women and punishes women who play around.

Dr. Donald Symons, an anthropologist at the University of California at Santa Barbara, points to the evidence of evolutionary biology for the ultimate explanation.

Q. From the perspective of evolution, why are men and women so different sexually?

A. Our ancestors faced entirely different reproductive opportunities and constraints. For example, a woman is limited in the number of offspring she can produce in a lifetime. But a man is reproductively successful in direct proportion to the number of women he fertilizes.

As a result of these environmental differences, it is reasonable to suppose that brains and nervous systems of men and women evolved quite differently.

Q. Do you mean that male and female erotic centers are hooked up to different spots in the brain?

A. We don't know enough about the brain to say that. But I predict that anatomists will eventually discover that portions of male and female brains are as different as male and female genitals.

Q. So feminists are in error when they

troduced.

For example, if a bull is presented with a cow in estrus, he will copulate a number of times and then stop. He appears exhausted, but he's really not. As soon as a new female is presented, the bull starts all over again.

Q. From a few fellows of my acquaintance, I'd guess that the Coolidge Effect does affect man.

A. How humans would actually behave in a Coolidge Effect experiment is irrelevant. The fact is that we immediately appreciate the similarities between the human male and other mammals. For novelty is one of the major determinants of sexual attraction in man. This desire is always present in males

reality rather than fantasy, I predict that the women who said yes for curiosity's sake would find the encounter far less satisfying than sex with their husbands and would subsequently decline.

Q. Why are women incapable of diversity?

A. In fact, they are more capable. Any reasonably young and attractive woman can get far more sex than her male counterpart.

From the evolutionary perspective, women don't crave diversity because this desire was never adaptive for them.

Q. Doesn't the monogamous ideal of Judeo-Christian ethics completely overlook the kinds of sexual longings that evolution has

APPENDIX B-ITEM 1

o chop suey

PACIFIC DAILY NEWS, Friday, February 15, 1980

By BEN LIN
Special, Gannett News Service

ıe Chinese may say ıey to chop suey, but the ture is probably the best-vn Chinese restaurant in this country.

beginnings go back e 80 years when a Chinese esman by the name of Li g-chang visited the ed States. He not only ted a media stir but left a cy that may go on ver.

e Ch'ing dynasty viceroy ived royal treatment. e were all kinds of ban- ts and dedication monies in his honor, and in. Naturally they wanted to know what he was eating. On the spur of the moment he came up with two Chinese words that meant "assorted tidbits" — "chop suey."

The same vegetable mixture served over fried noodles is chow mein.

The connection between these dishes and Cantonese cooking is a historical one. Since the mid-1800s, thousands of southern Chinese (Cantonese) laborers had come to this country to work in the mines, or the farms and railroads. Subsequently some of them went into the restaurant business, partly to fill their own needs,

APPENDIX B-ITEM 1

this week in

islander

the conclusion of

Uncle Sam, Please Come Back to Guam

By PEDRO C. SANCHEZ

Emotional exhaustion hits at end of day

Working woman

By NIKI SCOTT

It's emotional exhaustion that gets us at the end of the day. It's not that we're too tired to run errands and cook dinner, it's just that sometimes we're too tired to think and talk and care.

It takes energy to listen to a child. You have to nod and smile and respond, even though you don't really care what the biology teacher said to the class cut-up.

It takes energy to answer questions without sounding annoyed. They are so important — the trust behind each one is so fragile — we know that. We are exhausted, nevertheless, and yearn for silence after work.

That's hard to explain to an exuberant 8-year-old, a serious 12-year-old, or a moody, sensitive adolescent. They need to touch base with us at the end of the day, need to re-establish their place in our lives,

not having to smile or talk," she laughed.

"I feel so drained when I come home from work. There are some nights when I can't find enough energy for anything, or anyone. It doesn't happen often, but when it does I really question whether I should be working..."

All parents (male and female) feel that way occasionally. But if you feel that way most of the time, you may want to examine options for avoiding some of the after-work horrors.

"The first is to believe absolutely that you have rights as a parent, and one of those rights is a brief period after work to relax," said family counselor Jonathan Steere.

PUBLIC NOTICE

The Mental Health and Substance Abuse Agency (MHSAA) is presently developing in Five Year Plan for Mental, Health, Drug, and Alcohol Services for the Territory of Guam.

The public is invited to present comments in writing to MHSAA, P.O. Box 20999, Guam 96921, or by attending a meeting to be held on Saturday, February 16, 1980, 9:00 a.m., at the MHSAA office, Ada Plaza, building 2, Agana.

PUBLIC HEARING

Notice is hereby given that a combined corridor/design public hearing will be held for the purpose of receiving testimony on the proposed Rota Airport Road project between Songsong Village and Rota International Airport and the Environmental Impact Assessment for the project. This public hearing will be held on the island of Rota, Songsong Village, Office of the Mayor, at 7:00 P.M., Friday, February 29, 1980. Maps, drawings and other pertinent information, as well as transcript of the Public Informational Meeting held in Songsong Village on December 11, 1979, are available at the following government agencies for your review:

Federal Highway Administration, Guam
Office of the Mayor, Rota
Governor's Representative, Rota
Public Works Officer, Rota
Office of the Director, Public Works, Saipan

Tentatively, design and right-of-way acquisition is scheduled for the latter part of 1980 with construction to begin about a year later. All those wishing to testify at the Public hearing will be asked to fill out a speaker information card. In order to give everyone wishing to testify an opportunity to do so, speakers will be limited to 5 minutes the first

U.S. businessmen aid town takeover

SYDNEY, Australia (AP) — Armed separatists, supported by a group of U.S. businessmen looking for a tax haven as well as by French plantation owners, are in control of Santo, the second largest town in the New Hebrides' island chain, government sources said today.

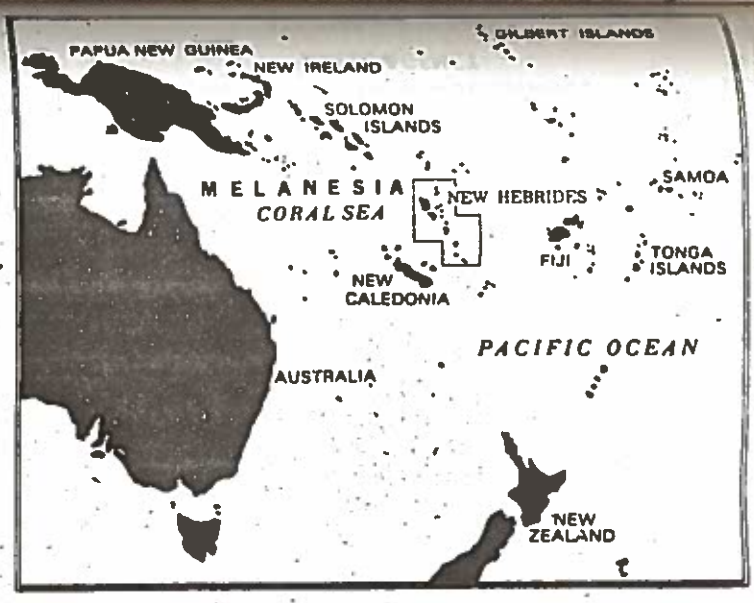
They said a policeman in Santo was wounded by an arrow, but that no Europeans were hurt or captured in the town of 5,000.

The sources also said the separatists kidnapped police and seized government offices in Tanna, the biggest town 300 miles southeast of Santo, but that police had retaken Tanna after an exchange of gunfire and freed all the hostages with no casualties reported.

The sources identified the American supporters of the insurrection as members of the Phoenix Foundation, which they described as a right-wing group headed by a Carson City, Nevada real estate developer who has supported Jimmy Stevens, the self-styled leader of the Santo breakaway group.

The Phoenix Foundation had tried previously without success to establish an independent country, free of taxes and government restrictions, in the Pacific and in the Bahamas, the sources said.

Independent confirmation of the sources' report on the Americans was not immediately available. The names of the developer and other Americans involved were not disclosed.



The chief minister ordered the airport closed to traffic to Santo after the separatists seized it, and by people who will not accept the lawful democratic government," Lini said.

Lini, who was elected chief minister last year, said the government had suspended

acknowledge the lawfully elected government."

Insurrection has been fermenting in the New Hebrides for several years, brought about by its unique

He said one of the two doctors who testified before the grand jury that indicted the 32-year-old Ms. Adams said she "might have" killed Fraser by turning down the oxygen on his respirator, but the judge pointed out the doctor said that was merely conjecture. Another doctor testified before the panel that the alleged tampering with the oxygen would not have a "significant" effect on Fraser over the short period of time.

Ms. Adams was in the crowded courtroom along with her attorneys, Gary Logan of Las Vegas and noted San Francisco lawyer Melvin Belli.

TEACHERS-THIS SUMMER GET A LITTLE WET AND WILD

Wet and Wild is a whole new concept in teacher's workshops. A week-long summer seminar that will give you the information, materials and methods to bring ecology into your classroom.

WET AND WILD TOPICS

- **Environmental Education (EE) - the state of the art**
- **How to Select and Develop EE Curricula**
- **Infusion of EE into Existing Programs**
- **Guam's Natural History, Geology and Wildlife**
- **Wildlife Conservation**
- **Endangered Species**
- **Soil Conservation**
- **Air Pollution**
- **Water Conservation and Pollution**
- **Pesticide Hazards**
- **People Overpopulation**
- **Wildfire Prevention**

PUBLIC NOTICE

The draft of the Five Year State Plan for Drug and Alcohol Abuse is available for public review at the Mental Health and Substance Abuse Agency, located at the Ada Plaza Building No. 2, second floor, Agana.

PETER A. SAN NICOLAS
Administrator

MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY

477-9704 or 477-9705

Kangaroos imported. by leaps and bounds?

WASHINGTON (UPI) — Americans may soon be able to buy pet kangaroos, and also shoes, belts and bags made from the hides of the marsupials.

The Interior Department Friday proposed lifting a five-year ban on commercial imports of kangaroos and kangaroo products into the United States for a two-year trial period.

Assistant Interior Secretary Robert Herbst said the proposed action is based on a review of recent information indicating there are 32 million kangaroos in Australia, a figure much higher than previously believed, and the Australian government has improved its management program of the animals.

If the ban is lifted following a 30-day public comment period, the department will continue to monitor the situation during the two-year period and may reimpose the ban at anytime if necessary.

Marian Newman of the Society for Animal Protective Legislation said the decision was "hypocritical" since President Carter campaigned for office with a pro-environment stance. She said the proposal could cause the animals to be "anihilated throughout their range."

16 Check it out

Powdered carpet cleaner works better

By DAVID LIEBER
Gannett News Service

Our man from Check It Out was heard crumbling a bit during the past week.

Something about how he became a newspaperman so he wouldn't have to perform any manual labor.

But there he was — on his hands and knees, scrubbing carpets and vaccuming — all in the noble pursuit for the answer to this week's question: Is the advertising claim made by the makers of "new Plush carpet drycleaner and conditioner" an accurate one?

It seems that every time a consumer product is in- that is sprinkled on your carpet with a sponge.

the Consumer Products Division of Airwick Industries, which makes New Plush, said the implication in the commercial should be very clear — "that Plush will clean better then any other carpet spot cleaner of a similar nature."

We purchased a 16-ounce can of Plush for $2.29 and also a 22-ounce bottle of "Woolite Self-Cleaning Rug Cleaner" for $2.05.

Woolite appears to be the closet product to Plush, so we thought the two would make for a fair match. But there are some differences in the two products.

Plush is a white powder

We tested the products on two different types of rugs.

First, we sampled a fluffy shag carpet with obvious dirt stains in its "heavy traffic areas." There was the portion by the front door where that first dirty footprint from outdoors hits the rug. This stain was divided in half with plastic wrap. Woolite was sprayed on one half and Plush was sprinkled on the other.

There also were two separate but equal spots, also by the front door. One spot received a dose of Plush; the other a dash of Woolite.

There was the big boo-boo by the kitchen door where the carpet, contrary to Plush's claim that it does the job "without wetness."

Plush recommends that for set-in stains "a heavier application of Plush may be necessary ... followed by rubbing in thoroughly with a damp, stiff brush." We carefully followed these directions and the result:

But we wanted to be absolutely certain about the superiority of New Plush. So late one night we traveled clear across town to the boss' house. The boss had said he had a dirty carpet that he wanted cleaned.

How do you say no to your boss? Besides we had a nor-

a little elbow grease never hurt anyone.

Check It Out is a weekly test of advertising claims. We welcome your ideas for future columns; if we use your idea, we'll send you a Check It Out T-shirt. Send ideas to Check It Out, P.O. Box 10,Fort Myers, Fla., 33902.

Foreign exchange

BUDGET HEARINGS FISCAL YEAR 1981 FOR THE

APPENDIX B-ITEM 3

May 2, 1980

Memorandum

To: Chairman, Guam Clearinghouse

From: Administrator, Mental Health and Substance Abuse Agency

Subject: NOI, Comprehensive Five-Year Plan for Mental Health, Alcohol and Drug Abuse for the Territory of Guam

Enclosed, please find the NOI for the Comprehensive Five-Year Plan for Mental Health, Alcohol and Drug Abuse for the Territory of Guam. The Plan will be submitted sometime near the end of May for your review.

Thank you.

PETER A. SAN NICOLAS

Enclosure

MPOWELL:mgl
5/2/80

cc: Chrono
File
Director's Chrono
Director's File
Mike P.

APPLICATION: [ ] [ ] [X] NOTIFICATION OF INTENT (SPA) [ ] REPORT OF FEDERAL ACTION

APPLICATION: 2. DATE 1980 5 2

3. DATE ASSIGNED 19

1. APPLICANT/RECIPIENT
: Mental Health & Substance Abuse Agency
: Planning Division
: Post Office Box 20999
: Guam Main Facility County : N/A
: Guam ZIP Code 96921
Name (Name : Larry Aflague
Telephone No.) : (671) 477-9704/5

3. FEDERAL EMPLOYER IDENTIFICATION NO.
19800189447-CI/T517

4. PROGRAM (From Federal Catalog)
a. NUMBER
b. TITLE Formula Grants
1. NIAAA 13.257 (PL 91-616)
2. NIDA 13.269 (PL 92-255)
3. NIMH 13.210 (PL 94-63)

5. TITLE AND DESCRIPTION OF APPLICANT'S PROJECT
Comprehensive Five-Year Plan for Mental Health, Alcohol and Drug Abuse for the Territory of Guam.
Combined plan per ADAMHA Guidelines

6. TYPE OF APPLICANT/RECIPIENT
A-State H-Community Action Agency
B-Interstate I-Higher Educational Institution
C-Intrastate J-Indian Tribe
District K-Other (Specify):
D-County
E-City
F-School District
G-Special Purpose District
Enter appropriate letter: A

9. TYPE OF ASSISTANCE
A-Basic Grant D-Insurance
B-Supplemental Grant E-Other
C-Loan
Enter appropriate letter(s): A

10. AREA OF PROJECT IMPACT (Names of cities, counties, States, etc.)
Territory of Guam

11. ESTIMATED NUMBER OF PERSONS BENEFITING
120,000

12. TYPE OF APPLICATION
A-New C-Revision E-Augmentation
B-Renewal D-Continuation
Enter appropriate letter: B

13. PROPOSED FUNDING
a. FEDERAL $ Unknown .00
b. APPLICANT .00
c. STATE .00
d. LOCAL .00
e. OTHER .00
f. TOTAL $ .00

14. CONGRESSIONAL DISTRICTS OF: Guam
a. APPLICANT
b. PROJECT

15. TYPE OF CHANGE (For 11c or 11e)
A-Increase Dollars F-Other (Specify):
B-Decrease Dollars
C-Increase Duration
D-Decrease Duration
E-Cancellation
Enter appropriate letter(s):

16. PROJECT START DATE Year month day 19 80 10 1

17. PROJECT DURATION 60 Months

18. ESTIMATED DATE TO BE SUBMITTED TO FEDERAL AGENCY Year month day 19 80 7 31

19. EXISTING FEDERAL IDENTIFICATION NUMBER
1. U9X66-9500-80-0
2. DAX149600-80-0
3. N/A

20. FEDERAL AGENCY TO RECEIVE REQUEST (Name, City, State, ZIP code)
ADAMHA, Rockville, MD. 20857/ ADAMHA, Region IX, San Francisco, CA. 94102

21. REMARKS ADDED
[ ] Yes [X] No

a. To the best of my knowledge and belief, data in this preapplication/application are true and correct, the document has been duly authorized by the governing body of the applicant and the applicant will comply with the attached assurances if the assistance is approved.

b. If required by OMB Circular A-95 this application was submitted, pursuant to its procedures thereto, to appropriate clearinghouses and all responses are attached:

	None Known	Response attached
(1) Guam Clearinghouse	[X]	[ ]
(2) Guam Health Planning and Development Agency	[X]	[ ]
(3) Guam Health Coordinating Council	[X]	[ ]

c. TYPED NAME AND TITLE
PETER A. SAN NICOLAS, Administrator

b. SIGNATURE
Peter A. San Nicolas

c. DATE SIGNED Year month day 19 80 5 2

23. AGENCY NAME

24. ORGANIZATIONAL UNIT

27. ADMINISTRATIVE OFFICE

25. APPLICATION RECEIVED Year month day 19

26. FEDERAL APPLICATION IDENTIFICATION

28. ADDRESS

30. FEDERAL GRANT IDENTIFICATION

29. ACTION TAKEN
[ ] AWARDED
[ ] REJECTED
[ ] RETURNED FOR AMENDMENT
[ ] DEFERRED
[ ] WITHDRAWN

32. FUNDING
a. FEDERAL $ .00
b. APPLICANT .00
c. STATE .00
d. LOCAL .00
e. OTHER .00
f. TOTAL $ .00

33. ACTION DATE Year month day 19

34. STARTING DATE Year month day 19

35. CONTACT FOR ADDITIONAL INFORMATION (Name and telephone number)

36. ENDING DATE Year month day 19

37. REMARKS ADDED
[ ] Yes [ ] No

38. FEDERAL AGENCY A-95 ACTION
a. In blocks above enter, any comments received from clearinghouses were considered. If agency response is due under provisions of Part I, OMB Circular A-95, it has been or is being mailed.

b. FEDERAL AGENCY A-95 OFFICIAL (Name and telephone no.)

STANDARD FORM 424 PAGE 1 (10-75)
Prescribed by GSA, Federal Management Circular 74-7

AGANA, GUAM

PROJECT NOTIFICATION AND REVIEW SYSTEM
Notification of Intent to Apply for Federal Assistance

(1) Applicant Department	(2) Division
Mental Health and Substance Abuse Agency	Planning
Applicant Address Street	City / Zip Code
Post Office Box 20999	Guam Main Facility / 96921
Contact Person	Phone / Extention
Larry Aflague	477-9704/5 / --------

Federal Funds		(6) Non-Federal, Matching Funds	
(a) Grant	(b) Other	(c) Local	(d) Other
Subject to appropriation and computation	-0-	-0-	-0-
(e) In-Kind (Specify)		(f) Total Funds	
-0-		Unknown	

Federal Program Title	(8) Federal Domestic Catalog Number / Public Law No. and Title
a) NIAAA Formula Grant b) NIDA Formula Grant c) NIMH Formula Grant	See Attached
Federal Agency Name	(10) Federal Agency Address
See Attached	See Attached

) Type of Application:

New Grant ____ Continuing Grant ____ Supplemental Grant ____

Renewal Since: 1976

) Has Federal funding agency been notified?

Yes ____ No X

) What Fiscal Year will this program be implemented?

FY 1981

) If project includes local funding, identify source.

N/A

) Is this program:

Budgeted X or Non-Budgeted ____

Yes ____ No X Number ____

Will this program require maintenance of effort?

Yes ____ No X $ ____

Funding Method:

	FEDERAL SHARE		STATE SHARE		TOTAL	
Year	% 100%	$ Unknown	% -0-	$ ____	% ____	$ ____
Year	% 100%	$ Unknown	% ____	$ ____	% ____	$ ____
Year	% 100%	$ Unknown	% ____	$ ____	% ____	$ ____
Year	% 100%	$ Unknown	% ____	$ ____	% ____	$ ____
Year	% 100%	$ Unknown	% ____	$ ____	% ____	$ ____

Project Title

Comprehensive Five_Year Plan for Mental Health, Alcohol and Drug Abuse for the Territory of Guam.

Project Location

Territory of Guam

Summary Project Description (Attach Supporting Documents as Necessary).

Five-Year plan for mental health, alcohol and drug abuse in conformance with Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) of HEW Guidelines. The plan conforms to the ADAMHA Guidelines, format and information requirements.

Does this application require an Environmental Impact Statement?

Yes ____ No X

Will this application conflict with any existing local law?

Yes ____ No X

Department of Administration

Guam Health Planning and Development Agency

Indirectly:

Department of Education

Department of Youth Affairs

Department of Public Safety

Guam Memorial Hospital

5) *Is enabling legislation required?*

*Yes*_____ *No* X

6) *Does this application require the signature and approval of the Governor?*

*Yes*_____ *No* X

7) *REMARKS:*

NOTICE OF INTENT
Attachment

Item 10. Funding Agencies to Receive Request

Dr. Fred Oeltjen
National Institute on Drug Abuse
Room 912
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-2440

Ms. Dorine Loso, Director
Division of Alcohol, Drug Abuse and
Mental Health Administration
Region IX
Department of Health, Education and
Welfare
Room 322
50 United Nations Plaza
San Francisco, California 94102
(415) 556-8185

Item 9. Authorizing Legislation

NIAAA PL 91-616
Amendment PL 96-180
NIDA PL 92-255
Amendment PL 96-181
NIMH PL 94-63

Item 8. Federal Catalog Numbers

NIAAA 13.257
NIDA 13.269
NIMH 13.210

APPENDIX B-ITEM 4

May 2, 1980

Memorandum

To: Administrator, Guam Health Planning and Development Agency

From: Administrator, Mental Health and Substance Abuse Agency

Subject: NOI, Comprehensive Five-Year Plan for Mental Health, Alcohol and Drug Abuse for the Territory of Guam

Enclosed, please find the NOI for the Comprehensive Five-Year Plan for Mental Health, Alcohol and Drug Abuse for the Territory of Guam. The Plan will be submitted sometime near the end of May for your review.

Thank you.

151

PETER A. SAN NICOLAS

Enclosure

MPOWELL:mgl
5/2/80

cc: Chrono
File
Director's Chrono
Director's File
Mike P.

NOTICE OF INTENT TO SUBMIT AN APPLICATION

1. DATE SUBMITTED: May 2, 1980

APPLICANT IDENTIFICATION

2. NAME OF APPLICANT AGENCY, INSTITUTION, OR ORGANIZATION: Mental Health and Substance Abuse Agency

3. ADDRESS: Post Office Box 20999, Guam Main Facility, Guam 96921

4. CONTACT PERSON	5. TITLE	6. TELEPHONE
Larry Aflague	Chief, Planning	477-9704/5
7. CHIEF EXECUTIVE OFFICER	**8. BOARD PRESIDENT OR CHAIRMAN**	**9. TYPE OF ORGANIZATION**
Peter A. San Nicolas	--------	Government of Guam

PROJECT DESCRIPTION

10. TITLE AND DESCRIPTION OF PROPOSED PROJECT

Comprehensive Five-Year Plan for Mental Health, Alcohol and Drug Abuse for the Territory of Guam

This plan will be submitted as a combined plan per the format mandated by ADAMHA of HEW. The ADAMHA Guidelines were submitted to your office earlier, under separate cover.

11. ESTIMATED AMOUNT OF FUNDS TO BE REQUESTED $ Subject to Appropriation and Computation

14. ESTIMATED TOTAL PROJECT BUDGET
A. FEDERAL 100%
B. APPLICANT
C. STATE
D. LOCAL
E. OTHER
F. TOTALS

12. TYPE OF ASSISTANCE TO BE REQUESTED
A. GRANT * X
B. CONTRACT
C. LOAN
D. LOAN GUARANTEE
E. OTHER (SPECIFY)
* Formula Grants

13. TYPE OF APPLICATION
A. NEW
B. CONTINUATION
C. OTHER (SPECIFY) X
Five-Year Plan Renewal

15. YEAR OF SUPPORT (CONTINUATIONS ONLY) N/A

FUNDING SOURCE INFORMATION

16. FUNDING AGENCY TO RECEIVE REQUEST (NAME AND ADDRESS)
See Attached.

17. TITLE OF FUNDING PROGRAM	18. PUBLIC LAW AUTHORIZATION NUMBER	19. FEDERAL CATALOG NUMBER
NIAAA, NIDA and NIMH Formula Grants	See Attached	See Attached
20. CONTACT PERSON	**21. TITLE**	**22. TELEPHONE**
See Attached	See Attached	See Attached
23. ESTIMATED DATE OF SUBMISSION OF COMPLETED APPLICATION TO FUNDING AGENCY	**24. ESTIMATED PROJECT START DATE**	**25. ESTIMATED PROJECT END DATE**
7 / 31 / 80	10 / 1 / 80	60 MONTHS

26. TYPE OF REVIEW REQUESTED
SUBSTANTIVE X NON-SUBSTANTIVE UNKNOWN AT THIS TIME

ADAMHA

TO BE COMPLETED BY HSA

A. DATE RECEIVED	B. CONTROL NUMBER	C. TEAM LEADER
/ /		

NOTICE OF INTENT
Attachment

Item 16. Funding Agencies to Receive Request

20.

21. Dr. Fred Oeltjen

22. National Institute on Drug Abuse
Room 912
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-2440

Ms. Dorine Loso, Director
Division of Alcohol, Drug Abuse and Mental Health Administration
Region IX
Department of Health, Education and Welfare
Room 322
50 United Nations Plaza
San Francisco, California 94102
(415) 556-8185

Item 18. Authorizing Legislation

NIAAA	PL 91-616
Amendment	PL 96-180
NIDA	PL 92-255
Amendment	PL 96-181
NIMH	PL 94-63

Item 19. Federal Catalog Numbers

NIAAA	13.257
NIDA	13.269
NIMH	13.210

GOVERNMENT OF GUAM
AGANA, GUAM 96910

April 11, 1980

Memorandum

To: The Governor

From: Acting Administrator, Mental Health and Substance Abuse Agency

Subject: Travel Report - Vicente B. Calvo
Phyllis R. Luminelli

The trip to Saipan included meetings with Frances S. Morse, PhD., Director Mental Health and Drug and Alcohol Agency, Saipan and with Louis Morse, Ph.D., Trust Territory. The nature of these meetings were: (1) to identify what areas the Guam Mental Health and Substance Abuse Agency can provide technical assistance to Saipan MHSAA, (2) to identify the nature of technical assistance to be provided by Guam Mental Health and Substance Abuse Agency for the Saipan Prevention Workshop to be held this summer and (3) to determine the feasibility of callaboration by the islands in the Pacific Basin for the purpose of gaining appropriate action from DHEW in the area of mental health, drug, alcohol programming.

On item 1, above, Guam MHSAA provided the following information: Federal model of Uniform Alcoholism Intoxication Treatment Act; Guam model of same; copy of schedule and recommendations of the recent Guam Prevention Workshop; guidelines for application procedures for funding based on Uniform Alcoholism Intoxication Treatment Act; a summary of states that have enacted alcoholic beverage tax and earmarked same for alcohol treatment. Also, discussions were held on funding strategies for Saipan MHSAA which is still in very early stage of development and on the availability of drug and alcohol treatment on Guam for residents of Saipan. Discussion also involved the possibility of Saipan sending mental health workers to Guam for training with the Guam Community Mental Health Center as the training placement site.

On item 2, we met with Michael Kircher, Social Worker and Frances S. Morse regarding the upcoming Prevention Workshop in Saipan. They were interested in Peer Counseling, or FADA. After a series of meetings with the Community Action Group and the Youth Group working with the Saipan MHSAA, it was decided that they would notify us exactly what training they want us to provide after they survey the areas of interest of the individuals to be trained. We could not provide FADA information because the course has been changed to DIP so we wrote to Western Regional Support Center to obtain 5 copies.

Item 3 - Based on discussions with Morse and Morse it is felt that moving for a Pacific Basin Region may be premature at this time. However, it was generally felt that politics is a very real issue and Saipan political officials as well as officials in the Trust Territory should be contacted to determine their interest.

Frances Morse is interested in a written agreement with Guam MHSAA if it is politically acceptable to both Guam and Saipan. She suggests that meetings should be held at a higher governmental level between Guam and Saipan to begin formalizing the process.

Vicente B. Calvo
VICENTE B. CALVO

Attachments

M. CALVO
Governor

MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY
P. O. Box 20999 Main Facility Guam 96921 Tel: 477-9704/5

PETER A. SAN NICOLAS
Administrator

March 20, 1980

Dr. Frances Schwaninger-Morse
Chief, Director of Mental Health
Commonwealth of the Northern Marianas
Office of the Governor
Saipan, M.I. 96950

Dear Dr. Schwaninger-Morse:

Mr. Ben Calvo, Deputy Administrator of this agency has tentative plans to travel to Saipan on March 31, 1980 and will remain there until April 2, 1980. He will be accompanied by Ms. Phyllis Luminelli who is presently a consultant here in Guam in the area of alcohol, drug, and mental health program development and administration.

The purpose of this trip is in response to recent meetings with you and Mr. Mike Kircher, Social Worker, wherein discussions were held regarding Guam's capabilities to provide technical assistance to you in your efforts in Saipan. Also, they will gather pertinent details regarding your Prevention Workshop scheduled for June 1980 and what assistance our agency can provide.

I feel certain that this will be a productive trip for all concerned and I look forward to a close working relationship between our agencies.

Sincerely,

Peter A. San Nicolas
PETER A. SAN NICOLAS
Administrator

cc: Mike Kircher

April 3, 1980

Dr. Frances Schwaninger-Morse
Chief, Director of Mental Health
Commonwealth of the Northern Marianas
Office of the Governor
Saipan, M.I. 96950

Dear Dr. Schwaninger-Morse:

Enclosed, please find most of the materials requested by you during our recent visit.

We are writing directly to the Western Regional Support Center to send to you, 5 copies each of the Trainee and Instructor manuals for the "Drugs in Perspective" course of NIDA. (When the FADA course was updated this year, the name was changed) We will send you a copy of this letter with other material we are gathering as soon as possible.

Again, we thank you for your hospitality and wish you and your husband the best in your efforts.

Sincerely,

VICENTE B. CALVO

Enclosures

MPOWELL:gjl
cc:chrono
file
Director's file
Director's chrono
MPowell

MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY
P.O. Box 20999 Main Facility Guam 96921 Tel: 477-9704/5

M. CALVO
ernor

MHSAA

PETER A. SAN NICOLAS
Administrator

April 7, 1980

Ms. Sandra Robinson, Director
Western Regional Support Center
1361 South State, Suite 132
Salt Lake City, Utah 84115

Dear Sandra:

When I talked to Michael Moore of Hawaii SSA recently, he made it very clear that the request I have now should be made to you. Your reliable, understanding, instant service cannot be found elsewhere in the system.

Phyllis and Ben Calvo, our Deputy Director, recently visited Dr. Frances Schwaninger-Morse SSA Director for the Northern Mariana Islands and her husband, Dr. Louis F. Morse, SSA Director for the Trust Territories of the Pacific concerning a number of issues, one of which was the possibility of Carl providing training for NMI. They have a particular interest in "Drugs In Perspective" to begin with and would like copies of both the Instructor and Trainee manuals as soon as possible so that credit can be arranged with the Community College.

If you can justify the cost in your budget, five copies of each and any other information you consider pertinent, such as accreditation, sent Airmail First Class to the address below, would be very much appreciated by all involved. Please send at least one set Airmail First Class, though. You may also have some suggestions for most effectively getting benefits of NIDA training to those working in NMI and the TT.

Phyllis says hi and looks forward to the opportunity to see you again, perhaps at the September conference in Washington. Thank you for your help and best to you.

Yours truly,

MICHAEL B. POWELL
Chief, Treatment and Rehabilitation Division

Dr. Frances Schwaninger-Morse
Director of Mental Health
Commonwealth of the Northern Marianas
Office of the Governor
Saipan, Marianas Islands 96950

cc: Dr. Frances Schwaninger-Morse
Phyllis Luminelli

April 2, 1980

Vicente B. Calvo
Mental Health and Substance Abuse Agency
P.O. Box 20999
Agana, Guam 96921

Dear Vicente,

I enjoyed our meeting yesterday during which we shared our views concerning needs, future projects and the possibilities for collaboration.

Regarding your desire to seek support for the establishment of a Pacific Basin DHEW Region Headquartered at Guam, I suggested you approach the appropriate authorities in the emerging States of Micronesia at a time that seems fitting to you.

Accordingly, I am enclosing the current list of authorities in the Micronesian states that you will want to contact.

Best wishes for every success.

Sincerely,

Louis F. Morse

Louis F. Morse, Ph.D.
Mental Health Specialist
Mental Health Branch

State of Kosrae:

Governor:
The Honorable Jacob Nena
Governor, State of Kosrae
Kosrae, 96944

Director of Health:
Dr. Arthur Sigrah, M.O.
Kosrae Hospital
Kosrae, 96944

State of Truk:

Governor:
The Honorable Erhart Aten
Governor, State of Truk
Moen, Truk, E.C.I. 96942

Director of Health:
Dr. Ngas Kansou, M.O.
Truk Hospital
Moen, Truk E.C.I. 96942

State of Yap:

Governor:
The Honorable John Mangefel
Governor, State of Yap
Colonia, Yap, W.C.I 96943

Director of Health:
Mr. Samuel Giltamag
Yap Hospital
Colonia, Yap, W.C.I. 96943

District of Palau: (Soon to be Government of Palau)

District Administrator: (until President elected)

Mr. Kim Batcheller
District Administrator
Koror, Palau W.C.I. 96940

Director of Health:

Mr. Minoru Ueki
Director of Health Services
MacDonald Memorial Hospital
Koror, Palau W.C.I. 96940

Marshall Islands:

President:
The Honorable Amata Kabua
Government of the Marshall Islands
Majuro, Marshall Islands 96960

Minister of Health:
Dr. Henry Samuel, M.O.
Government of the Marshall Islands
Majuro, Marshall Islands 96960

Chief Secretary for Health:
Dr. Ezra Riklon, M.O.
Amer Ishoda Memorial Hospital
Majuro, Marshall Islands 96960

Chief Secretary: (for the entire government)
Mr. Oscar DeBrum
Government of the Marshall Islands
Majuro, Marshall Islands 96960

Federated States of Micronesia:

President:
The Honorable Tosiwo Nakayama
Federated States of Micronesia
Kolonia, Ponape, E.C.I. 96941

Chief of Health Services:
Dr. Eliuel K. Pretrick, M.O.
Ponape Hospital
Kolonia, Ponape, E.C.I. 96941

Director, Department of Social Services: (Health & Education
Mr. Yosiwo P. George
Government of Federated States of Micronesia
Kolonia, Ponape, E.C.I. 96941

State of Ponape:

Governor:
The Honorable Leo Falcam
State of Ponape
Kolonia, Ponape, E.C.I. 96941

Director of Health:
Alexander Panuelo
Ponape Hospital
Kolonia, Ponape, E.C.I. 96941

RESOURCE LIST

Counseling and Substance Abuse Services

Prepared by: Mental Health and Substance Abuse Agency

Revised: June 26, 1980

Program:	Guam Community Mental Health Center Drug and Alcohol Program
Contact Person(s):	Beverly Boska, Alcohol Coordinator Richard Hartendorp, Drug Coordinator
Phone:	Alcohol Coordinator (646-9378) Drug Coordinator (646-9191/2/3)
Location:	Separate buildings at ocean end of Old GMH
Services:	Methadone Detox. & Maintenance Drug and Alcohol Outpatient Counseling
Program:	Catholic Social Services
Contact Person(s):	Sister Ursula Sister Marian Mary Alice Cowan
Phone:	477-9460
Location:	Above Family Shoe Store, O'Brien and Route 4
Services:	All kinds of our client counseling, on-religious
Program:	ISA (Catholic Social Services)
Contact Person(s):	Joaquin Perez, Director Claudia Sechler, Head Counselor Jackie Fields, Assistant Director
Phone:	734-3593
Location:	Route 10, Mangilao
Services:	Drug and Alcohol Residential Treatment (Modified Therapeutic Community)
Program:	GMH, Emergency Room
Contact Person(s):	Dr. Olivia Cruz or Staff on duty
Phone:	646-8104
Location:	MCM, rear of building, Tamuning
Services:	Alcohol Detox in cases with medical considerations/Emergency overdose and poisoning treatment

Program:	Human Services Corporation (Private, Non-Profit)
Contact Person(s):	Phyllis R. Luminelli
Phone:	477-2276
Location:	Corn Building, Second floor above Dollar Store, Agana
Services:	Life crisis, drug and alcohol, family counseling. Consulting: program design, development and management. Performs contracts for services related to health, education and welfare.
Program:	The Behavioral Clinic (Private)
Contact Person(s):	Dr. Lewis-Kanaiaupuni, Ph. D., APA
Phone:	646-7340
Location:	Marine Drive, near Tamuning-Agana line, cliffside
Services:	Psychological Services, Adults and Children
Program:	(Private)
Contact Person(s):	Teresita R.L.G. Cottrell, MA.
Phone:	472-2313 or 472-6545
Location:	Maina
Services:	Psychotherapy
Program:	Mental Health and Substance Abuse Agency
Contact Person(s):	Peter A. San Nicolas, Administrator Michael B. Powell or other staff
Phone:	477-9704/5
Location:	2nd. floor, Ada Plaza, behind RCA, Agana
Services:	Planning, Administration, Program Development, Training and Prevention, Federal Liaison, Technical Assistance and Consulting, some counseling (usually for referral)
Program:	Alcoholics Anonymous/Alanon
Contact Person(s):	None
Phone:	734-9433 or 646-1811 Ext. 111 or check with AAFB or NAS below.
Location:	Various
Services:	100% Volunteer Support Groups/Alanon is support and information for families and close friends of persons with alcohol problems

Parish Priests, Other Clergy, Village Commissioners and Suruhanus are all valuable resources:

Program:	Social Action Office (Air Force)
Contact Person(s):	Major Rust and Capt. Perez
Phone:	366-9181
Location:	Andersen AFB
Services:	For active-duty military and civilian personnel but not dependants; substance abuse counseling and education; Educational presentations in the community.
Program:	Counseling Assistance Center
Contact Person(s):	Ltn. Dowling
Phone:	342-5109 or 342-2152
Location:	NAS
Services:	For active-duty military and civilian personnel but not dependant; Outpatient Counseling and Residential Treatment; Educational Community Presentation.
Program:	(Private)
Contact Person(s):	Marilyn Karolle, M.A.
Phone:	653-2894
Location:	Agana
Services:	Psychotherapy; Marriage Family and Adolescent; Individual/Group
Program:	Teen Challenge
Contact Person(s):	Dave and Joanne Hayes
Phone:	646-6491
Location:	Marine Drive across from Route 8 Junction Post Office Box 7121 Tamuning, Guam 96911
Services:	Troubled youth, counseling limited residential treatment

APPENDIX D-ITEM 2

A. A. Meetings on Guam as of 20 March 1980

Sunday: St. John's Episcopal Church Cafeteria, Tumon 7 P.M. (Closed)	789-1173 Debbie K.
Camp Covington, Old C.O.'s Conference Room 7 P.M. (Closed)	339-1115 Howard B.
Monday: NAS ARD, Barracks 5 Lower 8 P.M. (Open)	342-2152 Cheryl S.
AAFB Social Actions Complex, Bldg. 26023 7 P.M. (Closed)	366-9181
Tuesday: NRMC ARS, Ward E-2 8 P.M. (Open)	344-9266 Frank Y.
Polaris Point (Training Building 2) (Open) 1145 A.M.	339-3136 Dean C.
Wednesday: NAS ARD, Barracks 5 Lower (Open) 8 P.M.	342-2152 Arnie K.
Camp Covington Admin. Building (Open) 8 P.M.	339-1115 Howard B.
Thursday: Calvary Baptist Church, Harmon (Open) 8 P.M.	33-4197 Lynn C. (Smokey)
Womens Group Catholic Social Services Above Family Shoe Store (Closed) 7 P.M.	789-1173 Alice K.
Friday: Camp Covington, Old C.O.'s Conference Room (Open) 8 P.M.	339-1115 Howard B.
NAS ARD, Barracks 5 Lower Noon (Open)	342-2152 Cheryl S./ Arnie
Guam Mental Health, Building 2 (Old GMH) (Closed) 8 P.M.	646-6390 Phil G.
NAVCAMS Human Goals Office (Dispensary Building 198) (Open) 8 P.M.	355-5022 or 355-5743 (Butch)

AL-ANON On Guam:

Sunday: St. John's Church School, Tumon 7 P.M. (Closed)	789-1173 Alice K.
Friday: 386A Dyer Drive NAVCAMS WESTPAC (Open) 8 P.M.	355-5022 or 355-5743 Butch or Lori B.
Wednesday: AL-ANON ALATEEN 7 P.M. Above Family Shoe Store	789-1173 Debbie K.

MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY
Government of Guam

APPENDIX E-ITEM 1

March 6, 1980

Memorandum

To: Administrator, Mental Health and Substance Abuse Agency

From: Chief, Planner

Subject: Secondary Public School - D&A Survey

On January 7, 1980 MHSAA completed printing of 11,230 Drug and Alcohol forms, 10,000 of which were distributed to GCC and DOE schools. Total returns amounted to 7,072 forms or 70 percent.

Methodology - Using the "Kish technique" or multi-stage sampling procedure, a carefully drawn random sample of 10 percent was selected to represent the true population base of 10,000 students. The sequence therefore yields a systematic equal interval of 10. The random sample of every 10th case yields a representative element of 1,000 unit.

Sampling Accuracy - Using Table 3, "Needs Assessment Methodology --- Approximate Sampling Error of Percentage" (NIDA), a probable sampling error of 2 to 2.8 percent is a safe assumption. Each school is carefully weighted in proportion to student population to avoid underrepresentation of student's true sample size.

Variables - Variables selected for cross-tabulation analysis from this survey include age, grade-range, sex, village, frequency rate, and ethnicity.

Statistical Elements - The statistics presented hereafter constitutes preliminary-unbiased estimates based on a true random representation of the respondents' population base. Correlations expressed from each variable are extrapolated from the following key statistical elements:

Alcohol, narcotics, barbiturates, hallucinogens, marijuana, cocaine, anorexants, tranquilizers/sedatives, caffeine, nicotine, inhalants/solvents, betel nut.

Needs Assessment's Objective - The objective of this DATA is to serve as a basis for determining the community's needs, prevalence, incidence, and frequency (level of use indicator) for the current drug and alcohol problems in existence today.

LAWRENCE R. AFLAGUE

Junior and Senior High Schools
Drug & Alcohol Survey

RGET DRUG(S)	Narcotics, Barbiturates, Hallucinogens, Marijuana, Cocaine, Anorexants, Tranquilizers/ Sedatives, Caffeine, Nicotine, Inhalants/ Solvents, Betel Nut
MPLE SIZE	N = 1,000 (RANDOM SAMPLE) POPULATION GROUP - 10,000 STUDENTS
MPLE TYPE	Public Junior and Senior High School Students
E/GRADE RANGE	Ages 11-21 - Grades 7-12
EX	Both Sexes
NICITY	Chamorro, Chamorro/Filipino, Filipino, Statesider, Chamorro/Statesider, Other
OGRAPHICAL AREA	Public/Private Secondary Schools Throughout Guam
THODOLOGY	Exploratory/Survey
TA COLLECTION INSTRUMENT/ SIGN FEATURES	27 - Item Questionnaire Completion, Yes/No, Multiple-Choice
MINISTRATION	Self-Administered Questionnaire Untimed, Anonymous
SESSMENT AREAS	(1) Demographic or Personal Data, Practices, Use History, Correlates (2) Attitudes, Opinions, Knowledge
TE(S) CONDUCTED	January - February 1980
CILITATORS	MHSAA - STAFF L. R. Aflague - Chief, Planner & Project Director F. F. Ungacta - Chief, Research & Evaluation Don Ploke - Planning, Coordinator Paul Merfalen - Research & Evaluation Assistant Mike Powell - Associate Project Director Frank Taitano - Technical Assistant Jr. Aniceto S. Dignadice - Medical Advisor
EDS ASSESSMENT'S OBJECTIVE	Needs, Prevalence, Incidence, Severity

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TABLES/CHARTS

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MHSAA DRUG AND ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS

INTRODUCTION

MHSAA recently completed a comprehensive drug and alcohol survey throughout the island's secondary public school system. A total of 10,000 survey forms were distributed to the eight secondary schools (three senior and five junior high schools), of which 7,072 forms were returned, yielding a respondent rate of 70%.

Several key variables in the survey were chosen for cross-correlation purposes. These included sex, age, grade level, ethnicity, village of residence, and frequency of use, each of which was compared with eleven different major drug categories. Additionally, specific emphasis was given to the importance of alcohol as it relates to attitudinal prevalence.

VALIDITY OF SURVEY DATA

One primary concern with survey data is the credibility of what respondents say, in this case their responses to drug use. There is no direct, objective validation of a self-report measure of this kind, but, as NIDA contends, "a good deal of inferential evidence exists to support their validity." One of these, like a number of methodological studies, was the inclusion of a fictitious or bogus drug in the survey questionnaire. In previous surveys, these bogus drugs have shown very low levels of reported use, an indication that intentional overreporting is likely to be at a minimum. NIDA is also of the opinion that "while there is almost certainly some degree of underreporting of illicit drug use on self-report surveys, it is far less than most people intuitively assume. Further, for purposes of monitoring trends across time, a fairly constant degree of underreporting should have almost no effect on trend estimates."

At present, a random sample of 1,000 was taken from the total number of survey respondents since, from a statistical standpoint, this is the most straightforward type of sample. It is, however, difficult to determine exactly how much error has resulted from sampling when final percentages are calculated. While at present no sophisticated statistical analyses have been implemented in this survey, reasonable good estimates of confidence intervals, simple cross-correlations, and multivariate analyses can be derived without much difficulty with some computer assistance.

I. ANALYTICAL FINDINGS

A. Prevalence/Frequency of Use

1. Narcotics - of the total number of students surveyed, MHSAA's results indicate a total prevalence rate of 3.1% for narcotics use (either once, daily, weekly, or monthly). 87% of the actual number of narcotics users (approximately 27 students) used the drug at least once, 7% are using it daily, 3% weekly, and 3% monthly. 85% of the total narcotics users indicated heroin use. As derived from

this representative sample, it can be estimated that approximately 310 students of the entire population have used narcotics at least once. Of the total number of actual narcotics users, 77% are male and 23% female; 19% are between the ages of 12-15 and 81% between 16-21; 29% are from grades 7-9 and 71% from 10-12; 55% are Chamorro; 9% Chamorro-Statesider, 9% Chamorro-Filipino, 3% Filipino, 15% Statesider and 9% of other ethnic backgrounds; 35% of the users reside in Dededo, followed by Yigo (16%), and Tamuning 10%.

2. Caffeine - survey results for this category show a total prevalence rate of 77.3% (either once, daily, weekly, or monthly). 13% of the actual number of caffeine users have used the drug at least once, 53% are currently using it daily, 20% weekly, and 14% monthly. A majority of those users indicated cola drinks as their preferred source of caffeine. It can be estimated that of the entire target population, 7,730 have used this drug at least once, with 4,130 students using it daily. This category also represents the highest percentage of use among all other major drugs. Of the total number of actual caffeine users, 55% are male and 45% female; 56% are between the ages of 12-15 and 44% between 16-21; 47% are from grades 7-9 and 53% from 10-12; 51% are Chamorro, 4% Chamorro-Statesider, 10% Chamorro-Filipino, 17% Filipino, 9% Statesider, and 9% of other ethnic backgrounds. The top three villages where caffeine users reside are; Dededo (22%), Yigo (11%), and Tamuning (8%).

3. Nicotine - as indicated in the results for this category, a total prevalence rate of 30.9% (either once, daily, weekly, monthly) exists. 31% of the actual number of nicotine users have used the drug at least once, while those using it daily, weekly, and monthly run 56%, 8% and 5%, respectively. Cigarettes were by far the students' preference as their source of nicotine. Approximately 1,740 students of the entire target population are daily users. This particular drug category is second only to caffeine in popularity and highest usage rate. Of the total number of actual nicotine users, 55% are male and 45% female; 44% are between the ages of 12-15 and 56% between 16-21; 37% are from grades 7-9 and 63% from 10-12; 54% are Chamorro, 7% Chamorro-Statesider, 13% Chamorro-Filipino, 9% Filipino, 10% Statesider, 7% other ethnic backgrounds; and the top three villages where nicotine users reside are; Dededo (28%), Yigo (14%), and Mongmong-Toto-Maite (8%).

4. Inhalant/Solvents - survey results for this drug category show a 1.9% total prevalence rate (either once, daily, weekly, or monthly), one of the lowest of all major drug categories. One-time use of inhalants/solvents is 90% with weekly/monthly use running the same at 5%. Glue was the greatest indicator of use in this category. It can be estimated that of the entire target population, 190 students have tried it at least once. Of the total number of actual inhalant/solvent users; 68% are male and 32% female; 37% are between the ages of 12-15 and 63%

between 16-21; 16% are from grades 7-9 and 84% from 10-12; 53% are Chamorro, 21% Chamorro-Filipino, 16% Filipino, 5% Statesider, and 5% other ethnic backgrounds; the top 3 villages where these users reside are Dededo (32%), Mongmong-Toto-Maite (16%), with both Agat and Santa Rita rating at (11%).

5. Barbiturates - the results for this drug category indicate a total prevalence rate (either once, daily, weekly, or monthly) of 1.3%, the lowest of all major drug categories. 100% of the total number of actual users are one-time users, of which the majority indicated a preference for "reds". It can be estimated that 130 students have experimented with barbiturates at least once out of the entire target population. Of the total number of actual barbiturate users, 85% are male and 15% female; 31% are between the ages of 12-15 and 69% between 16-21; 15% are from grades 7-9 and 85% from 10-12; 39% are Chamorro, 15% Chamorro-Statesider, 8% Chamorro-Filipino, 23% Statesider, and 15% of other ethnic background; the top villages where barbiturate users resides include Dededo (38%), with several other villages rating the same at 8%.

6. Hallucinogens - survey results for this category show a total prevalence rate (either once, daily, weekly, or monthly) of 1.9%, or approximately 190 students out of the entire target population who have used the drug at least once. 84% of the total number of actual users have used a hallucinogenic drug at least once, none are using it daily or weekly, and 16% are using it monthly. Of the different types of hallucinogens, angel dust (PCP) rated a 47.3% prevalence rate in comparison to all the others. Of the total number of actual hallucinogen users, 74% are male and 26% female; 26% are between the ages of 12-15 and 74% between 16-21; 32% are from grades 7-9 and 68% from 10-12; 42% of the users are Chamorro, 11% Filipino, 20% Statesider, 11% Chamorro-Statesider, 5% Chamorro-Filipino, and 11% of other ethnic background; the two highest villages where users reside include Dededo (63%) and Yigo (11%) with several others rating (5%).

7. Marijuana - the survey results of this major drug category indicate a total prevalence rate (either once, daily, weekly or monthly) of 26.6%, or approximately 2,660 users of the entire target population. 48% of the total number of actual users have used marijuana at least once, 26% are using it daily, 15% weekly, and 11% monthly. Types of marijuana used range from the "homegrown" variety to the stronger opiated Thai sticks/rods. The prevalence rate of marijuana use ranks third highest among all the different major drug categories, surpassed only by caffeine and nicotine. Of the total number of actual marijuana users, 63% are male and 37% female; 38% are between the ages of 12-15 and 62% between 16-21; 29% are from grades 7-9 and 71% from 10-12; 58% are Chamorro, 7% Chamorro-Statesider, 12% Chamorro-Filipino, 5% Filipino, 11% Statesider, and 7% of other ethnic background; Dededo rates 22% for marijuana, Yigo (14%) and Mongmong-Toto-Maite (9%).

8. Cocaine - total prevalence rate for cocaine use (either once, daily, weekly or monthly), as indicated from the survey findings, puts this major drug category in the 1.4% bracket, one of the three lowest along with barbiturates and tranquilizers/sedatives. Taken from the entire target population, this would represent approximately 140 students who have used cocaine at least once. Of the total number of actual users, 100% have tried the drug once, as there were no daily, weekly, or monthly users. Cocaine's low frequency rate use appears to be an indication that these students who've tried it were only first-time experimental users. Of the total number of actual cocaine users, all were male (100%); 29% were between the ages of 12-15, 71% between 16-21; 29% were from grades 7-9 and 71% from 10-12; 64% of the users were Chamorro, 29% Chamorro-Statesider, and 7% Statesider; 21 of the cocaine users are from Dededo, with Agat, Chalan Pago, Ordot, Inarajan, and Yona rating 14% each.

9. Anorexants - survey results show that there is a 2.7% prevalence rate (either once, daily, weekly, or monthly), of anorexant use from the entire target population, representing approximately 270 students who have used drugs of this category at least once. 77% of the total number of actual users have tried an anorexant once, 15% are currently using it daily, with 4% weekly and 4 % monthly. Types of anorexants used included mostly diet pills and amphetamines. Total use prevalence in this category ranks slightly above cocaine, hallucinogens, barbiturates, inhalants/solvents, and tranquilizers/sedatives. Of the total number of actual anorexant users, 59% are male and 41% female; 19% are between the ages of 12-15 and 81% between 16-21; 26% are from grades 7-9 and 74% from 10-12; number of actual users, 30% are Chamorro, 18% Chamorro-Statesider, 26% Chamorro-Filipino, 4% Filipino, 15% Statesider, and 7% of other ethnic background; 30% of anorexant users are from Dededo, 19% from Yigo, with Agat and Barrigada rating 11%, respectively.

10. Tranquilizers/Sedatives - the total prevalence rate either (once, daily, weekly, or monthly) for this category of drugs was at a low 1.5% or approximately 150 students from the entire target population, 67% of the total number of actual users indicated having used the drug at least once, 13% admitted to using it daily, 7% weekly, and 13% monthly. As with barbiturates and cocaine, overall drug use for this category was quite low. Of the total number of actual users in this category, 67% were male and 33% female; 40% were between the ages of 12-15 and 60% between 16-21; 33% were from grades 7-9 and 67% from 10-12; 40% were Chamorro, 14% Chamorro-Statesider, 6% Chamorro-Filipino, 13% Filipino, 27% Statesider; 27% of the tranquilizer users are from Agat, 20% from Mongmong-Toto-Maite, and 13% from Piti.

11. Betel Nuts - total prevalence rate for betel nut (either once, daily, weekly, or monthly) was 24.4%, or approximately 2,440 users from the entire target population. 38% have used the drug once, 35% are using it daily, 17% weekly, and 10% monthly.

Betel nut use ranks fourth highest among all major drug categories. Of the total number of actual betel nut users, 64% were male and 36% female; 50% were between the ages of 12-15 and 50% between 16-21; 44% were from grades 7-9 and 56% from 10-12; 64% were Chamorro, 6% Chamorro-Statesider, 11% Chamorro-Filipino, 7% Filipino, 3% Statesider, and 9% other ethnic backgrounds; 21% of all betel nut users are from Dededo, 13% from Yona, and 8% from both Mongmong-Toto-Maite and Yigo.

B. Comparative Results

Several interesting comparisons can be made from MHSAA's drug and alcohol survey findings and those of previous studies - particularly NIDA's highlights from their national drug abuse survey, DPS' recent follow-up survey of the one done a couple of years ago and of course, Dr. Roy Chung's comprehensive drug survey conducted in 1974.

Comparative findings among these studies reveal significant changes in a number of variables over the last few years. Like NIDA's national survey and the local ones conducted on island, MHSAA attempted to derive some quantification of drug use patterns among our youth, specifically among the secondary school students, relative to drug type, sex, age, grade level, ethnicity, village of residence, and prevalence. Equally important was the examination of attitudinal questions in regard to alcohol knowledge and use.

1. Narcotics - nationally, NIDA's 1978 drug survey revealed a prevalence of approximately 2% among high school seniors. Locally, Chung's extensive 1974 survey showed a 7% prevalence of narcotics use among 9th graders and senior high school students, compared to DPS' 1980 results (senior high school students) of 4% (a similar survey conducted in 1977 revealed a 16.5% prevalence). MHSAA's survey findings also indicated a 4% prevalence for this major drug category.

2. Caffeine - this was the only major drug category not assessed by NIDA, DPS, or Chung. MHSAA's results indicated a prevalence of 81%.

3. Nicotine - NIDA's national survey indicated a national prevalence of 75% for this major drug category, compared with Chung's findings of 59% and MHSAA's results of 40%. This drug category was not assessed by DPS.

* Refer to table of NIDA's, DPS', and Chung's survey results (note that the target population is not as encompassing as MHSAA's - NIDA surveyed high school seniors only; DPS, high school students only; Chung, high school students and 9th. graders; percentages are rounded off to the nearest whole number.

4. Inhalants/Solvents - NIDA's national results indicated an 11% prevalence for this drug category, while MHSAA's findings revealed a 3% prevalence. This particular drug category was not similarly assessed by DPS or Chung.

5. Barbiturates - NIDA's, Chung's and MHSAA's survey findings for this major drug category indicated a prevalence of 16%, 12%, and 2%, respectively. DPS did not assess this drug category.

6. Hallucinogens - for this major drug category, national results from NIDA showed a 14% prevalence, compared with Chung's results of 16% and MHSAA's findings of 3%. This drug category was not assessed by DPS.

7. Marijuana - nationally, findings from NIDA's survey indicated a 59% prevalence of marijuana use. Chung's results showed a 40% prevalence and DPS' findings revealed a 48% prevalence (a similar survey conducted in 1977 showed a 45% prevalence). MHSAA's survey findings indicated a 39% prevalence.

8. Cocaine - NIDA's national results revealed a 13% prevalence for this major drug category, compared with Chung's findings of 11% and MHSAA's results of 2%. DPS did not assess this area.

9. Anorexants - prevalence figures for this major category indicated a 23%, 11% and 4% use rate from NIDA, Chung, and MHSAA, respectively. No comparative figures were available from DPS.

10. Tranquilizers/Sedatives - nationally, survey findings from NIDA showed a 17% prevalence for this category, compared with Chung's results of 4% and MHSAA's findings of 2%. DPS had no available comparative data.

11. Betel Nut - Chung's local findings revealed a 49% prevalence for this particular drug category. MHSAA's recent survey results indicated a 28% prevalence. No similar assessment was made by NIDA or DPS.

12. Alcohol - of particular interest were a few questions concerning attitudes, opinions, and knowledge of alcohol. DPS' survey findings showed that 7% of the students surveyed "stated they either thought they had an alcohol problem or were unsure if it was a problem." MHSAA's results indicated 3% of the students surveyed felt they had a drinking problem.

II. SUMMARY

The policy of this Agency (Guam Mental Health and Substance Abuse Agency) is to be "primarily concerned with alleviating the personal, social and economic costs of substance abuse within our community." To be sure, the actualization of such a noble undertaking will require the continued cooperation and solidarity of all departments within the Government of Guam branches; the Executive, Legislative and Judicial.

The research section of MHSAA's Planning Division has attempted to conduct a fruitful and accurate needs assessment in the important area of drug and alcohol use/abuse among our youth, especially in the secondary school system, which constitutes an important developmental stage within our society. Consequently, a drug and alcohol survey was designed and implemented to determine key areas of assessment relative to drug and alcohol use/abuse. Like several previous national and local

surveys, one of the primary objectives of this survey was to obtain some quantification of drug use patterns among secondary school students with respect to drug type, prevalence of drug use, and various socio-demographic variables.

MHSAA's and DPS' 1980 survey results both indicate that one particular hard drug category, narcotics, has a local prevalence of 4%, twice the national average derived by NIDA in 1978. Though alarming as such, it is encouraging that this current 4% prevalence has fallen from the 7% figure reported in Chung's 1974 study - a significant decrease. Interestingly enough, only 7% of the actual number of narcotics users from the target population are taking it daily (approximately 22 students).

Nationally, marijuana use prevalence in 1978 was 59% according to NIDA statistics. Locally, January 1980 DPS' current follow-up survey results indicate a 48% prevalence, up 8% compared to Chung's 1974 findings of 40%, but still lower than the national average. MHSAA's present findings of 39%, however, show that there hasn't been much change in local marijuana use prevalence among high school students since 1974, but the results of all combined junior and senior high school students from MHSAA's survey indicate a significantly lower prevalence of 27%.

The Agency's findings also indicate that the overall prevalence of all other major drug categories has decreased significantly. Use of inhalants/solvents has a 3% local prevalence, lower than the national average of 11%; use of barbiturates at 2% is down from Chung's findings of 12% and lower than the 16% national prevalence reported by NIDA; use of hallucinogens is 3% locally, a decrease from Chung's results of 16% and the 14% national average; cocaine use prevalence is at 2%, down from Chung's findings of 11% and lower than the national average of 13%; anorexants use has a 4% local prevalence, a decrease from Chung's 11% findings and much lower than the 23% national prevalence; use of tranquilizers/sedatives has a local prevalence of 2%, lower than Chung's findings of 4% and a considerable decrease from the 17% national average.

MHSAA also included four non-illicit drug categories in its drug and alcohol survey. Each of these, caffeine, nicotine and alcohol are socially approved and betel nut, is an integral part of our island culture.

Comparatively, NIDA's findings on nicotine use prevalence was 75%, much higher than our local findings of 40%. This 40% local prevalence has also dropped since 1974, when Chung reported a 59% prevalence. There were no comparative figures on caffeine from NIDA, DPS, or Chung, but this Agency's results indicated a local prevalence of 81%. Betel nut use has apparently decreased significantly since 1974, when Chung reported a 49% prevalence, compared to our findings of 28%.

The only comparative data we had on the alcohol attitude questions was from DPS, which reported that 7% of the students surveyed "stated they either thought they had an alcohol problem or were unsure if it was a problem". Our results indicated that 3% of the students surveyed felt they had a drinking problem.

III. RECOMMENDATIONS

Although it was beyond the scope of this particular survey, a worthwhile target for the near future would be to develop an on-going and effective research program similar to NIDA's that would go beyond observing substance abuse prevalence and trend estimation - a program with the following goals in mind:

1) to gain a better understanding of the lifestyles and value orientation associated with various patterns of drug use and monitoring how these orientations are shifting over time

2) to determine the immediate and more general concepts of the social environment which are associated with drug use and abuse

3) to determine how drug use is affected by major transitions in the social environment (i.e., entry into military service, civilian employment, college, unemployment) or social roles (i.e., marriage, parenthood).

4) to distinguish age effects from cohort and period effects in determining drug use

5) to determine the effects of social legislation - in particular marijuana decriminalization - and its application on all types of drug use

6) to determine the changing connotations of drug use and changing patterns of multiple drug use among our youths

It is evident from MHSAA's drug and alcohol survey results and the comparative findings of other similar surveys (both local and national) that significant changes in drug use prevalence on Guam have occurred over the last few years.

CONCLUSION

MHSAA's drug and alcohol survey findings appear quite encouraging for most of the major drug categories. Not only is prevalence of drug use on Guam down in comparison to the national average, but there has also been a significant decrease in prevalence since Chung's local study in 1974.

Narcotics use prevalence among our senior high school students, though twice the national average, has shown a substantial and promising decrease over the last few years. Marijuana use prevalence has remained relatively constant, but it is still lower than the national average.

Alcohol, on the other hand, is definitely considered a problem area by most of the students surveyed. An overwhelming majority felt there was an alcohol problem on Guam, about half felt they knew someone with a drinking problem, and almost a third felt someone in their family had a drinking problem. It is evident, however, that an estimated 300 students of the total population base admitted to having a drinking problem.

To be sure, a number of important factors have contributed to this encouraging decrease in drug use prevalence. The combined teamwork and efforts of MHSAA and such departments and agencies as DOE, GCC, DPS, and DEA have helped bring about greater community awareness, concern, and participation in effectively dealing with the substance abuse problem. Agressive media campaigns and, most importantly, serious prevention efforts within homes, schools, and villages have laid a solid foundation for greater understanding and self-administered initiatives to deal with the substance abuse problem.

Recently, other encouraging statistics have been gathered from various department/agencies. The Territorial Medical Examiner reported a significant drop in drug-related deaths (one for 1979, a significant

decrease as compared to the eight recorded drug-related deaths for all of 1978). Customs and Quarantine reported a decrease in drug seizure quantities and DPS reported a decrease in drug-related crimes; the total number of narcotics law violations was 99 in 1979, as compared to 119 cases in 1978.

The alcohol problem, however, is still of considerable concern. Survey results indicate that alcohol abuse is thought to be a serious problem among personal acquaintances and family, with approximately 3% admitting to having a drinking problem. It is more than apparent that a sizeable potential treatment population exists who are in need of alcohol treatment services. The development and refinement of such services (i.e., outpatient counseling, social detoxification settings, etc.) and good prevention programs will play a crucial role in intervening this serious problem. Other treatment modalities can eventually be developed as we gain a greater understanding of the needs of the people who require these services.

MHSAA will continue in its efforts to put together a current and realistic needs assessment study through the careful collection and anlysis of accurate and relevant data. MHSAA plans to expand its continued support and encourage active community outreach activities in order to guarantee maximum utilization of existing programs, as well as recognize, encourage, and develop specialized direct services programs for special treatment populations. The recently formed task force, which resulted from MHSAA's last prevention workshop, will need the full support of the government and community to ensure its success.

The substance abuse problem is not an easy one to understand and effectively deal with unless we really understand its causes, and not just its effects. The impact of good humanistic prevention programs really comes into play here, and this, coupled with adequate and effective treatment, will always be a winning combination in the fight against substance abuse. With the combined efforts and cooperation of everyone involved in the human services field, and especially the key support of the family, there's no doubt that the future will hold many beautiful value-creating alternatives to drug use.

TARGET DRUGS BY CATEGORY/TYPES
DRUG & ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS

NARCOTICS:

* OPIUM
* MORPHINE
* HEROIN
* METHADONE
* OTHERS

CAFFEINE:

* COFFEE
* COCA COLA (PEPSI COLA)
* TEA
* CHOCOLATE
* OTHERS

NICOTINE:

* TOBACCO/PIPES, ETC.
* CIGARETTES
* CIGARS
* OTHERS

INHALANTS AND SOLVENTS:

* ETHER
* CHLOROFORM
* GLUE
* LAUGHING GAS
* PAINT
* PETROLEUM
* BENZEDRINE (NASAL SPRAY)

BARBITURATES:

* BARBITAL
* BARBS
* REDS
* YELLOW JACKETS
* BLUE HEAVENS
* PURPLE HEARTS
* RAINBOWS (CHRISTMAS TREE)
* TOOTIES
* OTHERS
* PHENOBARBITAL
* SECOBARBITAL

HALLUCINOGENS:

* PEYOTE (MESCAL BUTTON)
* FLY AGARIC (MUSHROOMS)
* NUTMEG (MYDISTICA FRAGRANS)
* YUREMA (DMT)
* MORNING GLORY
* LSD-25
* BZ
* PHP
* ANGEL DUST (PCP)
* OTHERS

MARIJUANA:

* WEED (CANNABIS SATIVA)
* BHANG
* JOINTS
* ROACH
* HASHISH (CHARAS)
* ACAPULCO GOLD
* THAI/STICKS
* RODS
* THC
* OTHERS

COCAINE:

* COKE
* SNOW
* CANDY
* CHARLIE
* BIG "C"
* OTHERS:

ANOREXANTS:

* AMPHETAMINES
* DIET PILLS
* DEXAMYL
* PEP PILLS
* SPEEDBALL (COMB. H/A)
* SPEED (METHAMPHETAMINE)
* BENZEDRINE
* DEXEDRINE

TRANQUILIZERS/SEDATIVES:

* VALIUM
* LIBRIUM
* QUAALUDE
* MEPROBAMATE
  EQUANIL
  MILTON
* VALMID
* CHLORAL HYDRATE
  NOCTEC
  SOMNOS
* PARALDEHYDE
* DORIDEN
* NOLUDAR

BETEL NUT (MATURE NUT):

* NUT ALONE
* NUT/LEAF
* NUT/TOBACCO
* NUT/LIME
* NUT/LIME/LEAF
* NUT/LIME/LEAF/TOBACCO

BETEL NUT (GREEN YOUNG NUT WITH HUSK

* NUT ALONE
* NUT/LEAF
* NUT/LEAF/TOBACCO
* NUT/LIME/LEAF
* NUT/LIME/LEAF/TOBACCO

DREXINE: (BOGUS DRUG)

* LICTOHINE
* ZYMORAX

FREQUENCY RATE BREAKDOWN
(TOTAL PERCENTAGE)
DRUG & ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS
N=1,000 (Random Sample)

DRUGS	FREQUENCY RATE → (TOTAL No. STUDENTS)			ACTUAL No. → DRUG USERS			TOTAL		
	ONCE	DAILY	WEEKLY	MONTHLY	No.	%	ONCE	DAILY	WEEKLY	MONTHLY	%
NARCOTICS	27	2	1	1	31	3.1	87	7	3	3	100
CAFFEINE	99	413	156	105	773	77.3	13	53	20	14	100
NICOTINE	95	174	24	16	309	30.9	31	56	8	5	100
INHALANTS/ SOLVENTS	17	0	1	1	19	1.9	90	0	5	5	100
BARBITURATES	13	0	0	0	13	1.3	100	0	0	0	100
HALLUCINOGENS	16	0	0	3	19	1.9	84	0	0	16	100
MARIJUANA	127	70	39	30	266	26.6	48	26	15	11	100
COCAINE	14	0	0	0	14	1.4	100	0	0	0	100
ANOREXANTS	21	4	1	1	27	2.7	77	15	4	4	100
TRANQUILIZERS/ SEDATIVES	10	2	1	2	15	1.5	67	13	7	13	100
BETEL NUT	92	85	41	26	244	24.4	38	35	17	10	100

PERCENT TOTAL
BY SEX

DRUG & ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS
N=1,000 (Random sample)

DRUGS	(Sex) No. Male	%	(Sex) No. Female	%	Total No.	Total %
Narcotics	24	2.4	7	.7	31	3.1
Caffeine	426	42.6	347	34.7	773	77.3
Nicotine	171	17.1	138	13.8	309	30.9
SOLVENTS/ Inhalants	13	1.3	6	.6	19	1.9
Barbiturates	11	1.1	2	.2	13	1.3
Hallucinogens	14	1.4	5	.5	19	1.9
Marijuana	167	16.7	99	9.9	266	26.6
Cocaine	14	1.4	0	0	14	1.4
Anorexants	16	1.6	11	1.1	27	2.7
Sedatives/ Tranquilizers	10	1.0	5	.5	15	1.5
Betel Nut	157	15.7	87	8.7	244	24.4

PERCENT TOTAL
BY AGE

DRUG & ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS
N=1,000 (Random sample)

DRUGS	(Age) 12-15	%	(Age) 16-21	%	Total No.	Total %
Narcotics	6	.6	25	2.5	31	3.1
Caffeine	432	43.2	341	34.1	773	77.3
Nicotine	137	13.7	172	17.2	309	30.9
SOLVENTS/ Inhalants	7	.7	12	1.2	19	1.9
Barbiturates	4	.4	9	.9	13	1.3
Hallucinogens	5	.5	14	1.4	19	1.9
Marijuana	101	10.1	165	16.5	266	26.6
Cocaine	4	.4	1	.1	14	1.4
Anorexants	5	.5	22	2.2	27	2.7
Sedatives/ Tranquilizers	6	.6	9	.9	15	1.5
Betel Nut	123	12.3	121	12.1	244	24.4

PERCENT TOTAL
BY GRADE

DRUG & ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS
No. =1,000 (Random sample)

DRUGS	(Grade) 7-9	%	(Grade) 10-12	%	Total No.	Total %
Narcotics	9	.9	22	2.2	31	3.1
Caffeine	376	37.6	397	39.7	773	77.3
Nicotine	113	11.3	196	19.6	309	30.9
Solvents/ Inhalants	3	.3	16	1.6	19	1.9
Barbiturates	2	.2	11	1.1	13	1.3
Hallucinogens	6	.6	13	1.3	19	1.9
Marijuana	76	7.6	190	19.0	266	26.6
Cocaine	4	.4	10	1.0	14	1.4
Anorexants	7	.7	20	2.0	27	2.7
Sedatives/ Tranquilizers	5	.5	10	1.0	15	1.5
Betel Nut	108	10.8	136	13.6	244	24.4

PERCENT TOTAL
BY ETHNICITY
DRUG & ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS
N=1,000 (Random sample)

	Chamorro	%	Chamorro Statesider	%	Chamorro Filipino	%	Filipino	%	Statesider	%	Others	%	TOTAL %	TOTAL No.
Narcotics	17	1.7	3	.3	3	.3	1	.1	4	.4	3	.3	3.1	31
Caffeine	388	38.8	33	3.3	80	8.0	135	13.5	69	6.9	68	6.8	77.3	773
Nicotine	166	16.6	21	2.1	39	3.9	27	2.7	34	3.4	22	2.2	30.9	309
Solvents/ Inhalants	10	1.0	0	0	4	.4	3	.3	1	.1	1	.1	1.9	19
Barbiturates	5	.5	2	.2	1	.1	0	0	3	.3	2	.2	1.3	13
Hallucinogens	8	.8	2	.2	1	.1	2	.2	4	.4	2	.2	1.9	19
Marijuana	155	15.5	17	1.7	31	3.1	14	1.4	30	3.0	19	1.9	26.6	266
Cocaine	9	.9	4	.4	0	0	0	0	1	.1	0	0	1.4	14
Anorexants	8	.8	5	.5	7	.7	1	.1	4	.4	2	.2	2.7	27
Sedatives/ Tranquilizers	6	.6	2	.2	1	.1	2	.2	4	.4	0	0	1.5	15
Betel Nut	157	15.7	15	1.5	27	2.7	17	1.7	6	.6	22	2.2	24.4	244

PERCENT TOTAL
BY VILLAGE
DRUG AND ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS
N= 1000 (RANDOM SAMPLE)

Villages	Narcotics		Caffeine		Nicotine		Solvents/ Inhalants		Barbiturates		Hallucinogens		Marijuana		Cocaine		Anorexants		Sedatives/ Tranquilizers		Betel Nut	
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
1. Agana	0	0	13	1.3	5	.5	1	.1	0	0	1	.1	3	.3	0	0	1	.1	1	.1	0	0
2. Agana Hgts.	0	0	9	.9	8	.8	1	.1	0	0	0	0	3	.3	0	0	0	0	0	0	2	.2
3. Agat	2	.2	36	3.6	17	1.7	2	.2	1	.1	1	.1	15	1.5	2	.2	3	.3	4	.4	14	1.4
4. Asan	0	0	7	.7	4	.4	0	0	0	0	0	0	3	.3	0	0	0	0	1	.1	3	.3
5. Barrigada	0	0	50	5	12	1.2	0	0	1	.1	0	0	15	1.5	1	.1	3	.3	1	.1	15	1.5
6. Chalan Pago/ Ordot	2	.2	28	2.8	9	.9	0	0	0	0	0	0	14	1.4	2	.2	0	0	0	0	5	.5
7. Dededo	11	1.1	173	17.3	85	8.5	6	.6	5	.5	12	1.2	58	5.8	3	.3	8	.8	0	0	52	5.2
8. Inarajana	1	.1	21	2.1	8	.8	0	0	0	0	0	0	11	1.1	2	.2	0	0	0	0	9	.9
9. Maina	0	0	0	0	1	.1	0	0	0	0	0	0	1	.1	0	0	0	0	0	0	0	0
10. Mangilao	0	0	33	3.3	13	1.3	0	0	1	.1	0	0	13	1.3	0	0	1	.1	0	0	10	0
11. Merizo	0	0	13	1.8	6	.6	0	0	0	0	0	0	5	.5	0	0	0	0	0	0	16	1.6
12. M/T/M **	1	.1	61	6.1	24	2.4	3	.3	0	0	1	.1	24	2.4	1	.1	2	.2	3	.3	19	1.9
13. Piti	1	.1	22	2.2	6	.6	2	.2	0	0	1	.1	9	.9	1	.1	1	.1	2	.2	9	.9
14. Santa Rita	0	0	23	2.3	6	.6	1	.1	1	.1	0	0	7	.7	0	0	0	0	1	.1	7	.7
15. Sinajana	0	0	28	2.8	13	1.3	0	0	0	0	1	.1	8	.8	0	0	0	0	0	0	3	.3
16. Talofofo	0	0	35	3.5	10	1.0	1	.1	0	0	0	0	6	.6	0	0	1	.1	0	0	15	1.5

** MONGMONG/TOTO/MAITE

PERCENT TOTAL BY VILLAGE
DRUG AND ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS
N= 1000 (RANDOM SAMPLE)

Villages	Narcotics		Caffeine		Nicotine		Solvents/ Inhalants		Barbiturates		Hallucinogens		Marijuana		Cocaine		Anorexants		Sedatives/ Tranquilizers		Betel Nut	
	no.	%	no.	%	no	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
17. Tamuning	3	.3	58	5.8	20	2.0	0	0	1	.1	0	0	10	1.0	0	0	1	.1	1	.1	10	1.0
18. Tumon/ Harmon	1	.1	23	2.3	5	.5	0	0	1	.1	0	0	7	.7	0	0	0	0	0	0	4	.4
19. Umatac	0	0	1	.1	1	.1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20. Yigo	5	.5	87	8.7	43	4.3	0	0	1	.1	2	.2	37	3.7	0	0	5	.5	1	.1	19	1.9
21. Yona	2	.2	47	4.7	13	1.3	0	0	1	.1	0	0	17	1.7	2	.2	1	.1	0	0	32	3.2
	***																					
TOTAL:	31	3.1	773	77.3	309	30.9	19	1.9	13	1.3	19	1.9	266	26.6	14	1.4	27	2.7	15	1.5	244	24.4

*** 2 CASES OF NARCOTICS USE DID NOT INDICATE A VILLAGE OF RESIDENCE

PERCENT TOTAL
BY VILLAGE
DRUG AND ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS
N= 1000 (RANDOM SAMPLE)

Villages	Narcotics		Caffeine		Nicotine		Solvents/ Inhalants		Barbiturates		Hallucinogens		Marijuana		Cocaine		Anorexants		Sedatives/ Tranquilizers		Betel Nut	
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
1. Agana	0	0	13	1.3	5	.5	1	.1	0	0	1	.1	3	.3	0	0	1	.1	1	.1	0	0
2. Agana Hgts.	0	0	9	.9	8	.8	1	.1	0	0	0	0	3	.3	0	0	0	0	0	0	2	.2
3. Agat	2	.2	36	3.6	17	1.7	2	.2	1	.1	1	.1	15	1.5	2	.2	3	.3	4	.4	14	1.4
4. Asan	0	0	7	.7	4	.4	0	0	0	0	0	0	3	.3	0	0	0	0	1	.1	3	.3
5. Barrigada	0	0	50	5	12	1.2	0	0	1	.1	0	0	15	1.5	1	.1	3	.3	1	.1	15	1.5
6. Chalan Pago/ Ordot	2	.2	28	2.8	9	.9	0	0	0	0	0	0	14	1.4	2	.2	0	0	0	0	5	.5
7. Dededo	11	1.1	173	17.3	85	8.5	6	.6	5	.5	12	1.2	58	5.8	3	.3	8	.8	0	0	52	5.2
8. Inarajana	1	.1	21	2.1	8	.8	0	0	0	0	0	0	11	1.1	2	.2	0	0	0	0	9	.9
9. Maina	0	0	0	0	1	.1	0	0	0	0	0	0	1	.1	0	0	0	0	0	0	0	0
10. Mangilao	0	0	33	3.3	13	1.3	0	0	1	.1	0	0	13	1.3	0	0	1	.1	0	0	10	0
11. Merizo	0	0	13	1.8	6	.6	0	0	0	0	0	0	5	.5	0	0	0	0	0	0	16	1.6
12. M/T/M **	1	.1	61	6.1	24	2.4	3	.3	0	0	1	.1	24	2.4	1	.1	2	.2	3	.3	19	1.9
13. Piti	1	.1	22	2.2	6	.6	2	.2	0	0	1	.1	9	.9	1	.1	1	.1	2	.2	9	.9
14. Santa Rita	0	0	23	2.3	6	.6	1	.1	1	.1	0	0	7	.7	0	0	0	0	1	.1	7	.7
15. Sinajana	0	0	28	2.8	13	1.3	0	0	0	0	1	.1	8	.8	0	0	0	0	0	0	3	.3
16. Talofofo	0	0	35	3.5	10	1.0	1	.1	0	0	0	0	6	.6	0	0	1	.1	0	0	15	1.5

** MONGMONG/TOTO/MAITE

PERCENT TOTAL BY VILLAGE
DRUG AND ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS
N= 1000 (RANDOM SAMPLE)

Villages	Narcotics		Caffeine		Nicotine		Solvents/ Inhalants		Barbiturates		Hallucinogens		Marijuana		Cocaine		Anorexants		Sedatives/ Tranquilizers		Betel Nut	
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
17. Tamuning	3	.3	58	5.8	20	2.0	0	0	1	.1	0	0	10	1.0	0	0	1	.1	1	.1	10	1.0
18. Tumon/ Harmon	1	.1	23	2.3	5	.5	0	0	1	.1	0	0	7	.7	0	0	0	0	0	0	4	.4
19. Umatac	0	0	1	.1	1	.1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20. Yigo	5	.5	87	8.7	43	4.3	0	0	1	.1	2	.2	37	3.7	0	0	5	.5	1	.1	19	1.9
21. Yona	2	.2	47	4.7	13	1.3	0	0	1	.1	0	0	17	1.7	2	.2	1	.1	0	0	32	3.2
	***																					
TOTAL:	31	3.1	773	77.3	309	30.9	19	1.9	13	1.3	19	1.9	266	26.6	14	1.4	27	2.7	15	1.5	244	24.4

*** 2 CASES OF NARCOTICS USE DID NOT INDICATE A VILLAGE OF RESIDENCE

Comparative Drug Usage Among Schools
Drug & Alcohol Survey
Secondary Public Schools
N = 1,000 (Random Sample)

SCHOOL	DRUG - - -	NARCOTICS				CAFFEINE				NICOTINE				INHALANTS/ SOLVENTS				BARBITURATES				HALLU-CINOGENS				MARIJUANA				COCAINE				ANOREXANTS				TRANQUILIZERS/ SEDATIVES				BE
	FREQUENCY RATE* (%) - - -	O	D	W	M	O	D	W	M	O	D	W	M	O	D	W	M	O	D	W	M	O	D	W	M	O	D	W	M	O	D	W	M	O	D	W	M	O	D	W	M	O
GEORGE WASHINGTON SENIOR HIGH		3	-	-	1	10	15	50	6	11	26	2	1	3	-	-	1	3	-	-	-	1	-	-	1	20	10	5	7	2	-	-	-	2	2	-	-	2	-	1	1	11
GUAM COMMUNITY COLLEGE (VOC/TECH)		3	-	-	-	6	34	20	5	7	25	5	-	-	-	-	-	-	-	-	-	-	-	-	-	24	8	5	1	4	-	-	-	4	-	-	-	2	-	-	-	2
JOHN F. KENNEDY SENIOR HIGH		5	1	1	-	30	30	19	12	12	25	3	3	4	-	1	-	3	-	-	-	5	-	-	1	21	7	4	6	9	2	2	1	5	1	-	-	-	-	-	1	11
AGUEDA JOHNSTON JUNIOR HIGH		1	-	-	-	13	37	10	-	4	5	3	3	2	-	-	-	-	-	-	-	-	-	-	-	2	5	4	-	3	6	2	-	-	-	-	-	2	-	-	-	3
DEDEDO JUNIOR HIGH		2	-	-	-	13	51	18	-	6	15	2	-	2	-	-	-	-	-	-	-	2	-	-	-	8	6	3	2	-	-	-	-	1	-	-	1	-	-	-	-	12
INARAJAN JUNIOR HIGH		1	-	-	-	23	28	9	5	4	8	-	3	-	-	-	-	-	-	-	-	-	-	-	-	5	5	3	-	-	-	-	-	-	-	1	-	-	1	-	-	11
SIMON SANCHEZ JUNIOR HIGH		4	-	-	-	16	52	11	7	22	8	1	-	-	-	-	-	1	-	-	-	1	-	-	1	6	7	4	-	-	-	-	-	2	-	-	-	-	1	-	-	10
LUIS P. UNTALAN JUNIOR HIGH		-	-	-	-	13	49	20	3	9	15	3	3	-	-	-	-	1	-	-	-	1	-	-	-	4	8	3	1	1	-	-	-	3	-	-	-	1	-	-	-	11

* O --- ONCE
D --- DAILY
W --- WEEKLY
M --- MONTHLY

COMPARATIVE DRUG USAGE AMONG SCHOOLS
DRUG & ALCOHOL SURVEY
SECONDARY PUBLIC SCHOOLS
N=1,000 (RANDOM SAMPLE)
N=490 (SR. HIGH SCHOOLS); N=510 (JR. HIGH SCHOOLS)

SCHOOL	DRUG	NARCOTICS	CAFFEINE	NICOTINE	INHALANTS/ SOLVENTS	BARBITU-RATES	HALLUCIN-OGENS	MARIJUANA	COCAINE	ANOREXANTS	TRANQUILIZERS SEDATIVES	BE NU
		TOTAL PREVALENCE %										
George Washington Sr. High		4	80	39	4	3	2	41	2	3	3	3
Guam Community College (VOC/TECH)		3	65	37	---	---	---	38	4	4	2	1
John F. Kennedy Sr. High		6	91	43	5	3	5	37	2	5	1	3
Agueda Johnston Jr. High		1	60	15	2	---	---	11	1	---	2	1
Dededo Jr. High		3	86	23	1	---	2	19	---	2	---	2
Inarajan Jr. High		1	64	14	---	---	---	13	---	1	1	2
Simon Sanchez Jr. High		4	86	31	---	1	2	17	---	2	1	2
Luis P. Untalan Jr. High		---	84	29	---	1	1	15	1	3	1	2
Total Prevalence (%) Jr. High Schools		2	74	22	1	.5	1	15	.5	1	1	1
Total Prevalence (%) Sr. High Schools		4	81	40	3	2	3	39	2	4	2	1
Total Prevalence (%) All Secondary Schools Combined		3	77	31	2	1	2	27	1	3	2	2

COMPARATIVE FINDINGS
LOCAL AND NATIONAL
DRUG USE SURVEYS

DRUG	1980 MHSAA's Local Survey (Senior High Schools) Prevalence (%)	1980 DPS' Local Survey (Senior High Schools) Prevalence (%)	1978 NIDA's National Survey (High School Seniors Only) Prevalence (%)	1974 Chung's Local Survey (Senior High Schools) And 9th Graders Prevalence (%)
NARCOTICS	4	4	2	7
CAFFEINE	81	-	-	-
NICOTINE	40	-	75	59
INHALANTS/SOLVENTS	3	-	11	-
BARBITURATES	2	-	16	12
HALLUCINOGENS	3	-	14	16
MARIJUANA	39	48	59	40
COCAINE	2	-	13	11
ANOREXANTS	4	-	23	11
TRANQUILIZERS/SEDATIVES	2	-	17	4
BETEL NUT	28	-	-	49

DRUG & ALCOHOL SURVEY
PUBLIC SECONDARY SCHOOLS
N=1,000 (RANDOM SAMPLE)

XI

SCHOOL	Do you think there's an alcohol problem on Guam?			Do you feel you have a drinking problem?			Do you know someone who has a drinking problem?			Do you feel anyone in your family has a drinking problem		
	YES	NO	NO ANS	YES	NO	NO ANS	YES	NO	NO ANS	YES	NO	NO ANS
GEORGE WASHINGTON SENIOR HIGH SCHOOL	156	38	6	3	191	6	129	66	5	41	156	3
JOHN F. KENNEDY SENIOR HIGH SCHOOL	144	41	5	8	180	2	92	96	2	72	117	1
GUAM COMMUNITY COLLEGE (VOC / TECH)	76	24	0	3	95	2	64	36	0	31	69	0
AGUEDA JOHNSTON JUNIOR HIGH SCHOOL	105	19	1	2	119	4	73	50	2	39	85	1
DEDEDO JUNIOR HIGH SCHOOL	94	29	2	1	119	5	48	74	3	30	93	2
INARAJAN JUNIOR HIGH	73	6	1	2	77	1	36	42	2	17	63	0
SIMON SANCHEZ JUNIOR HIGH	82	15	3	4	93	3	54	44	2	36	63	1
UNTALAN JUNIOR HIGH	56	15	9	2	76	2	42	30	8	15	59	6
TOTAL NO:	786	187	27	25	950	25	538	438	24	281	705	14
TOTAL %	78.6	18.7	2.7	2.5	95	2.5	53.8	43.8	2.4	28.1	70.5	1.4

DRUG AND ALCOHOL SURVEY

In accordance with MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY's philosophy, goal, and mission, Research and Evaluation section requires the need to conduct an actual survey of Guam's socio/cultural influences contributing to the island's underlying problems. This survey is primarily a statistical report used as a tool in the construction of R&E's needs assessment report. This report is to determine the nature of our problem, the level of our island needs, and the nature of action which Mental Health and Substance Abuse Agency will pursue. THE SOURCE OF INFORMATION ACQUIRED WILL REMAIN CONFIDENTIAL.

PLEASE CHECK OR ANSWER THE FOLLOWING: 10/31 LAflague

1. Village you reside in: _____ 2. Age: _____ Sex: _____
3. What is your grade level? 7 ___ 8 ___ 9 ___ 10 ___ 11 ___ 12 ___
4. Do you have a part-time job? Yes ▱ No ▱
5. Number of family members in household: _____
6. Ethnic background: Chamorro ___ Chamorro/Filipino ___ Filipino ___ Statesider ___
   Chamorro/Statesider ___ Other(s) _____
7. Do you think there is an alcohol problem on Guam? Yes ▱ No ▱
8. Do you drink alcohol (Beer, mixed liquor, etc.) Yes ▱ No ▱
9. If so, how many cans of beer or jiggers of liquor do you consume per day at an average?
   2 cans or jiggers and under _____ 2 cans or jiggers and over _____
10. A. Do you feel you have a drinking problem? Yes ▱ No ▱
    B. Do you know someone who has a drinking problem? Yes ▱ No ▱
    C. Do you feel anyone in your family has a drinking problem? Yes ▱ No ▱
    How many? _____
11. At what age did you first start drinking? _____
12. Do you experience restlessness and discomfort from the absence of liquor? Yes ▱ No ▱
13. A. If you had a drinking problem, from whom would you seek help? Doctor ▱ Friend ▱
    Brother/Sister ▱ Relative ▱ Neighbor ▱ Commissioner ▱ Priest ▱
    Parent ▱ Other (Specify) _____
    B. Do you have any close friends you can count on when you need help? Yes ▱ No ▱
    Uncertain ▱ Don't know ▱ No answer ▱
14. Do you have any relatives you can count on when you need help? Yes ▱ No ▱
    Don't know ▱ No answer ▱
15. Would you say you've ever been troubled by "cold sweats?" Often ▱ Sometimes ▱
    Never ▱ Don't know ▱ No Answer ▱
16. How does the future look to you? Excellent ▱ Good ▱ Fair ▱ Poor ▱
    Bad ▱ Don't know ▱ No Answer ▱
17. Have you ever used drugs? Please answer and check the following:

DRUGS BY CATEGORY/TYPES	NO	AGE STARTED	AGE STOPPED	FREQUENCY RATE: ONCE HOW MANY	ONCE UNIT AMT.	DAILY HOW MANY	DAILY UNIT AMT.	WEEKLY HOW MANY	WEEKLY UNIT AMT.	MONTHLY HOW MANY	MONTHLY UNIT AMT.
NARCOTICS:											
OPIUM											
MORPHINE											
HEROIN											
METHADONE											
OTHERS:											
CAFFEINE:											
COFFEE											
COCA COLA (PEPSI-COLA)											
_											

DRUGS BY CATEGORY/TYPES	NO	AGE STARTED	AGE STOPPED	FREQUENCY RATE: ONCE HOW MANY	ONCE UNIT AMT.	DAILY HOW MANY	DAILY UNIT AMT.	WEEKLY HOW MANY	WEEKLY UNIT AMT.	MONTHLY HOW MANY	MONTHLY UNIT AMT.
CAFFEINE:											
TEA											
CHOCOLATE											
OTHERS											
NICOTINE:											
TOBACCO/PIPES, ETC.											
BRAND											
CIGARETTES											
NO. OF PACKS											
CIGARS											
OTHERS											
INHALANTS AND SOLVENTS:											
ETHER											
CHLOROFORM											
GLUE											
LAUGHING GAS											
PAINT											
PETROLEUM											
BENZEDRINE (NASAL SPRAY)											
BARBITURATES:											
(1) BARBITAL											
BARBS											
REDS											
YELLOW JACKETS											
BLUE HEAVENS											
PURPLE HEARTS											
RAINBOWS (CHRISTMAS TREE)											
TOOTIES											
OTHERS											
(2) PHENOBARBITAL											
(3) SECOBARBITAL											
HALLUCINOGENS:											
PEYOTE (MESCAL BUTTON)											
FLY AGARIC (MUSHROOMS)											
NUTMEG (MYDISTICA FRAGRANS)											
YUREMA (DMT)											
MORNING GLORY											
LSD-25											
BZ											
PHP											
ANGEL DUST (PCP)											
OTHERS											

DRUGS BY CATEGORY/TYPES	NO	AGE STARTED	AGE STOPPED	FREQUENCY RATE							
				ONCE		DAILY		WEEKLY		MONTHLY	
				HOW MANY	UNIT AMT.	HOW MANY	UNIT AMT.	HOW MANY	UNIT AMT.	HOW MANY	UNIT AMT.
MARIJUANA:											
WEED (CANNABIS SATIVA)											
BHANG											
JOINTS											
ROACH											
HASHISH (CHARAS)											
ACAPULCO GOLD											
THAI/STICKS											
RODS											
THC											
OTHERS:											
COCAINE:											
COKE											
SNOW											
CANDY											
CHARLIE											
BIG "C"											
OTHERS:											
ANOREXANTS:											
AMPHETAMINES											
DIET PILLS											
DEXAMYL											
PEP PILLS											
SPEEDBALL (COMB. H/A)											
SPEED (METHAMPHETAMINE)											
BENZEDRINE											
DEXEDRINE											
TRANQUILIZERS/SEDATIVES:											
VALIUM											
LIBRIUM											
QUAALUDE											
MEPROBAMATE											
EQUANIL											
MILTON											
VALMID											
CHLORAL HYDRATE											
NOCTEC											
SOMNOS											
PARALDEHYDE											
DORIDEN											
NOLUDAR											
BETEL NUT (MATURE NUT)											
NUT ALONE											

DRUGS BY CATEGORY/TYPES	NO	AGE STARTED	AGE STOPPED	FREQUENCY RATE							
				ONCE		DAILY		WEEKLY		MONTHLY	
				HOW MANY	UNIT AMT.	HOW MANY	UNIT AMT.	HOW MANY	UNIT AMT.	HOW MANY	UNIT AMT.
NUT/LEAF											
NUT/TOBACCO											
NUT/LIME											
NUT/LIME/LEAF											
NUT/LIME/LEAF/TOBACCO											
BETEL NUT (GREEN YOUNG NUT WITH HUSK)											
NUT ALONE											
NUT/LEAF											
NUT/LEAF/TOBACCO											
NUT/LIME/LEAF											
NUT/LIME/LEAF/TOBACCO											
DREXINE:											
LICTOHINE											
ZYMORAX											

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding is entered into on this 13th day of March, 1980, by and between the Mental Health and Substance Abuse, hereinafter known as MHSAA, and the Guam Health Planning and Development Agency, hereinafter known as GHPDA. This memorandum is consummated to: promote the attainment of optimal mental health, alcohol and drug abuse services for the residents of the Territory of Guam; coordinate and minimize the duplication of efforts in data analysis and planning; and, foster a spirit of cooperation between the parties hereto.

This memorandum is entered into pursuant to Title XV of the Public Health Service Act, as amended by the Health Planning and Resources Development Amendments of 1979 (Public Law 96-79), and Guam Executive Order 78-3 which established the MHSAA.

I. Organizational Relationships

A. The parties to this memorandum agree not to engage in actions which may nullify any provisions of this agreement without 30 days written notice.

B. To encourage the coordination of planning activities, MHSAA and GHPDA will exchange data, pertinent planning documents, newsletters, or other publications which may provide information mutually useful and helpful to each party.

II. Planning and Policy Coordination

A. MHSAA shall recognize the responsibilities and requirements of GHPDA in the development of the Guam Health Plan (GHP) and Annual Implementation Plan (AIP) in accordance with the provisions of Title XV of the Public Health Service Act, particularly in relation to mental health, alcohol, and drug abuse programs.

B. GHPDA shall recognize MHSAA as the primary planning agency for mental health, alcohol, and drug abuse treatment and prevention activities in the Territory of Guam as provided in Executive Order 78-3 and P.L. 92-255,91-616 and subsequent amendments thereto.

C. To assure relevant maximum community input in the revision of the Guam Health Plan, MHSAA will supply names of persons who are members of its advisory council to be considered for inclusion on a plan development ask force of GHPDA.

D. As a part of the required public hearing on the completed mental health, alcohol and drug abuse portion of the GHP, GHPDA agrees to submit the proposed plan to MHSAA's Advisory Council for review and comment.

E. GHPDA agrees to consider and utilize where appropriate the state/territorial plan developed by MHSAA as required in Executive Order 78-3 and P.L. 92-255 in the development/revision of the GHP and AIP and in project funding reviews.

F. GHPDA shall assure MHSAA the opportunity for input in the revision of the GHP and agrees to submit the proposed revision to MHSAA for review and comment by its Advisory Council at least 60 days prior to final adoption.

G. MHSAA and GHPDA shall take all necessary precautions to ensure that no unilateral actions are made on plans or policies which may have the effect of altering the functions or plans of the other, and shall assure that proper notification and opportunity for consultation are given pending actions which may have such an effect.

III. Review and Comment Coordination

A. GHPDA will notify MHSAA of all mental health, alcohol, or drug abuse project applications within 10 days of receiving an application.

B. GHPDA will solicit comments from MHSAA concerning these applications. Results of GHPDA review of these applications will be shared MHSAA within 10 days after completion of the review process.

C. Results of review of these applications will be shared with MHSAA within 10 days afrer completion of the review process.

IV. Mutual Support and Technical Assistance

A. Resources permitting, MHSAA and GHPDA agree to provide mutual technical assistance through information sharing and staff support for the development of those portions of the GHP and AIP related to mental health, alcohol and drug abuse activities.

B. GHPDA and MHSAA agree to coordinate planning efforts prior to GHFDA's formalization of plan documents.

C. GHPDA and MHSAA agree to coordinate in all activities related to planning for mental health, alcohol and drug abuse including the development of methodologies, determining plan content, participation in related meetings, and other activities which may be of mutual interest and benefit.

V. Data and Information Sharing

A. MHSAA and GHPDA agree to coordinate their data and information systems in ways which minimize duplications and make maximum use of the resources and expertise in each agency, and to share available data and information upon request according to mutually agreed upon protocols for access and utilization.

B. All parties shall adhere to the confidentiality and security regulations and guidelines for DHEW in handling data.

VI. This Agreement may be amended by mutual consent of the parties herein, and its terms are subject to modification in accordance with amendments to the laws and regulations governing their activities and instructions issued by the Federal and Territorial governments. This agreement is not intended to preclude contracts and agreements among the parties hereto for the performance of services not covered by this agreement.

IN WITNESS WHEREOF, we the undersigned, duly authorized representatives of the Guam Health Planning and Development Agency and the Mental Health and Substance Abuse Agency do hereby enter into this Memorandum of Understanding.

GUAM HEALTH PLANNING AND DEVELOPMENT AGENCY

By: Cerila Matias Kapadas
CERILA MATIAS KAPADAS
Administrator

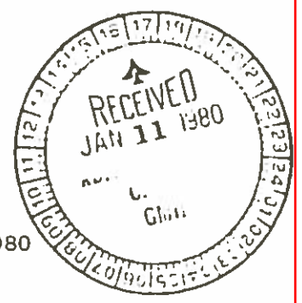
Date: 3-13-80

MENTAL HEALTH AND SUBSTANCE ABUSE AGENCY

By: Peter A. San Nicolas
PETER A. SAN NICOLAS
Administrator

Date: 3-17-80

GOVERNMENT OF GUAM
AGANA, GUAM 96910



January 10, 1980

Memorandum

To: Administrator, Guam Memorial Hospital

From: Administrator, Mental Health and Substance Abuse Agency

Subject: NIDA Statewide Services Grant Sub-Contractor

We have received the "Notice of Grant Award" for the FY 1980 Statewide Services Grant as Prime Contractor for provision of Methadone Maintenance Services. The number of slots involved remain at Twenty (20) at the same budget level as the FY 1979 Statewide Services Contract. It should be noted that the federal share in FY 1980 is 70% rather than 75% as in FY 1979. Therefore, GMH is eligible for $31,850.00 federal monies which must be matched by $13,650.00 non-federal monies. The $31,850.00 federal share is the maximum amount the Agency may become liable for under this agreement. The award is based upon provision of services as described in the September 7, 1978 proposal of the Guam Community Mental Health Center, without substantial changes.

We expect release of the funds to our authority soon. Before quarterly payments under this Grant can be made, we require your signed agreement to perform as Sub-Contractor under this Grant. In addition to the provisions of the September 7, 1978 proposal and the Monthly Expenditure Reports, GMH must agree to abide by all grant requirements and cooperate with all Prime Contractor responsibilities as described and/or referenced in Part 1 of 2 of the NIDA SWSG Proposal (RFP 271-78-2510) dated August, 1979 (attached) and NIDA "Standard Terms and Conditions for Statewide Services Grant Program" (attached) and other DHEW regulations as relevant. Non-compliance with these provisions and conditions are grounds for termination of this Sub-Contract.

Your signature or that of another GMH officer with contracting authority in the space provided below and return of this letter will constitute your agreement to act as Sub-Contractor under this Grant, as described.

Peter A. San Nicolas
PETER A. SAN NICOLAS

Enclosures: Proposal (RFP 271-78-2510)
Terms and Conditions

cc: Chairman, Board of Trustees

The Guam Memorial Hospital agrees to be Sub-Contractor under the National Institute on Drug Abuse Statewide Services Grant to Guam Mental Health and Substance Abuse Agency and accepts the provisions and conditions described and referenced above.

Guam Memorial Hospital | Director, Community Mental Health Center | Jan 11 1980
Guam Memorial Hospital | Title | Date

APPENDIX G-ITEM 1

FACT SHEET--WOMEN & ALCOHOL

Drinking Practices of American Women

* The proportion of adult women who drink has been increasing steadily since World War II, and the results of recent surveys indicate that this is continuing About 47 percent of adult women now drink once a month or more.

* However, men are nearly twice as likely to be moderate drinkers and three times as likely to be heavy drinkers in comparison with women.

* The highest proportion of heavier drinkers occurred among men aged 18 to 20 and 35 to 39. Women aged 21 to 29 had the highest proportion of heavier drinkers.

* There is a reported increase in the number of women exhibiting alcohol problems. Ten years ago, one out of every six persons with an alcohol problem was a woman, now it is one out of three. In a 1974 survey, Alcoholics Anonymous found that one out of every three new members in the last three years was a woman, and that women account for 28 percent of AA's total membership.

* Preliminary findings from the 1974 national survey of junior and senior high-school students indicate that among seventh graders, 63 percent of boys and 54 percent of girls have had a drink . . . the proportion of teenage drinkers increased with grade to 93 percent of twelfth-grade boys and 87 percent of twelfth-grade girls.

* The use of alcohol among girls has approached that of boys, though the proportion of girls who drink at least every week is smaller. There has been an increase in the drinking frequency of all students at each grade level.

Why Women Drink

* In a 1957 comparison study of male and female alcohol outpatients by Edith Lisansky, she discovered that male patients began drinking at an earlier age than women and came to the clinic with a longer history of problem drinking. All the women studied attributed the onset of heavy drinking to a specific life crisis, such as a parent's death, divorce, or post partum depression. Only half the men studied reported a life crisis as a precipitating factor.

* Another researcher, Joan Curlee (1970) observed the same characteristic in her subjects. She states that female drinking is often precipitated by a "middle age identity crisis," such as the death of a husband, divorce or menopause.

* Barry Kinsey, in 1966, found that marital disruption and instability seem to be precipitating factors in female alcoholism. Kinsey's study shows a high rate of broken marriage and divorce, and marital relationships were characterized by jealousy, brutality and chronic conflict.

Psychological Aspects of Female Alcoholism

* Results of two surveys, one in 1949 and one in 1968 show that alcoholic females have more disturbed family backgrounds, including alcoholism and psychiatric disorders, than men. The alcoholic females also showed a higher incidence of depressive symptoms, particularly suicidal thoughts and delusions. These women were, however, being treated on an in-patient basis.

* A research project in 1966 indicated that a large proportion of female patients had dominant mothers and alcoholic fathers. And alcoholic women have a higher frequency of alcoholism among relatives than do alcoholic men.

* Sharon Wilsnak, in a 1973 study reported that women drink to feel more feminine. The female subjects said they felt warm, loving, considerate, expressive, open, affectionate, sexy and feminine when drinking.

* Wilsnak gives us this "Profile of an Alcoholic Female." The potential female alcoholic experiences chronic doubts about her adequacy as a woman. These doubts arise in part from inadequate feminine identification on an unconscious level, and they may be enhanced by acute threats to her sense of feminine adequacy, such as marital problems, a miscarriage, or children leaving home. The potential alcoholic does not consciously reject her identity as a woman; rather she consciously values traditional female roles. She may manage to cope with her fragile sense of feminine adequacy for a number of years, but when some new threat severely exacerbates her self doubts, she turns to alcohol in an attempt to gain artificial feelings of womanliness.

* Dr. Morris Chafetz (1974) "However, in view of the recent significant increase in female problem drinkers concurrent with the women's liberation movement, it (heavy drinking) apparently may also result from a dissatisfaction or confusion about self-identity brought on by a new consciousness and pressure for change. Just as youth drink to achieve a demonstrable measure of adulthood, it may be that women who are confused about their current role are drinking heavily as a measure to indicate they have achieved equal status with men."

Attitudes of Society

* Chafetz (1974) "Many women developing alcohol problems have the opportunity to do their drinking in isolation at home during the day, and they are able to progress a long way down the road to chronic alcoholism without the knowledge of either family or friends. Further, the woman who does become alcoholic is forced by society to carry a double burden. She is tagged with the moral stigma of alcoholism, and she is doubly stigmatized because it has always been considered 'unladylike' for a woman to be drunk...As a result, family and friends continue to help conceal the woman's drinking problems. This delays recognition and treatment of her illness."

*With the development of occupational alcoholism programs, the working woman may have a better chance of seeking help for her alcoholism than the housewife. On the job, her problem is more visible to those around her. If she is lucky enough to work for a company with an employee alcoholism program, she has a greater chance of detecting her problem in the earlier phases of her illness.

*Vera Lindbeck (1972) tells us that studies indicate that the alcoholic wife receives less understanding and acceptance than the alcoholic husband. She adds, "Among therapists as well as the lay public, the nonalcoholic spouse of the drinking male is suspected of contributing to her husband's drinking, but the nonalcoholic spouse of the alcoholic woman is more likely to be regarded as a deprived person, one who receives more sympathy than censure."

*The alcoholic woman has a higher divorce rate than the alcoholic man. Lindbeck believes that the above-mentioned lack of understanding and societal censure contributes to this divorce rate.

*Shuckit (1972) "The scorn which is felt for the drunk male is felt with even greater intensity for the drunk woman. Social custom once denied women access to public drinking places, with a few special exceptions. Bar maids and "female companions" were there for the male patrons' pleasure. Any woman seen alone in a bar was assumed to be a prostitute, or at least a woman looking for a bed partner. By extension, any woman who was drunk, or even drinking, might have been perceived in the same context."

*Chafetz (1974) "Once women establish a heavy drinking pattern, they generally develop alcoholism much more rapidly than men. Evidently, it appears that greater condemnation, fear of being a social outcast, and feelings of guilt contribute both to the concealment of drinking and its telescoped development in women."

Effects of Maternal Alcoholism on Children

*Reports by several investigators (Jones/Smith 1973, and others) strongly indicate that maternal alcoholism can cause serious aberrant fetal development, and infant addiction to alcohol.

*The fetal alcohol syndrome is manifested in shorter babies, low birth weight, underdeveloped jaw, small head, heart and limb abnormalities and low I.Q. Some researchers say this may be caused by a combination of the effects of the alcoholism and malnutrition of the mothers. Jones and Smith, however, say the fetal alcohol syndrome can be shown to be directly attributed to alcohol.

*In addition to tremors, irritability and other symptoms of alcohol withdrawal among babies born to alcoholic mothers, there is evidence of brain damage, and early stages of liver disease.

*Doctors who have been studying these problems agree that there is a high risk of deformity and retardation among children born to alcoholic mothers, but many factors may contribute to these conditions. Studies are continuing and on April 29, in Milwaukee, at a National Council on Alcoholism meeting, there will be a panel discussion on the subject by doctors from many parts of the nation who are studying this problem.

* Abramson (Georgetown University Hospital) says infants born to alcoholic mothers during 40 weeks of gestation become a true alcoholic person with physical withdrawal. There may be many more cases than we suspect, says Abramson, and he asks, "Is this baby a set-up for alcoholism when he or she begins to drink socially?"

* Most doctors do not, however, recommend abstaining from alcohol during pregnancy, since alcohol in small doses will relax both mother and fetus.

* An alcoholic mother will probably physically and emotionally abuse her children. Numerous studies have documented a relationship between parental alcoholism and emotional disturbance in the children. Neglected and abused children and juvenile delinquents frequently come from alcoholic families, and children of alcoholic parents have more neurotic symptoms and a greater tendency toward depression. Studies also show that these children of alcoholic parents have a greater tendency to be alcoholic themselves than the general population.

* There is evidence that heavy drinking by parents is a major factor in many cases of child abuse that come to the attention of authorities.

ALCOHOL & SEXUALITY

* Schuckit (1972) "Women who drink have loose morals, or so it is commonly believed. The popular image of the scarlet woman is a fiction--promiscuity is appropriate to only 5 percent of all women drinkers. Most of the other 95 percent complain of diminished interest in sex."

* Schuckit (1972) The aphrodisiac powers of alcohol are greatly magnified in the eyes of the public. There is scant evidence that sexual behavior exhibited while drinking is due solely to the powers of alcohol. Promiscuity while drinking may be a reflection of a sexual proclivity . . . which may come to the fore when societal inhibitions are diminished.

* Alcoholic women complain of general dissatisfaction with sexual contact, along with a high incidence of partial, if not complete, inability to achieve orgasm. Further complicating the picture is the high incidence of somatic complaints, such as pelvic pain.

* Concomitant with sexual dissatisfaction, the alcoholic woman's marriage is often a nightmare says Schuckit. She frequently marries a man many years her senior with whom she is incompatible. Often he is also an alcoholic person and physically abusive. She may blame her drinking on these interpersonal and sexual marital problems.

* Over 40 percent of alcoholic women suffer broken marriages, adds Shuckit. And many "express dissatisfaction with their husbands, who in 20 to 40 percent of the cases are themselves alcoholics."

* Paredes (1973) "A striking aspect in the life of the alcoholic is the subordination of sexual gratification to the use of alcohol."

* Paredes (1973) "Many women married to alcoholic persons admit lack of interest in sexual intercourse or actual dislike of it. Frigidity is common; these women complain about insufficient foreplay and inadequate verbal expressions of affection."

References

Alcohol and Health - New Knowledge, DHEW Second Special Report to Congress (July 1974).

Chafetz, M., Press conference, New York, N.Y., October 1974.

Colen, B.D., The Infant Alcoholics, Washington Post, February 2, 1975.

Fraser, J., The Female Alcoholic, Addictions, 20(3):64-80, 1973.

Jones, K.L.; Smith, D.W.; Ulleland, C.N.; and Streissguth, A.P., Pattern of Malformation in Offspring of Chronic Alcoholic Mothers, Lancet I, 1267-71, June 9, 1973.

Kinsey, B.A., The Female Alcoholic: A Social Psychological Study, Springfield, Ill.: Charles C. Thomas, 1966.

Lindbeck, F.L., The Woman Alcoholic: A Review of the Literature, Int J Addictions, 7(3):567-580, 1972.

Paredes, A., Marital Sexual Factors in Alcoholism, Medical Aspects of Human Sexuality, April 1973.

Sanchez-Dirks, R., Women and Alcoholism, Food & Drug Administration Speech, January 1975.

Schuckit, M. The Alcoholic Woman: A Literature Review, Psychiatry Med. 3:37-40, 1972.

Wilsnak, S.C., Femininity by the Bottle, Psychology Today, 6(1):39-43, 1973.

National Clearinghouse for Alcohol Information
February 1975

Clinic Management By Exception Calculations for Guam's Programs
Prepared by: Mike Powell
May 7, 1980

Program	In Treatment Over 120 Days	Completed Treatment	Drug Free	Productive	Arrest Free During Treatment
CMHC [1]	65%	29%	55%	52%	81%
CSS [2]	50% *	25%	100%	50%	100%

* Two individuals have been in the CSS program for 8 months, are continuing to make progress and have been counted with those discharges in treatment over 120 days due to the small numbers involved.

[1] CMHC Methadone "Maintenance/Outpatient" Modality Environment

[2] "Drug Free/Residential" Modality/Environment

Norms

Modality/Environment	In Treatment over 120 days	Completed Treatment	Drug Free	Productive	Arrest Free During Treatment
Drug Free/Outpatient	44%	31%	40%	61%	89%
Drug Free/Residential	27	14	73	32	96
Maintenance/Outpatient	65	25	52	45	75

The criteria at or below which a score is an exception, fifth percentile, are indicated below:

Exception Criteria

Modality/Environment	In Treatment over 120 days	Completed Treatment	Drug Free	Productive	Arrest Free During Treatment
Drug Free Outpatient	12%	5%	11%	30%	72%
Drug Free Residential	4	0	29	4	84
Maintenance Outpatient	34	2	19	24	45

Catholic Social Services
CODAP Statistics
September 1, 1979-March 31, 1980

Total Admissions	7
Sex	
Male	7
Female	0
Age at Admission	All between 22-29 years old
Marital Status at Admission	
Never Married	5
Divorced	1
Separated	1
Ethnic Group	
White	4
Pacific Islander	2
Black	1
Employment Status at Admission	
Unemployed (No effort 30 days)	7
Highest Grade Completed at Admission	
Did not graduate High School	4
Graduated High School	3
In Educational or Skill Development Program	
Yes	3
No	4
Number of Arrests in Prior 2 Years	
None	5
One	1
Two/or more	1

Catholic Social Service
CODAP Statistics
September 1, 1979-March 31, 1980

Number of Prior Admissions to any Drug TrT	
None	3
Four or More	4
Primary Problem	
Heroin	2
Alcohol	3
Tranquilizers	1
Inhalants	1
Total Discharges	4
Ethnic Group	
White	2
Pacific Islander	1
Black	1
Drug Problem at Discharge	
Yes	0
No	4
Weeks in Treatment	
3 weeks	1
6 weeks	1
7 weeks	1
26 weeks	1
Reason for Discharge	
Completed TrT, No drug use	1
Noncompliance with Rules	1
Client left before completing TrT	2
Employment Status	
Unemployed (looking in last 30 days)	3
Full-time	1

Catholic Social Services
CODAP Statistics
September 1, 1979-March 31, 1980

Currently in Educational or Skill Development Program

Yes	3
No	1

Number of Arrests during TrT

None	4

Community Mental Health Genter
Methadone Maintenance

Admission and Discharges Statistics

Statistic Description		Total	1st Quarter 79	2nd Quarter 79	3rd Quarter 79	4th Quarter 79	1st Quarter 80
Total Admissions		17	4	6	2	4	1
Male		5	1	1	2	1	0
Female		12	3	5	0	3	1
Age	18-20	0	0	0	0	0	0
	21-24	9	2	4	0	3	0
	25-28	2	1	0	1	0	0
	29-32	3	0	1	0	1	1
	33-36	3	1	1	1	0	0
	Over 36	0	0	0	0	0	0
Marital Status At Admission	Never Married	5	1	3	0	1	0
	Married	6	1	1	2	1	1
	Widowed	0	0	0	0	0	0
	Divorced	5	2	1	0	2	0
	Separated	1	0	1	0	0	0
Employment Status at Admission	Unemployed (has not sought in last 30 days)	8	2	2	0	3	1
	Unemployed (has sought in last 30 days)	2	0	1	0	1	0
	Part-time (under 35 hours)	1	0	1	0	0	0
	Full-time (35 or more hours)	6	2	2	2	0	0

Community Mental Health Center
Methadone Maintenance

Admission and Discharges Statistics

Statistic Description		Total	1st Quarter 79	2nd Quarter 79	3rd Quarter 79	4th Quarter 79	1st Quarter 80
Currently in Educational or Skill Development Program at Admission	Yes	0	0	0	0	0	0
	No	17	4	6	2	4	1
Highest School Grade Completed	1-11	8	2	3	1	1	1
	12	9	2	3	1	3	0
	16 or higher	0	0	0	0	0	0
Number of times arrested within 2 years prior to admission	Zero	11	2	3	2	3	1
	Once	5	2	2	0	1	0
	2 or more	1	0	1	0	0	0
Total Discharges		31	8	5	4	7	7
Reason for Discharge							
Completed Treatment, No drug use		8	1	1	1	2	3
Completed Treatment, Some drug use		1	0	0	1	0	0
Referred Outside this Program		2	1	0	0	1	0
Non-Compliance with Rules		12	6	3	1	2	0
Client left before completing Treatment		5	0	0	1	1	3
Incarcerated		2	0	1	0	0	1
Death		1	0	0	0	1	0

Community Mental Health Center
Methadone Maintenance

Admission and Discharges Statistics

Statistic Description		Total	1st Quarter 79	2nd Quarter 79	3rd Quarter 79	4th Quarter 79	1st Quarter 80
Months in Program	1	5	2	1	0	2	0
	2-3	6	3	1	1	1	0
	4-6	4	1	1	0	1	1
	7-9	1	0	1	0	0	0
	10-12	3	0	0	1	1	1
	More than 12	12	2	1	2	2	5
Marital Status at Discharge	Never married	15	5	3	1	2	4
	Married	10	2	1	2	3	2
	Widowed	0	0	0	0	0	0
	Divorced	5	1	1	1	1	1
	Separated	1	0	0	0	1	0
Employment Status at Discharge	Unemployed (has not sought in last 30 days)	12	5	1	0	4	2
	Unemployed (has sought in last 30 days)	4	0	2	1	0	1
	Part-time (under 35 hours)	2	0	1	0	1	0
	Full-time (35 or more hours)	13	3	1	3	2	4

Community Mental Health Center
Methadone Maintenance

Admission and Discharges Statistics

Statistic Description		Total	1st Quarter 79	2nd Quarter 79	3rd Quarter 79	4th Quarter 79	1st Quarter 80
Currently in Educational or Skill Development Program	Yes	1	0	0	0	0	1
	No	30	8	5	4	7	6
Number of times arrested during Treatment	Zero	25	7	3	3	7	5
	Once	5	0	2	1	0	2
	2 or more	1	1	0	0	0	0
Drug Problem at Discharge	None	17	1	3	1	6	6
	Heroin	10	5	1	3	1	0
	Alcohol	1	0	0	0	0	0
	Other	3	2	1	0	0	0
Severity If Drug Problem at Discharge	Use (Not a Problem)	1	0	1	0	0	0
	Problem Use	13	7	1	3	1	1

Prepared By: Mike Powell/Mike Nacar
May 7, 1980

Source: CODAP Reports

APPENDIX I

ESTIMATING (1)

THE PREVALENCE OF HEROIN USE

IN THE COMMUNITY OF

GUAM

(1) Mark H. Greene, M.D.
Special Office Momograph
Series A, Number 4
August 1974

Michael B. Powell, Chief
Treatment and Rehabilitation
Mental Health and Substance Abuse
Agency, Guam
June 1980

APPENDIX I

Considerations In Estimating Heroin Incidence and Prevalence On Guam

With Guam's size, basically only one program[1] providing historical drug treatment data, only two (one Territory and one Federal) narcotics enforcement units, and a number of key indicator data in quantities less than 10 (several times quantities of one) various recognized means of estimating heroin prevalence lose their reliability as evidenced by the broad range of estimates produced. However, each estimate gives us a clue as we analyze what might be going on. Most of the indicators and the calculations of them have been included to provide readers with a fuller understanding of MHSAA's methodologies.

The methods of estimating heroin prevalence presented by Mark H. Greene, M.D.[2] in the President's Special Action Office Monograph, represent the state-of-the-art in this field and were all considered. Estimating heroin addiction presents problems not found with estimating or surveying legal diseases.

The simple enumeration method requires an investment of skilled staff time which would require special funding, but should perhaps be considered on Guam despite the dangers to the researchers.

Heroin "overdose deaths," actually heroin-related deaths, have been reported based often on informal knowledge in the absence of a toxicologist available to the Medical Examiner on Guam. On Guam, most heroin-related deaths have been murder.

Until recently, the standard interpretaiton of "overdose" deaths (nationally, and here, "overdose" becomes a catchall for heroin-related deaths) would indicate a dramatic drop in the heroin problem in 1979.

1/ The Guam Community Mental Health Center Drug and Alcohol program is the only program providing historical drug treatment since the Drug Crisis Center closed 11/22/78 and Catholic Social Services has not had the unduplicated client utilization to gain data from.

2/ "Estimating The Prevalence of Heroin Use In A Community," Mark H. Greene, M.D., Executive Office of the President Special Action Office for Drug Abuse Prevention, August, 1974, Washington, D.C.

However, at least two publicized murders seemed to be heroin-related. These two alone would raise the 1979 prevalence estimate from 100-200 to 300-600. Current Stateside views that many "overdose" deaths may actually be related to adulterants raises another question for Guam using this indicator, considering the high purity of heroin on Guam.[1]

The indicator-dilution method as applied to Guam, gives some cause to consider the estimates biased towards low estimates. The few months of busy Drug Crisis Center activity revealed a large heroin user population not seen by the methadone program. The opinion that methadone programs only attract a segment of the addict population seem confirmed by this. Also, it is known that some of the duplication between arrests lists and treatment lists, is due to referral from jail and prison to the CMHC program, seriously affecting the random sampling assumption upon which the indicator-dilution method is based. Also, the consistently small denominators generated by Guam's statistics creates questions.

Extrapolation from crime statistics suffers all the problems found with this method elsewhere. And again, Guam's figures are small, more easily affected by changes in police priorities or the arrest of the members of one burglary ring. Several informal reports made to staff members of MHSAA suggest that, as might be assumed, the extended family structure seems to increase the extent that the addict population supports heroin addiction by begging, borrowing and stealing from family.

The school survey, felt by us to be more reliable than home surveys, reveals early incidence double that estimated for the rest of the nation. This is considered strong data to support the position that Guam's current prevalence is probably that much greater than the national estimate of prevalence of 0.4 percent. This is emphasized with serum B hepatitis[1] showing the same national comparison, with Guam highest in the nation per formula grant figures.

1/ Conversations with DPS Narcotics Squad personnel reveal purity still ranges from 80-95%.

1/ See page 48, Chart III-M of this State Plan.

The last major consideration is the unduplicated count of known heroin users, using arrests for calendar years 1976-1979, Drug Crisis Center clients of eight months, 1978, and CMHC Drug Program from mid-1975 through May, 1980. This produces a total unduplicated count of 653 heroin users. By assuming that the list includes all reported heroin-related deaths, one-half of the 30% completed treatment rate of CMHC, a high spontaneous recovery rate, one half of DOC's entire inmate population and a number of individuals having left Guam, we estimate 425 known active cases. The estimated prevalence we quote (650) implies that approximately 35% of the active cases are "hidden" users. Even on Guam, this is probably a conservative estimate.

Attached for reference are a number of computations of heroin prevalence indicators. Also attached are incidence graphs. It should be noted that the Drug Crisis Center contributed incidence figures only for clients seen between April and November, 1978, when it ceased operation.

I. DIRECT METHODS

A. Simple Enumeration

1. Count of Drug Crisis Center (DCC) and Guam Community Health Center Methadone Clinic Clients as of December 31, 1979.

	DCC	Methadone Clinic	
Total Number of Clients	*200 (1)*	*392 (2)*	
Total Clients			*592*

(1) DCC Clients from April 24, 1978- 11/30/78 (closed)

(2) MC Clients from Oct. 1975- December 31,1979

*2. Count of Heroin Arrests: **

CY 1976	*37*
CY 1977	*34*
CY 1978	*55*
CY 1979	*32*
Total.....	*158*

Total 1&2	*750*
Minus duplications(known treatment or known deceased)	*-97*
Total number unduplicated heroin users known on Guam	*653*

** Unduplicated*

D. *MISCELLANEOUS METHODS OF ESTIMATING* HEROIN PREVALENCE IN A COMMUNITY

1. *Extrapolation from Crime Statistics- Newmeyer Technique (SFO)*

Guam 1979. . . . . .1117 total burglaries reported

A. Mean reported value of goods last per burglary. $699.00

B. Actual dollar value of goods lost per burglary

2/3 of (A) above. $466.23

**C. Burglaries are under-reported- 3.17 occur for*

each reported

D. Cash return to burglar is 1/3 of value of stolen goods:

(1117)reported value of stolen property (Burglary, Guam 1979)

$781,061.25

(3541)estimated value of stolen property (Burglary Guam 1979)

$1,650,869.10

**E. 50% of all burglaries are committed by heroin users:*

. . . . .1117 reported ÷ 2 =558.5

. . . . .3541 estimated ÷ 2=1770.5

***F. Average herion users habit $50.00 per day*

**G. Average user strung out 200 days/year*

**H. One out of 10 supports habit by burglary*

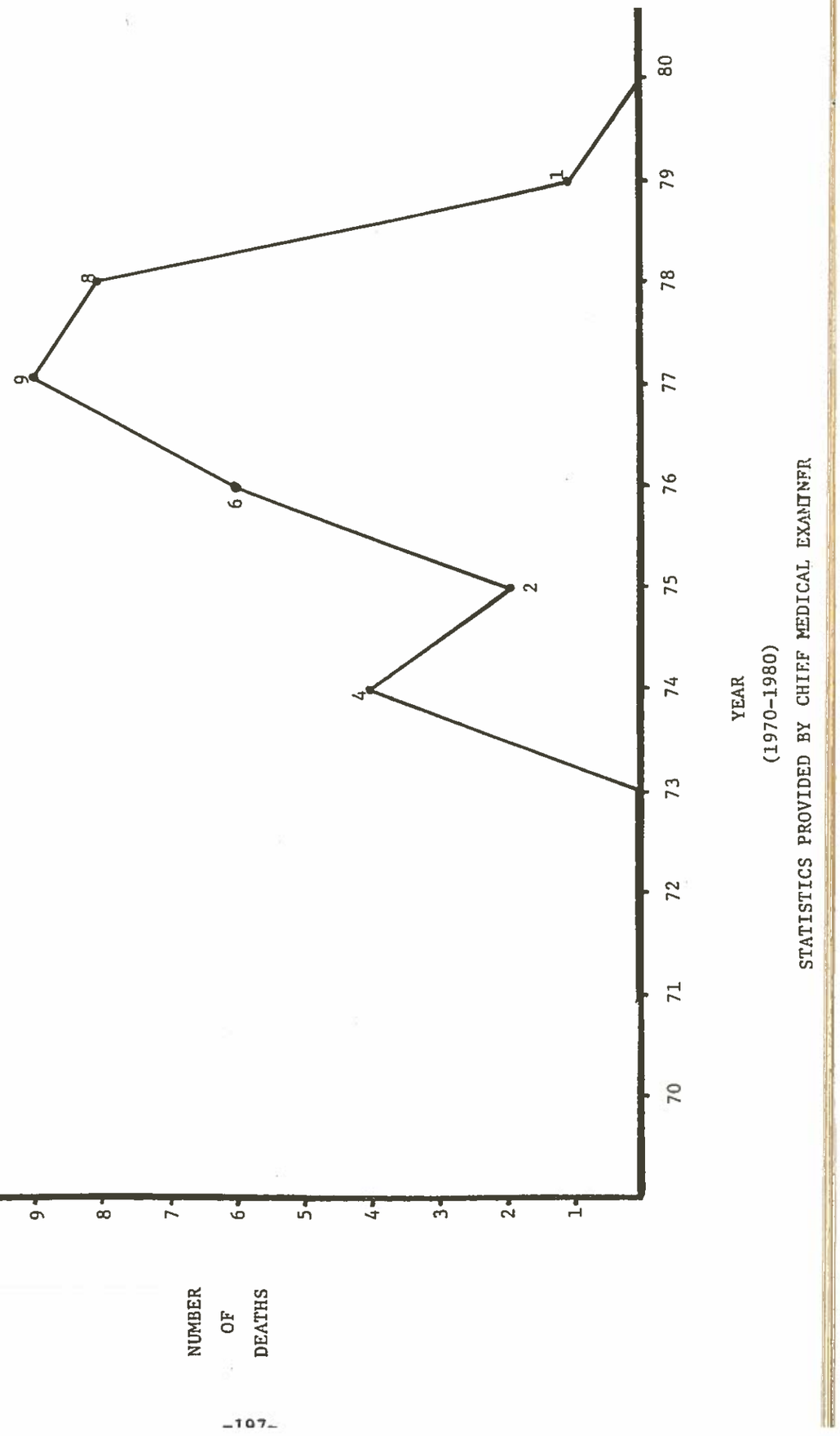
Computation: 1770.5 x $155.41(1/3 of $466.23 return to addict burglar) $275,153.40=

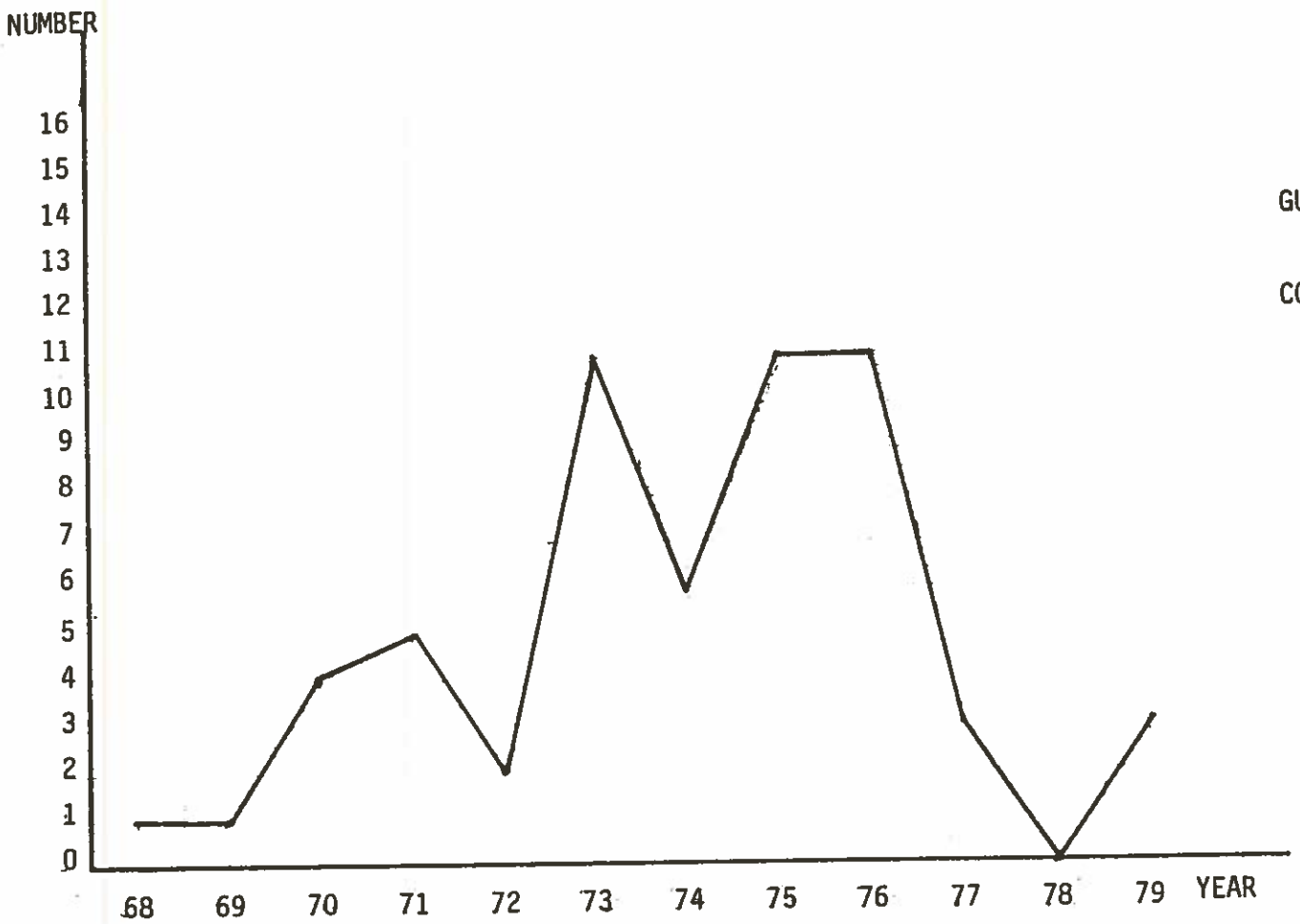
Total dollars raised by addict burglars. $\frac{\$275,153.40}{10,000.00}$ *habit= 27.5 addicts on Guam*

supported by burglary x 10=275 estimated herion users

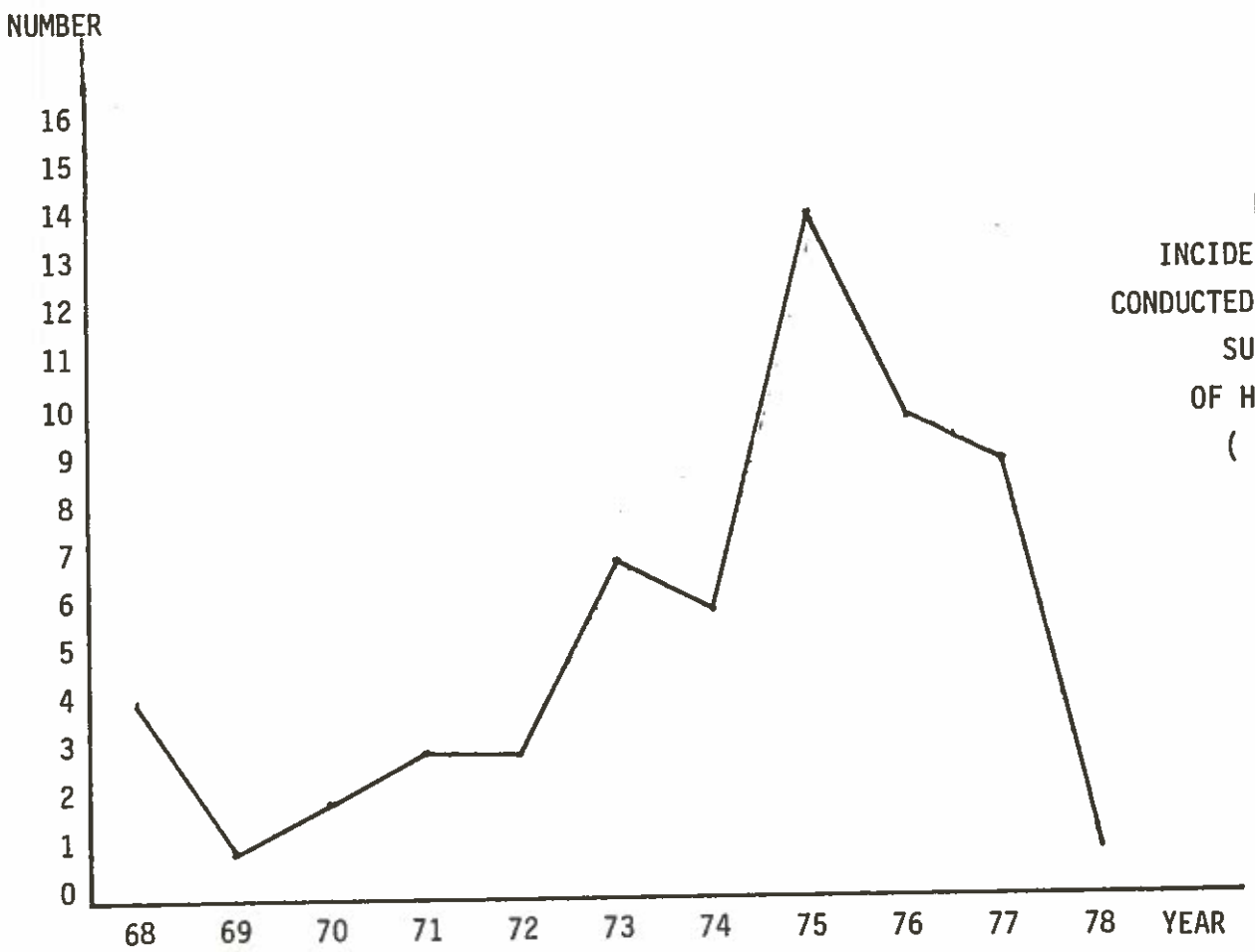
**Based on San Francisco Statistics*

***Based on most recent estimates available from MHSAA*

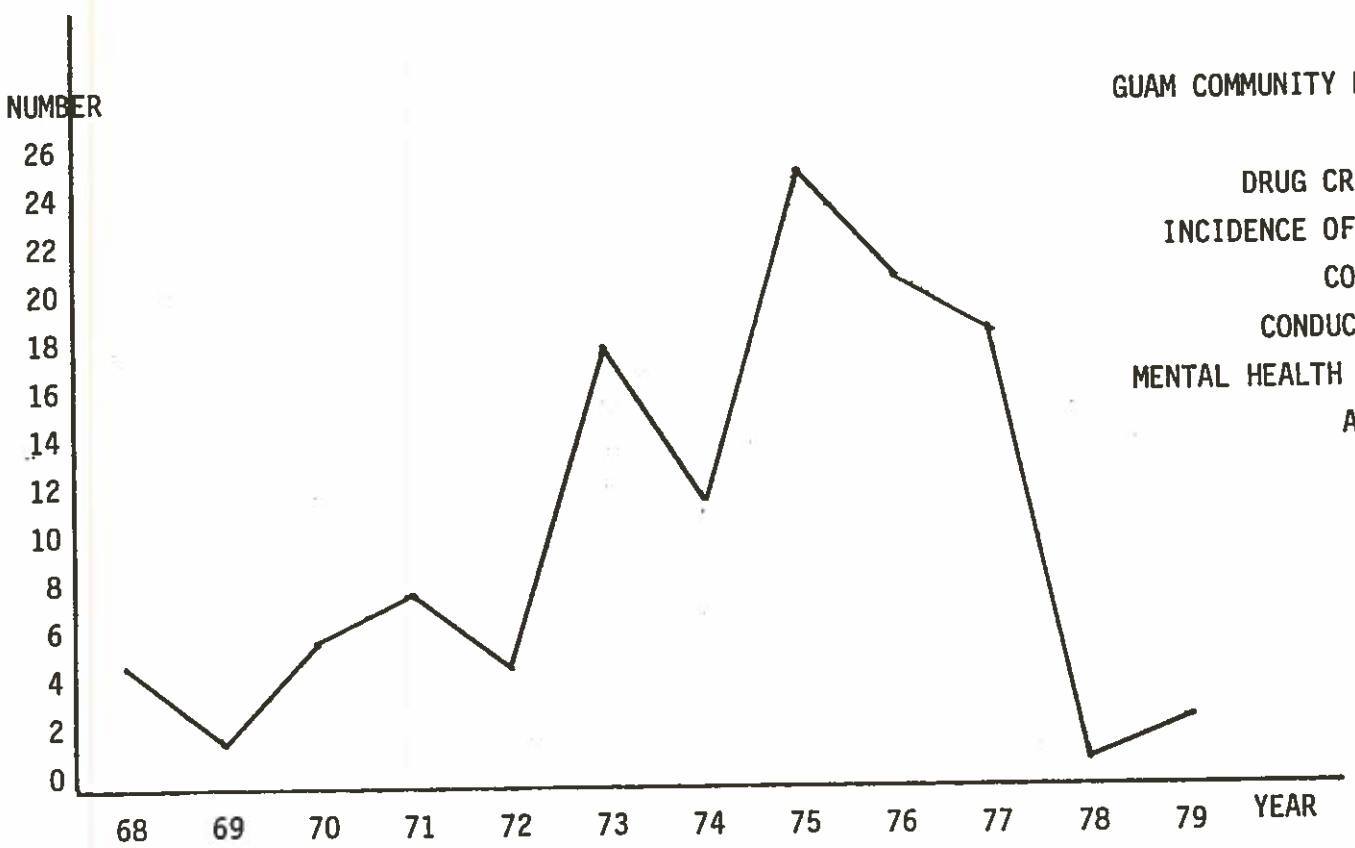




GUAM COMMUNITY MENTAL HEALTH CENTER
INCIDENCE OF FIRST USE STUDY
CONDUCTED BY THE MENTAL HEALTH AND
SUBSTANCE ABUSE AGENCY
OF HEROIN ABUSING CLIENTS
(1978 - 4/1980)



DRUG CRISIS CENTER
INCIDENCE OF FIRST USE STUDY
CONDUCTED BY THE MENTAL HEALTH AND
SUBSTANCE ABUSE AGENCY
OF HEROIN ABUSING CLIENTS
(4/24/68 - 11/21/78)



GUAM COMMUNITY MENTAL HEALTH CENTER
AND
DRUG CRISIS CENTER
INCIDENCE OF FIRST USE STUDY
COMBINED
CONDUCTED BY THE
MENTAL HEALTH AND SUBSTANCE ABUSE
AGENCY

Taxonomy

ADAMHA	93-641
1. Administrative Services o Planning and Coordination o Management Information System.	Health System Enabling (Health Planning and Financing Services.)
2. Treatment, Rehabilitation, and Diversion.	Diagnosis and Treatment Services, Rehabilitation and Rehabilitation Services, Maintenance Services.
3. Quality Assurance and Evaluation.	Health Service Enabling (Regulation and Research) Services.
4. Prevention and Education.	Prevention and Detection Services, Community Health Promotion and Protection Services.
5. Manpower and Training.	Health System Enabling (resource Development) Services.
	Personal Health Care Support Services *

* Not included in the ADAMHA Taxonomy. If your HSAs wish to include this category, it would correspond most closely to Administrative services.

NATIONAL INSTITUTE ON DRUG ABUSE
5600 FISHERS LANE
ROCKVILLE, MARYLAND 20857
AREA CODE 202 TEL 443-6500

RECEIVED JAN 17 1980

Mr. Peter A. San Nicolas
Administrator
Guam Mental Health and
Substance Abuse Agency
P.O. Box 20999
Guam, Mariana Islands 96921

Dear Mr. San Nicolas:

The National Institute on Drug Abuse has completed its review of the 1980 Guam Plan for Drug Abuse Prevention. The review committee was pleased with the level of responsiveness to Federal guidelines which was reflected in your plan. We are confident that this document will serve as a useful guide in the implementation of the statewide drug program. We commend you and your staff on the progress which has been demonstrated in planning activities during the past year.

The committee has identified a number of areas of the Plan for which additional material and clarification is needed in order to complete the planning requirements for Fiscal Year 1980. The following are conditions reflecting these areas:

1. Provide evidence of Governor's Endorsement /A-95 review.

2. Provide evidence that Plan was available for public comment through publication of appropriate notices.

3. Provide further clarification of the SSA's plans regarding licensure and accreditation including the specific role to be played by the SSA.

As soon as this material has been approved by the Institute, we will recommend that the State be eligible to receive formula funds for the period October 1, 1979 to September 30, 1981.

This information can be submitted to us in the form of an addendum to the State Plan. Should you need consultation in the course of developing this material, your Project Officer, Mr. Glen Smutz is prepared to offer technical assistance. Mr. Smutz will assist you in contacting other staff in the Institute who can provide consultation in their respective areas of program responsibility.

We look forward to working with you and your staff in the implementation of the Plan.

Sincerely yours,

Robert J. Roberton
Director
Division of Community Assistance

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IX
50 United Nations Plaza
San Francisco CA 94102

11/11/80 | 11/12 | 11/14
Necessary Action: Mike & Larry
SUSPENSE: PRA
MHSAA

NOV 05 1980

Mr. Peter A. San Nicolas
Administrator, Guam Mental Health
and Substance Abuse Agency
P.O. Box 20999, Main Facility
Agana, Guam 96921

Dear Mr. San Nicolas:

Thank you for providing evidence of the State Health Coordinating Council and State Clearinghouse review of your Alcoholism Plan Update for fiscal year 1981.

The information submitted adequately satisfies condition number 1b as identified in our letter of September 11, 1980. However, condition number 1 will not be released at this time, it will remain in effect until such time as evidence is provided indicating that the State Health Coordinating Council is represented on the advisory council.

We would like to inform you that we have not received your response to condition number 2 regarding the assessment of your progress relating to the implementation of the State Plan and a plan of action for the next three years. Please submit this information at your earliest convenience.

If you have any questions concerning these matters, please contact Miss Dorine Loso, Director, Division of Alcohol, Drug Abuse and Mental Health Programs, Public Health Service, 50 United Nations Plaza, San Francisco, California 94102. Miss Loso's phone number is (415) 556-2215.

Sincerely,

Eric R Swanson
for Alan S. Harris
Chief
Office of Grants Management

cc:
Dorine Loso
Carlos Reyna

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IX
Office of the Regional
Health Administrator
50 United Nations Plaza
San Francisco CA 94102

DEC. 1 1980

12/5/80 | 12/5
Necessary Action:
FRANK - mike
LARRY - FRED
MHSAA

Mr. Peter A. San Nicolas, Administrator
Mental Health and Substance Abuse Agency
P.O. Box 20999
Main Facility
Guam 96921

Dear Mr. San Nicolas:

The materials submitted in response to the two conditions for approval of the Mental Health Five-Year Plan (1981-1985) for the Territory of Guam have been reviewed.

I am pleased to inform you that, based upon this review, the conditions have been satisfied and are now removed.

Sincerely,

Sheridan L. Weinstein, M.D.
Assistant Surgeon General
Regional Health Administrator

APPENDIX N - ITEM 1

BBMR-C1

OFFICE OF THE GOVERNOR
GUAM STATE CLEARINGHOUSE
AGANA, GUAM

PROJECT NOTIFICATION AND REVIEW SIGNOFF

Date Received: 7/1/80

Review Terminated: 10/6/80

Clearinghouse ID: MHSAA7980DAS/SP

APPLICANT PROJECT TITLE: Five-Year State Plan - Drug and Alcohol Services

APPLICANT AGENCY: Mental Health & Substance Abuse Agency
ADDRESS: P. O. Box 20999
GMF, M.I. 96921

FEDERAL PROGRAM TITLE AND CATALOG NUMBER:

FEDERAL AGENCY:

AMOUNT OF FUNDS REQUESTED: *Local* N/A *Federal* N/A

PROJECT DESCRIPTION:

The State Clearinghouse makes the following disposition concerning this application:

X *reviewed and approved by Guam State Clearinghouse Procedures*

____ *disapproved with the enclosed comments*

____ *approved with the enclosed comments*

Brenda Sanchez
Signature of Analyst attesting Compliance to State Clearinghouse

Date: OCT 07 1980

X *APPROVED*

____ *DISAPPROVED*

Joseph F. Ada
JOSEPH F. ADA
Lieutenant Governor

OCT 07 1980

GOVERNOR OF GUAM

Read 10/28/80
Mau

APPENDIX O - ITEM 1

October 15, 1980

Sheridan Weinstein, M.D., M.P.H.
Regional Health Administrator
U.S. Public Health Service
Department of Health and Human Services
50 United Nations Plaza
San Francisco, California 94102

Dear Dr. Weinstein:

We wish to inform you that our Council has reviewed the State Plan on Alcohol and Drug Abuse submitted by Guam Mental Health and Substance Abuse Agency.

We found the State Plan in harmony with the Guam Health Plan.

Enclosed for your information are the results from a joint effort of our Plan Development and Project Review Committee.

Sincerely,

JUDITH P. GUTHERTZ
Chairperson, Guam Health
Coordinating Council

Enclosure

JDM:tlgb
10/15/80

cc: MHSAA
A-95 Clearinghouse
ADAMHA
NIDA
GHPDA Project Review File
GHCC Project Review Committee File
GHPDA Chrono

BOOK TWO

MENTAL HEALTH

INDEX OF TABLES
(Mental Health)

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(MENTAL HEALTH)

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(MENTAL HEALTH)

PART I. SYSTEM DESCRIPTION

INTRODUCTION

The Mental Health System involves not only the components which provide services, but also funding, planning, monitoring and evaluation, interfaces with other elements of society and legal authority relationships. A system description includes the entities, relationships and general processes surrounding as well as including the core functions. The description is the means of checking and documenting that all key functions and relationships have been considered, are agreed upon and understood by all concerned.

This part of the Plan, then, provides for a single understanding.

PART I. SYSTEM DESCRIPTION

A. Management System

1. Policy of mental health issues.

The following are policies of the Mental Health and Substance Abuse Agency(MHSAA) as Single State Agency(SSA) for the Territory of Guam in the area of mental health:

a. That preservation of the dignity of the individual is of paramount importance in the prevention and treatment of mental health problems;

b. That the MHSAA will support and foster (the growth and development of) the provision of quality services to individuals in need, and that these services will be offered in the least restrictive setting possible;

c. That treatment services will address the cultural issues germane to the residents of Guam including the "Natural Provider" concept,[1] cross-cultural program design and development, and special emphasis and treatment groups;

d. That priority will be given to 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;

e. That MHSAA will promote legislation favorable to the provision and receipt of services by all in need in the areas within its responsibility.

Since Guam is presently more advanced in some areas of service delivery than in others, every effort will be made towards eliminating barriers to treatment where they exist and opening appropriate alternatives and opportunities for treatment which do not exist. An example of this is that the mentally retarded presently receive services in the in-patient ward of the Guam Community Mental Health Center(CMHC) when in actuality they are more appropriately served in other settings. Also, acute and criminally insane are presently serviced in this same unit. These issues require close study and innovative planning to provide appropriate setting (treatment) with limited funds for a minimal number of clients requiring services.

Presently, the CMHC provides counseling services to the Department of Corrections(DOC) inmates; youth counseling services in (selected) public schools; teaching placement sites for the University of Guam; training for the employees of Department of Vocational Rehabilitation; and community outreach and services from satellite clinics. In-patient, outpatient, and aftercare services are provided at the CMHC main location in Tamuning. These services also require close monitoring and evaluation to assure the most effective provision (both cost and treatment) to those most in need.

The MHSAA recognizes the need for continued examination and alteration of services to assure quality of care in all areas of services within its jurisdiction. In some cases this requires legislation. An example of this is a bill recently introduced for defining the conditions for the involuntary commitment of the mentally ill. The MHSAA participated in hearings and submitted testimony regarding the passage of this bill. The MHSAA will continue to endorse and initiate legislation appropriate to the needs of the mentally ill on Guam.

1 Natural Providers - Clergy, village commissioners, village elders, suruhanus and others.

The MHSAA has a commitment to the people of Guam for the continued and conscientious planning, development, revision, and provision of quality services to those in need. This commitment includes enacting cost effective measures in the areas of service provision; coordination of resources; technical assistance; data sharing; and grants management. Sound, coordinated planning is seen as crucial to this commitment.

To facilitate the coordinated and cost effective service development, the MHSAA division chiefs are responsible for coordinated policy development in conjunction with the Agency Administrator and the Administrator of CMHC and Guam Health Planning and Development Agency(GHPDA). Each division chief also recommends legislation, policies, procedures, and program objectives within the divisional area of responsibility. Joint staff meetngs are held to finalize policy decisions. Major items, such as reorganizations, would require approval of the Governor of Guam for the SSA. Issues of similar importance for the CMHC would require approval of the Board of Trustees of the Guam Memorial Hospital as well as the Hospital Administrator, and input of the Mental Health Advisory Council.

The MHSAA has a 13-member combined Advisory Council for drug, alcohol, and mental health. The responsibility of the Council is to review and comment on activities and policies of the agency. This Council meets monthly, or more often if needed, with the staff of the MHSAA (Administrator, Deputy Administrator, Division Chiefs) to assure their active involvement and awareness of agency activity. This Council has a broad base representation of women, youth, retirees, professionals and grassroots members fulfilling the federal criteria. MHSAA Advisory Council members are listed in Appendix A, Item 1. The MHSAA's Advisory Council Activity Report is attached as Appendix A, Item 2.

2. The Single State Agency

The MHSAA was created by Executive Order 78-3 (Appendix A, Item 3) in February of 1978 and, as such, serves as the Single State Agency for mental health, drug and alcohol services within the Territory of Guam. (This Executive Order has recently undergone review by the Office of the Attorney General in order to develop an amendment to clarify the scope of and authority of the MHSAA. This amendment is being considered by the Governor's Office in light of pending issues under consideration by the Inter-Agency Task Force on the CMHC.)

The Administrator of the MHSAA reports directly to the Governor of Guam as reflected in the Government of Guam Organizational Chart, (Appendix A, Item 4). The Administrator also serves as a member of the Guam Health Coordinating Council and as administrative liaison to the MHSAA Advisory Council and the A-95 Clearinghouse. The Administrator and his staff serve as resource people to the Governor's Legislative Review Committee and to other agencies and organizations and, as appropriate, present testimonies on legislations relating to the areas within the purview of the MHSAA.

The MHSAA is organized into five major divisions: Planning (including Research and MIS); Direct Services (including treatment and technical assistance); Training and Prevention; Quality Assurance and Evaluation; and Administration (including contracts, grants, and budgeting). These divisions are represented on the Organizational Chart (Appendix A, Item 5). In addition to the five major divisions, the agency has a medical advisor as indicated on the chart. Divisional support staff are shown on this chart by respective division. Functional responsibilities are depicted on Appendix A, Item 6.

Each division, under a division chief, is responsible for inter- and intra-agency coordination to assure maximal coordination of effort and resources. At present, all MHSAA staff carry inter-disciplinary functions on a combined function basis.

The SSA has the authority to monitor, evaluate, and provide technical assistance to the two programs which provide services within the scope of the SSA authority and receive funding from the SSA or the local government. These programs are the Guam Community Mental Health Center and the Catholic Social Services, Inc. Technical assistance(TA) in the area of programming is provided by the Direct Services Division Chief; budgeting by the Administrative Division Chief, and monitoring and evaluation by the Chief, Quality Assurance and Evaluation. Program development is assisted by coordinated efforts of division chiefs by approval of the Agency Administrator, with final contract approval vested in the Governor of Guam after review by the Attorney General's Office, Department of Administrator, and the Bureau of Budget. The Fiscal Officer of the MHSAA, in conjunction with Bureau of Budget, determines the administrative costs based on federal guidelines and allowable charges for those services directly contracted by MHSAA. CMHC administrative costs are determined by the fiscal officer of CMHC and the Hospital Administrator in conjunction with the Government of Guam Bureau of Budget and Management Research.

Some functions of the SSA are performed as integrated functions across ADM disciplines. However, this only occurs with non-matching state funds. In all cases of federal funding, including state match funds, there is separate accounting by grant with distinct services (joint or combined) identifiable by ADM functions.

B. Planning

The MHSAA views coordinated planning as the basis for responsible program development. Since the MHSAA is not segregated by such categories as mental health, drug or alcohol, each division chief serves as the individual with ultimate divisional responsibility in all three categories for the Territory of Guam. Thus, the Chief Planner in conjunction with the agency consultant[2] for Guam in the MHSAA area is responsible for receiving and coordinating input to the State Plan by the public and private sector as well as from all other interested parties and government agencies. There are no formal sub-state planning units on Guam. However, the MHSAA recognizes the importance of the government agencies' involvement as well as that of the village commissioners, clergy, elders, and the service providers. These groups play an important part in the acceptance and utilization of community services in Guam. The MHSAA Chief Planner is responsible for scheduling public meetings, conducting surveys, accumulating incidence and prevalence data and coordination with GHPDA, A-95 Clearinghouse, and Guam Health Coordinating Council for the review and approval of plans (Appendix B). The A-95 Clearinghouse has, as members, representatives from the Bureau of Planning, Bureau of Budget and Management Research, GHPDA, Public Health and Social Services and other agencies as may be appropriate for specific issues. The State Plan is advertised for public input at the development stage, is presented to the Advisory Council for review and comment, and is also advertised as available for public review and comment upon completion (Appendix B).

The MHSAA is responsible for developing the mental health, drug and alcohol portion of the Guam State Health Plan. Joint meetings are held between staff of both planning and direct

2 Phyllis Luminelli; PRL Consultant Services: retained for the preparation of the Five-Year Plan.

service agencies to assure coordination of effort as provided by inter-agency agreement (Appendix C).

In addition, the staff of the MHSAA enjoys a close working relationship with Guam Health Planning and Development Agency, Public Health and Social Services, Department of Education, Department of Public Safety, Community Mental Health Center, Catholic Social Services, Department of Youth Affairs, Guam Memorial Hospital, and Department of Corrections. Written agreements are made for specific formal purposes.

C. Support System

Technical assistance(TA) is provided to programs as well as to other government agencies and the private sector in any area within the authority of the MHSAA. Each division chief is responsible for determining the division capabilities in the area of technical assistance to meet the needs (requests) for technical assistance and if the the Agency has the manpower and expertise on staff to deliver the specific technical assistance required. If the Agency is unable to directly provide the assistance, alternatives are offered towards obtaining it and, where funding exists, the Agency may partially or fully underwrite the cost of procuring the assistance of specialists (consultants) in the field to compliment the staff capabilities of the MHSAA.

Technical assistance is presently available in the areas of clinical supervision, program design/development, grants management, MIS development, internal monitoring and evaluation, and other areas of specialty such as clients' rights, client records, staff development and training, and media campaigns.

One of the main functions of the MHSAA is in the area of training and manpower development as will be addressed in later parts of this document. The Guam MHSAA recently provided technical assistance to Saipan, Northern Mariana Islands in the area of general program development and prevention and training.

D. Monitoring System

Presently the MHSAA is developing plans for monitoring site visits to CMHC, the only public service provider, and for the collection of MIS mental health data to determine utilization, quality of care, compliance with federal and local regulations, manpower needs, financial management, and service availability. It also collects data regularly from service providers as well as from Department of Public Safety, Public Health and Social Services, Guam Memorial Hospital and other agencies who acquire related data. MHSAA also plans a quarterly mini-survey of private service providers.

The MHSAA has, as part of the Planning Division, responsibility for the development, integration, and implementation of a Management Information System for mental health, alcohol, and drug. Presently the system is functioning manually and incorporates such data as is obtained from NDATUS,[3] CODAP,[4] SAPIS,[5] CMER,[6] NIDA Quarterly Report on SWSG[7] and other indicator data from the related agencies named above. In addition, CMHC has begun to provide to MHSAA the information compiled in the Monthly Management Report, The Annual CMHC Report, and other reports developed by the CMHC.

3 NDATUS - National Drug and Alcohol Treatment Utilization Survey
4 CODAP - Client Oriented Data Acquisition Process
5 SAPIS - State Alcoholism Profile Information System
6 CMER - Clinic Management By Exception Report
7 SWSG - Statewide Services Grant

Preliminary steps have been taken to acquire computer capabilities which will formalize the Management Information System and expand the capability of the MHSAA to accumulate, analyze and retrieve data relevant to the mental health, drug, and alcohol fields in Guam. The MIS will incorporate and expand upon data available from the Guam Community Mental Health Center, Guam Health Planning and Development Agency, and other agencies and service providers.

Client data are maintained in the area of drug and alcohol treatment by primary substance of abuse regardless of joint or combined nature of service delivery. Other, non-fiscal, planning data, such as population characteristics data and crime statistics, are utilized as appropriate to the specific ADM task.

E. Budget Process

In the case of the CMHC which is presently under the authority of Guam Memorial Hospital, a submission for total funding is submitted to the legislature by the Guam Memorial Hospital including the CMHC. Funds received by legislature appropriation are administered by the Guam Memorail Hospital. Any federal funds received from the MHSAA are identified as such in the MHSAA budget request and subsequent appropriation. The MHSAA does not contract for the provision of mental health services since the loss of the federal formula dollars. The MHSAA monitors program expenditures of the funds which are provided by the MHSAA to the CMHC and also of funds appropriated as matching by the legislature. Funds provided to the CMHC under the NIDA Statewide Services Grant are released to the program upon receipt of expenditure report. Formula funds to MHSAA are received through Government Division of Accounts, Department of Administration, in a lump sum appropriation with quarterly releases of funds to MHSAA. Catholic Social Services(CSS), Inc., a newly formed non-profit organization, received an initial contract from the MHSAA in June, 1979 to provide residential treatment for drug and alcohol abusers. CSS will submit a renewal request to the MHSAA for inclusion in the formal MHSAA budget request to the legislature for continuation of these services. Other programs of the CSS organization would receive funding from other appropriate agencies and/or by direct legislature appropriation. The CSS was monitored for budget and program compliance by the MHSAA. Funds under CSS are administered by the CSS Director and Board.

Renewal of any contract or grant is based on a priority system which includes several factor such as utilization, cost effectiveness, community need, quality of service, and the ability of the contractor to provide services and effectiveness of the modality(ies) involved. Those procedures will be followed in the event that the MHSAA contracts for mental health services with private or public agencies.

All expenditures of local and federal dollars by MHSAA are monitored by the Government of Guam Department of Administration by the newly implemented and sophisticated Financial Management System.

At this time, MHSAA exerts no direct authority for ADM funds not administered by MHSAA. Our informal working relationships with Department of Education, Department of Public Safety and others have had significant programmatic impact, however. The previously discussed revision of the empowering Executive Order will clarify the MHSAA's role concerning fiscal, MIS and quality assurance issues for ADM funds not administered directly by MHSAA.

With funds administered by MHSAA which are not specific to particular ADM functions, decisions are made by the division chiefs meetings and discussions, needs assessment data, service delivery resources, resources for planning, including availability of resources and other ADM functions. This input is available to the Administrator who has final authority within MHSAA for input to the larger Territory of Guam budget process. Sub-contract providers are required to maintain accounts and report expenditures and revenues by specific ADM disciplines and clients by contract provision.

F. Grants Management System

The MHSAA awards all drug and alcohol contracts and grants based on the demonstrated ability of the contractor to provide quality services to those in need. All contracts and grants are subject to local or federal regulations depending upon the source of funding. The MHSAA employs the Government of Guam procurement regulation which requires competitive bid process unless there is a justification for sole source procurement. Following the bid process all contracts are reviewed and approved by the Administrator of the MHSAA, the Office of the Attorney General, Department of Administration, and the Office of the Governor with final authority resting with the Governor of Guam. Those same procedures and policies would apply in the event that the MHSAA were to contract for mental health services.

Contracts and grants are monitored on a quarterly basis for compliance with the terms of the contract, fiscal expenditures, and treatment issues. Any deficiencies are submitted to the contractor, in writing, with recommended action steps and target dates for compliance. Continued non-compliance can result in withholding of payment under the contract. Technical assistance is offered to assist programs to attain substantial compliance with applicable regulations.

The Department of Administration, using the recently implemented Financial Management System, has established separate accounts by specific grant programs and periods for all federal funds received by the government (excluding semi-autonomous agencies). Revenues generated by government operated programs are identified by program. Administration of revenues, however, is determined by the terms of legislative appropriation.

In the case of the CMHC, financial procedures and policies have lacked refinement necessary to identify costs of units of services, collection data, and effective processing of billing. In part, this is due to split financial systems which result in some funds (federal) remaining within an account controlled by the Administration of CMHC and other funds, third party and state appropriation as well as self-pay going into the GMH Financial system. The CMHC financial situation has left much to be done to assure fiscal accountability. Steps have been initiated under the direction of the Lt. Governor to rectify this situation.

Under the Statewide Services Grant, funding is provided from MHSAA to CMHC specifically for the provision of methadone treatment for heroin addicts. Utilization figures for the program are monitored as are expenditures for compliance with the SWSG provisions.

G. Service Delivery System

Both CMHC and CSS have offered combined services in the area of drug, alcohol, and mental health though CMHC recently reorganized as a joint service for drug and alcohol. The continued operation of these programs at the existing level is highly dependent on availability of funds. The CMHC, in particular, faces the potential loss of $517,000 in

federal funds, all federal funds except SWSG and local match, based on the initial determent of the CMHC Distress Grant application. Should funds not be made available under the distress grant mechanism, the CMHC will transfer the provision of D&A services to another agency by the beginning of FY81. If one year funding is provided, D&A services will be transferred at the end of FY81. The MHSAA is working closely with CMHC to assure smooth transition of these services to the most appropriate agency or service provider. Although it is not clear what the funding level for CSS will be next year, all indications are that those services will be funded at a level sufficient to continue this quality program. MHSAA is working closely with the staff of CSS to assure funding continuation.

Table I-A represents the CMHC modalities available, by capacity and existing utilization, as of August, 1980.

Appendix A, Item 7 is the organizational chart of the Guam Memorial Hospital, under which authority CMHC functions. The only formal relationship between MHSAA and CMHC, besides SSA functions, is the contract for provision of drug services under the NIDA Statewide Services Grant mechanism. Appendix A, Item 8 presents the most recent (June, 1980) organizational chart for CMHC services.

Continuation of modalities will depend in large part on funding of the Distress Grant Application. The MHSAA is committed to support a smooth transitional phase down or relocation of services should this be necessary.

The CMHC D&A program offers specific services geared towards the special needs of women and has made services available to persons under 18. CSS[8], however, initiated the RTP[9] primarily geared towards men. Efforts have been made to secure funds to offer services to women but have not seen fruition. Although funding has not been available, CSS has provided some short term residential services to women at a location other than the RTP Program.

The MHSAA recognizes the important of prevention and those activities are identified in the Prevention Section. Treatment services geared toward youth are presently under study by the Chief of the Treatment and Rehabilitation Section.

Licensure and accreditation standards have not been developed specially for ADM. To date, the two service providers have been contractually required to conform to all relevant federal standards. Both providers are monitored for compliance with NIDA standards, including services as rendered to alocohol clients as applicable. In addition, GMH-CMHC is licensed by FDA and DEA as required for methadone programs. GMH is accredited by JCAH and, as part of the CMHC system, CMHC is monitored for compliance with JCAH standards. Also both providers must conform to Guam's laws and regulations involving fire and structural safety, food handling, etc. In lieu of formal licensure and accreditation, these standards assure quality services and client safety. As noted in the Quality Assurance and Evaluation Action Plan formal licensure and accreditation standards will

8 "Catholic Social Services - Residential Treatment Program" (CSS-RTP)
9 Residential Treatment Program

TABLE I-A.

CMHC CAPACITY AND UTILIZATION BY SERVICE COMPONENT (MODALITY)

FY 1980

Service Component	FTE Clinical Staff Total/Direct Only*	Utilization Projected FY81 Caseload/Visits or Days*	Expanded FY80 Caseload/Days Care or Pt. Visits**	Capacity Caseload/One Hr. Visits or Days***
Emergency	1.0/1.0	225/450	126/217	650/1300
In-Patient +	20.2/19.3	17/6205	17.9/6490	17/6205
Partial Hospitalization	10.9/10.3	61/4884	58.5/4990	61/4884
Progress House +	2.5/2.3	-0-	7.7/3224	8/3000
Aftercare	2.5/2.0	N/A/2338	48.7/1457	N/A/1752
Adult Outpatient	5.6/4.0	N/A/4674	73.5/2648	80/4672
Alcohol Service	2.6/2.0	N/A/2103	11.0/761	20/2336
Drug Program	5.4/4.0	N/A/5259	26.8/5934	40/4672
Programman Patgon ++	4.5/4.0	N/A/3506	51.8/2222	80/4672
Forensic	0.8/0.8	-0-	N/A	350/1400
Elderly (Included in Adult Outpatient Consultation and Education)			25.1/1366	---

* Based on Financial Distress Grant of June 23, 1980 FDG or Feb. 1980 staffing pattern and Page 219. Direct staff are best count of caseload staff.
** Data for October, 1979 through July, 1980 is expanded to give an annual figure.
*** Estimated by MHSAA if not clear from Page 219, June 1980 FDG or Feb. 1980 FDG, Page 99.
\+ Care-Days (otherwise Patient Visits)
++ Children's Services

be developed and presented for review, comment and discussion by GHPDA, GHCC, MHSAA Advisory Council, service providers and the public prior to finalization and recommendation for authorizing legislation. NIMH funding could greatly help manpower development and quality assurance issues especially relative to licensure and accreditation. JCAH is presently being studied for appropriateness as an accredited mechanism for mental health services on Guam.

PART II: PERFORMANCE REPORT

Introduction

There are two basic issues of concern in reviewing the last five years of mental health system development on Guam:

1. The present Single State Agency (SSA), the Guam Mental Health and Substance Abuse Agency (MHSAA), was formed by Executive Order 78-3 (APPENDIX) A, Item 3. The SSA involvement with mental health issues began to focus in November, 1979. This Plan should be reviewed in light of SSA history, considering the deficiencies to date and the MHSAA record of development on its initial priority areas, alcohol and drug abuse. SSA authority in the three disciplines when the last Five Year Plan was published rested with the Guam Memorial Hospital which at the time had significant developmental challenges in its own priority areas. Within two months of the creation of the current SSA authority, the Drug Crisis of Spring, 1978, drew the full attention of the Agency. The current administration basically began with a relationship with NIDA that was good, basically because of NIDA patience. For alcohol and mental health, minimal groundwork was laid. Indeed, the major CMHC Operations Grant was active, but SSA had no role in this under federal practice. The decision was made that, with a functioning and independent CMHC, focus would begin with alcohol and drug abuse issues. In the first 8 months, the Agency fostered a drug and alcohol therapeutic community to supplement the methadone services, produced a combined substance abuse State Plan Update (1980) which received very favorable response from NIAAA and NIDA for the development of knowledge and sophistication, and established national perspective and relationships in these two areas.

In November, 1979, the Agency was confronted with a rocking blow: "What is happening with CMHC funding? Is it going to be cut before the current fiscal year is completed?" The issues raised by the circumstances and SSA focus have resulted in an Inter-Agency Task Force mandated by the Governor, and a mental health system growing-up process. With the water-under-the-bridge to date, sophistication is now required for respect. With the lack of planning to date, for which MHSAA accepts responsibility, basics must be attended to, directions reviewed.

2. The only public mental health services on Guam, CMHC, has grown from staffing grant beginnings to satisfying federal CMHC standards with a full complement of services, while fulfilling functions of State Hospital and numerous specialized services performed by other entities in most locations. ADAMHA Guidelines call for analyzing cost effectiveness of Single State Agency function. MHSAA received zero dollars of NIMH support in FY 1980. Review of the first Mental Health Needs Assessment presented in this Plan and the rest of the Plan, reflect considerable accomplishment. The State support of the MHSAA and channeling of energies into mental health from the alcohol and drug abuse areas, account for the difference. CMHC progress has been greatly assisted through the years by the CMHC funding of NIMH. The most recent grant totaled $517,000 and is covering a 15 month period. Total expenses for this period are projected at approximately $2.7 million. Thus, local funds are covering approximately 81% of the budget. With the possible loss of NIMH funding for FY 1981, the CMHC program can be seriously hurt, progress of several years lost in program development areas (though progress is and will be made in administrative areas). While cost effectiveness for CMHC has to be questioned in relation to some service component caseloads, the NIMH funding has produced a great deal.

In this context, the "Performance Report" is presented in broad terms. There are no objectives from last year. No prior objectives have been stated for the five functional areas of ADAMHA format.

For these reasons, the "Performance Report" is organized as follows:

A. General report on progress in the five functional areas to bring matters up-to-date,
B. Review of the stated objectives in the last Five Year Plan, and
C. NIMH, "Annual Report on State Plan for Comprehensive Mental Health Services."

A. General Progress in Five Functional Areas

1. Administration

a. Planning and Coordination

From a fairly isolated position in the years past, current issues have brought CMHC (The public mental health services) to the concern and formalized inter-agency review under Governor's Office authority. Such coordinated effort anywhere is rare, if not unique. This effort, at its heart, is planning at its best. This period of time is characterized by emphasis on questions rather than answers. In direct response to the Guidelines, SSA is active as an entity, in the area of mental health planning and coordination, for the first time and with the kind of commitment which achieved respect in the other disciplines quickly. At the provider level (CMHC) the Financial Distress Grant process has fostered response to realities, planning with hard decisions and activities to rectify deficiencies, internally and in relation to other Agencies.

b. Management Information Systems (MIS)

With emphasis by the ADAMHA Region IX Consultant, the beginnings of a useful MIS was implemented within one month of his trip. MHSAA has begun establishing the external information system, has been involved in the definition of data needs and intends to utilize its authority to assure the substantial refinement needed with the internal CMHC MIS. As noted in the Needs Assessment, most of the information exists; the problem has been lack of procedures and programming necessary to compile the information in consistent, useful formats. The Financial Management System (FMS) of the hospital is currently under revision with the key issue being expansion from two care types to separate care type codes for each service component. The charge vouchers already carry this information. The programming and procedure changes are expected to be functioning in November, 1980. Between now and then, the Management Reports required for FDG approval are being produced manually. With the FMS changes, reports will be generated by service component, by units of service defined by the fee schedule, by staff by provision of direct services, by charges and services rendered. Collection reports by service component will be generated. Manually, client caseload summaries will be generated. (MHSAA is considering requiring a client flow information system which will yield considerably more management information with about the same effect.) Acute inpatient care will be separately identified from other inpatient care.

In summary, progress over the last few years has resulted in basic data being available so that the basis of a good MIS could be constructed in

the last few months with full implementation of this basic system by November, 1980. It should be noted that this internal system is not under the authority of MHSAA. However, timely reporting of MIS results will be made to MHSAA and additional data requirements of the Territory of Guam will be gathered with system design assistance by MHSAA.

2. Treatment, Rehabilitation and Diversion

CMHC deserves to be commended for establishment of the full range of CMHC services in close compliance with federal criteria. Utilization data and analysis for the last year are presented in the Needs Assessment. Cutbacks are presently taking place given the adverse fiscal circumstances. It is important, though, that the growth since the last Five Year Plan, has made it possible to see weaknesses, set priorities and minimize impact on patients while actually assuring improvement of services in some areas.

A close working relationship exists between CMHC and the Department of Vocational Rehabilitation (DVR). In-patients, partial hospitalization patients and closed-case or aftercare referrals are provided full DVR programming.

Diversion efforts have been established in the last year in the form of alternatives to incarceration for drug and multiple DWI offenders with the Catholic Social Service Residential Treatment program. Also, the Court is working with Human Services Corporation and a CMHC pilot project in terms of referring DWI offenders for alcohol education programs with a common incentive of reduced fines for program completion. These efforts are coordinated by the Alternative Community Service Office of the Court. Mental health cases, however, are handled by standard court procedure and no formalized diversion program is anticipated.

3. Quality Assurance and Evaluation

Single State Agency (MHSAA) beginning with NIDA monitoring tools and NIDA sponsored technical assistance in applying the tools, has developed capability and experience in procedures, analysis and evaluation for the full range of service organization functions. The tools are currently being adapted to application for site monitoring of mental health programs and this monitoring process will be implemented quarterly beginning with the first quarter of FY 1981. In addition, resource material is being collected in order to identify specific, state of the art methods and tools for mental health services quality assurance and evaluation. The internal MIS of CMHC is beginning to produce data useful for inclusion in the MHSAA MIS. Before now, CMHC performed internal quality assurance through regular meetings of the CMHC Professional Advisory Committee composed of all service supervision personnel. These meetings include case review, problems encountered and planning to resolve identified problem areas. Regular evaluation of services by patients is conducted by the In-patient unit. In addition, CMHC is included in the Guam Memorial Hospital accreditation by the Joint Commission on Accreditation of Hospitals. Regular JCAH monitoring processes include CMHC services in the reviews.

4. Prevention and Education

MHSAA again, has concentrated efforts to date in the areas of alcohol and drug abuse. However, the activities and infrastructure developed in these two functional areas are directly related to mental health concerns. For this reason, the progress report for these two functional areas from the "Territory of Guam Alcohol and Drug Abuse Five Year State Plan, 1981-1986" recently published MHSAA, is presented in APPENDIX D. Except for educational components, the MHSAA prevention efforts are generic, focusing on school and family. Thus far, financial support for prevention has only come from NIDA and State funds.

CMHC, through the Consultation and Education (C&E) component, has been active. Presented below is the CMHC C&E progress report as submitted in the June 23, 1980 Fianacial Distress Grant application:

C & E Progress Report

Past Objectives of the Program have been:

1. To promote consultation between and among the various agencies and groups on the island as they relate to or use the Guam Community Mental Health Center services.
2. Raise the awareness of the Island's health providers and residents on mental health problems and the mental health services available.
3. To establish active and meaningful communication with the community on all levels relative to good mental health.
4. To assist with preventive programs relating to rape, substance abuse, and mental health problems.

From October 1, 1979 to March 31, 1980, the following programs were presented:

1. Workshops.[10]
   a. Facilitator Training
   b. Behavior Modification
2. Courses.[11]
   a. Psychological Testing - 1 Semester
   b. Psychotherapy - 1 Semester
   c. Group Process - 1 Semester
   d. Review Course in Psychiatric Nursing - 1 Semester
3. Consultation.
   a. Vocational Rehabilitation
   b. Guam Community College
   c. University of Guam
   d. Juvenile Justice
   e. Department of Education
   f. Department of Corrections

10 Table II-A
11 Table II-A

TABLE II-A

...ow, according to recipient and type of consultation, the number of hours the client care staff listed in Question 8 ...ted to consultation, public information, and public education during the MONTH OF FEBRUARY 1978 (See Instructions ... definitions of recipients and types of consultation). DO NOT INCLUDE consultation time devoted to center staff in any ...ter participating facility.

STAFF HOURS DEVOTED TO CONSULTATION, PUBLIC INFORMATION, & PUBLIC EDUCATION DURING MONTH OF FEBRUARY 1978

RECIPIENTS OF CONSULTATION (NOTE: Exclude consultation to center staff; see instructions for recipient included in each category)	TYPE OF CONSULTATION: CASE-ORIENTED	STAFF DEVELOPMENT AND/OR CONTINUED EDUCATION	PROGRAM ORIENTED	PUBLIC INFO. & PUBLIC EDUCATION
1. State and local law enforcement and correctional agencies	10	2	4	9
2. Facilities & Organizations concerned with Alcoholism	5			
3. Facilities & Organizations concerned with Drug Abuse	5			
4. Facilities & Organizations concerned with Family Planning	8		2	
5. Mental Health Facilities not affiliated with the Center	10	10		
6. Health services delivery system	5	2		
7. Public Welfare Agencies	18			
8. Facilities and Agencies for the Aged	9			
9. Facilities & Organizations concerned with Children (other than schools)	8			
10. Schools				
A. Public Primary	20	6		
B. Public Secondary	0			
C. All Other (including Head Start, Universities, Private, Parochial & Professional schools)	2	174	15	2
11. VA facility or other organization concerned with veteran care e.g., Twice Born Men, etc.	0			
12. General public				
13. Other (Give itemized account of amount and type of consultation time devoted to each on continuation page)		92		
14. Total staff hours (lines 1-13)	110	286	21	11

Number of enrolled pupils in catchment area

15. In your catchment area, what is the total enrollment as of September 1977 in the:

	ENROLLMENT
K-6 (27 schools)	
1. Public Primary Schools (grades 1-8)	15,599 6,051
2. Public Secondary Schools (grades 9-12)	5,288

5. Personpower and Training

Again, MHSAA has concentrated on the areas of alcohol and drug abuse. With the receipt this year of NIDA's Request for Proposal for the State Training Support Program, MHSAA has become fully functioning and a full partner in the NIDA training program. Some participation has taken place with NIAAA training courses and a "State Manpower Development Program" grant application to NIAAA is pending. Much of this activity by MHSAA is of a generic nature and CMHC is regularly invited to participate in training experiences.

The generic nature of MHSAA training efforts is enhanced by the major thrust of the work: to establish a network, or system, of trained "natural providers" to provide crisis intervention, counseling, assessment and referral services. This concept is discussed in more detail in the summary of the needs assessment. To establish this system, a complimentary goal has been to provide a cadre of local trainers within various agencies, with a sense of team purpose, and for these trainers to adapt national courses and materials for most effective use in Guam's unique cultural setting.

Progress over the last year in these areas is also represented in Appendix D taken from the Alcohol and Drug Abuse Five Year State Plan.

For the MHSAA, the central issue regarding mental health training and personpower development, is the exclusion of Guam from NIMH Manpower programming. The battle on this issue with NIDA, which cooperated admirably, will now be engaged with NIMH.

CMHC has included an in-service training program internally. As presented in the revised Financial Distress Grant application submitted at the end of February 1980, the program is on-going. Specific training performed annually is presented in the Action Plan, Part IV-E.

B. Review of Mental Health Five Year State Plan, 1976-1981

Objective

1. To plan and promote on a territory-wide basis a multi-level mental health delivery system which links public and private mental health resources to deliver comprehensive community mental health services effectively and efficiently.

Discussion

1.1. This objective is a continuing objective which the CMHC has partially fulfilled through the provision of a referral system with private physicians and general practitioners including Guam Memorial Hospital's intake and referral procedures requiring psychiatric evaluation of self referrals, and referrees from the courts, Dept. of Corrections, and Territorial Crime Commission, etc. Based on the action strategy, some of the specific activities during the five years were discussed.

Action Strategy

1.A. To establish within the mental health catchment area multi-disciplinary service delivery teams with mobile outreach capability to service neighborhoods and capability to provide intensive care, acute general care and extended care on a geographically integrated basis.

a. To provide such services and facilities through contractual arrangement whenever possible.

Discussion

1.A.1. This activity was initiated through the arrangement made between public health satellite clinics and CMHC. Presently, the stratification of a multi-disciplinary service delivery teams had not been fulfilled because of complications existing within the staffng procedures of GMH coupled with the acceptability of service needers responding to service delivery system.

Sub-Action Strategy

1.A.a-1. This sub-activity was completed through the arrangement made between Public Health and Social Services and CMHC, in the use of satellite facilities geographically located and distributed throughout the catchment area by village.

Objective

2. To provide for the establishment of comprehensive community mental health services and facilities to ensure the avaialability of non-institutional services in meeting the mental health needs of children and youth, adults and the elderly and of special groups such as, substance abusers, rape victims, low income and immigrant families, delinquents and adult offenders.

Discussion

2.1. This objective is currently achieved through the provision of existing facilities located at the old Guam Memorial Hospital building and the two GMH complexes adjacent to the main additional facility. Services addressing mental health needs are provided under the 12 functional programs as identified under the system description portion of this plan. Each of the service component has on one program service or another the functional capacity to deal with the service needs of children, youth, adults and the elderly. Special population group such as substance abusers are provided the services under the existing drug and alcohol program which consists of the methadone dispensing and drug-free outpatient unit. Rape victims, low income and immigrant families, delinquents and adult offenders are special groupings which are identified through the center's referral system and accommodating appropriate service in its class either within the center's service components or to Public Health and Social Services and private non-profit organization.

This objective is a continuing objective which the center (CMHC) will continue to address the needs for.

Action Strategy

2.A. "To reduce the prevalence, severity of, and disability due to emotional disorders, mental illness, and substance abuse and maintain 97% or recipients of clincial services in the community through preventive services (e.g. consultation and education) screening outpatient treatment, partial hospitalization, rehabilitation, and the utilization of transitional residential facilities."

Discussion

2.A.1. The impact of services by component cannot be readily identified by CMHC. To quantify the recipients of clinical services is limited at this time due to lack of clinical documented data supporting types, and kinds of services identifiable from caseloads. Consequently, this action strategy will become an objective on the annual update of the plan. With the exception of measuring efficiency of service by component, the center provides ninety-six percent of recipients of clinical services in the community through preventive services (listed in comparison to action strategy).

Objective

3. To provide through the CMHC, comprehensive community mental health and substance abuse services which are coordinated with the provision of services by other health and social agencies to: (a) insure that persons receiving services through the centers have ready access to all such health and social services as they may require, (b) eliminate duplication of services, and (c) maximize the appropriate use of available resources.

Discussion

3.1. Client/patient screening procedures and exisitng referral system identifies appropriate services to meet the needs of service needers. Client caseload information as recently developed and identified in the newly created MIS establishes client caseload data reflective of services and transfer of services within CMHC program or same service. Referral system is identified as internal or external.

Action Strategy

3.A. To develop or formalize within the next two years, written agreements and procedures with the Department of Education, and Public Health and Social Services, Veterans Administration, and other appropriate health and social agencies to facilitate referrals to and from these agencies and to eliminate duplication of services.

Discussion

3.A.1. Written agreements and procedures are documented in the format of an external referral report which includes acknowledgment of referree, receipt of referral and referring agent. The document identifies the Department of Education and Public Health and Social Services and other affiliated concerns.

Objective

4. To insure the availability to an appropriate spectrum of residential facilities for individuals who, in the absence of such facilities might be inappropriately institutionalized.

Discussion

4.1. Residential facilities for the elderly and drug and alcohol for the community at large are presently provided by Public Health and Social Services, Senior Citizen's Division and Catholic Social Services, SSA sub-grantee respectively. CMHC's Progress House is also a residential facility serving the community.

Action Strategy

4.A. To provide, based on identified needs, for non-existent transitional residential facility services which meet the treatment, domiciliary and social rehabilitation needs of clients requiring such facilities as alternatives to hospitalization.

Discussion

4.A.1. Appropriate residential facilities with home-like environmental settings are currently designed to meet rehabilitation needs of clients requiring such facilities as alternatives to hospitalization. (Example: CMHC's Progress House, DPHSS' Elderly Home in Tumon, Guam.)

Objective

5. To provide an appropriate facility for those persons in need of highly specialized inpatient care.

Discussion

5.1. The CMHC Mental Health In-Patient Unit provides specialized 24-hour in-patient care facility.

Action Strategy

5.A. To improve the behavior of patients so that release from in-patient care is possible by providing individualized treatment programs.

Discussion

5.A.1. Table III-D of the Needs Assessment indicates that In-Patient Unit length of stay is longer than the national average. However, 35% of CMHC inpatients are mentally retarded and chronic care cases which significantly skew length of stay upward. We can assume that CMHC is doing fairly well on this objective and next year's data should tell us more.

Objective

6. To promote high quality care through: (a) peer and utilization review, (b) standards for the maintenance and operation of mental health programs and facilities, and (c) ongoing inservice training and continuing education programs to upgrade job-related knowledge, skills and abilities of staff engaged in the delivery of mental health, substance abuse and related services.

Dicussion

6.1. This objective is met. For (a) the Professional Advisory Committee of CMHC reviews services per the June 23,1980 CMHC Financial Distress Grant, pages 132-151. For (b) the JCAH monitoring process for Guam Memorial Hospital accreditation includes CMHC. For (c) the training Action Plan, Part IV-E of this Plan, reviews CMHC on-going training activities.

Action Strategy

6.A. To establish a system of quality assurance within the Community Mental Health Center.

Discussion

6.A.(a) See 6.1. above.

Sub-Action Strategy

6.A.(a) To continue the present patient care committee representing each organizational segment of the Community Mental Health Center, to initiate and conduct peer and utilization review and care evaluation studies or an ongoing basis.

Discussion

6.A.(a) 1. This activity needs readdressing. Although patient care committee had been established, the intent and purpose of its function is limited-to biased objectivity of its review, consequently, evaluation and review studies will be an ongoing activity of SSA.

Sub-Action Strategy

6.A.(b) 1. To begin implementing within the next biennium standards for the maintenance and operation of mental health programs and facilities.

Discussion

6.A.(b) 1. This activity of implementing standards for the maintenance and operation of mental health programs and facilities were fulfilled through the compliance of the hospital's JCAH requirements. CMHC being a part of the hospital's facility satisfies the requirement.

Sub-Action Strategy

6.A.(c)1. To initiate within the next fiscal year, a more coordinated inservice training and continuing education for 60 employees of all disciplines delivering services within the center and special programs, including relevant areas of service in GMH.

Discussion

6.A.(c)1. CMHC addressed the action plan for its manpower development program and is currently assisted as an adjunct function of SSA detailed in this plan's Manpower and Training Section of the action plans.

Objective

7. To promote and support adequate health care financing including public and private third-party payments, for a broad range of benefits covering psychiatric and substance abuse services and which will provide adequate reimbursements for cost of services rendered.

Discussion

7.1. Initiatives for CMHC's revenue programs regarding third-party reimbursements and insurance coverage for psychiatric and substance abuse services were previously under the purview of GMH fiscal management. Most recently, the activity had been reorganized to adequately meet the financial management system requirement of CMHC, by the Hospital. Objective is redefined to read on-going.

Action Strategy

7.A. To develop and/or update within the next fiscal year, agreements with the Department of Social Services and Housing (Title XIX), Veterans Administration, CHAMPUS, and local health care insurance providers.

Discussion

7.A.1. All the above are currently third-party payers except for local health care inusrance providers.

Sub-Action Strategy

7.A.(a) To collect a minimum of 80% of billings to third-party or other payors for reimbursable services and to clients for fees as allowed within the present codes of Guam.

Discussion

7.A.(a) 1. Collections activity was a part of GMH's fiscal management operation until most recently. The GMH system was not reporting collections by sub-unit of GMH and has had collection problems. The GMH system is being amended now and should be providing this data in November. In the meantime, some information will be handled manually.

Objective

8. To assure through various mechanisms that residents, clients, and agency consumers of services are provided opportunities for input on the acceptability and relevance of services.

Discussion

8.1. Client-census and survey reports reveals staff and clients input as related to services and patient care. Further refinement of the process is needed to address specific concerns identifying quality of care and consumer survey report. SSA addresses the issue under Quality Assurance and Evaluation portion of the Action Plan.

Action Strategy

8.A. To establish and maintain within the next fiscal year, an advisory body for the Community Mental Health Center, a Territory Advisory Council, and public forum held at least annually in conjunction with the Health Planning Agency of the Territory, and regular meetings with appropriate organized groups within the catchment area.

Discussion

8.A.1. A Community Mental Health Center Advisory Committee has been established

and is currently active. See Appendix E, Item 4 for details

Objective

9. To establish and maintain a management information system to gather data required for program evaluation, planning, management, and recoupment of third-party reimbursements and patient fees.

Discussion

9.1. A component for management information system has been developed and is currently being implemented by CMHC. The sub-system addresses the data-base needs for CMHC's services, caseloads, staff utilization and third party reimbursements. This objective is an on-going process to be further refined by SSA Planning.

Action Strategy

9.A. To establish an adequate management information systems within the next biennium.

Discussion

9.A.1. The recently developed MIS is adequate to service the needs for mental health although further refinement is necessary to ensure the quality of service being provided.

Objective

10. To conduct and perform program evaluation to increase the efficiency and effectiveness of the mental health program.

Discussion

10.1. Internal evaluation by CMHC is a means of solidifying the program's structure and may assist in the improvement of efficiently providing mental health services. This objective is an on-going process and may become a developed process in the annual update complimenting SSA's planning and program evaluation requirements.

Action Strategy

10.A. To plan, initiate and conduct statistical and other analysis required for program evaluation.

Discussion

10.A.1. This activity is redefined to compliment the needs of SSA integrating internal (CMHC) and external program evaluation requirements.

C. NIMH "Annual Report on State Plan for Comprehensive Mental Health Services"

1. State agency authority, functions and organizational structure are reported in Part I of this plan.

2. State Advisory Council membership and activities are presented in Part I of this plan. The Council will review this plan upon its completion and simultaneous submission to ADAMHA, Region IX.

3. The Needs Assessment presents the input from "key informants" through the Spring of 1980. Appendix B present proof of public hearing both at the beginning and ending of the plan process. The plan is simultaneously submitted to Guam Health Coordinating Council through GHPDA. The NOI is presented in Appendix B. The plan has been made available to the public at the centrally located MHSAA offices.

4. Personnel standards continue to be represented by the Guam Civil Service Commission and Department of Administration's Personnel Rules and Regulations. Copies are available upon request.

5. Reporting requirements and record-keeping have gone through no changes with MHSAA except that CMHC reporting and records have gone through substantial changes. These changes are presented in Appendix E but are best presented in the full context in the Financial Distress Grant of June 23, 1980 and addendums. Refinement will continue to take place with progress fully reported in the first Update to this plan.

6. Standards are fully discussed in Part I, G-2 and Part IV, C of this Plan.

7. MHSAA and GHPDA work closely together. Despite the time and content difficulties of this plan preparation, GHPDA is aware of the development and has been intimately involved with MHSAA in the CMHC Financial Distress Grant issue. Upon completion of this Plan, MHSAA and GHPDA will work mutually to adapt this Plan to Health Planning format for submission in Spring 1981. With GHCC review and comment, and by maintaining communication directly and through GHPDA, GHCC will have substantial impact on the continuing mental health planning process.

8. There have been no changes in the catchment area.

9. Needs Assessment is presented in Part III of this Plan. Facilities of CMHC are known, unchanged in significant ways over the last three years but have not been specifically inventoried for this plan. Changes of substantial nature are possible in the next year and the inventory will be complete for the first update.

10. Parts II, III, and IV of this Plan report the programmatic status of CMHC in detail.

PART III: NEEDS ASSESSMENT

Introduction

The following represents a preliminary analysis of Guam's need for mental health services. It is the beginning of an ongoing development of needs assessment, with steps for improvement reflected in the plan's objectives. In many cases, the lack of available data precludes a thorough analysis. This highlights one of the primary administrative needs identified in this plan: That of a well-designed management information system (MIS). That good annual data will be available for the first update of the Five Year Plan, as demonstrated by the July, 1980 data acquired from study of the MIS recommended by Dr. Edward Rudin during his June, 1980 consultation/technical assistance visit. (The Management Report is included as APPENDIX E, Item 3).

With consideration of admission, caseload and discharge data reported for the first 10 months of FY 1980, a fairly accurate picture of current utilization exists. The July study of the MIS represents a major step forward for Guam's mental health planning. It is hoped that deficiencies in this plan are viewed in light of the evidence that steps have been included to deal with these deficiencies in the future.

It must be recognized that the recently implemented MIS is only a beginning. For instance, changes which will allow reporting of care days per episode and defined units of service which can be related to costs and/or revenues, must be included.

To employ a good and sound comprehensive management information system, the Community Mental Health Center's implementation of an MIS should entail the commitment of evaluating, appraising and updating of the system including program management review guidelines as determined by SSA. The need to address these guidelines of the system can only add to the desired quality of a responsive management data base system and consequently improve the services of each functional component.

A key element of a comprehensive mental health needs assessment is a community based survey. Limited time and lack of example methodological instruments has precluded inclusion of this element in this year's need assessment. It is a stated objective of this Agency to conduct and analyze such a survey for inclusion in the first year update.

With these limitations, the following strategy is employed:

1) Historical perspective, socio-demographic data,
2) The limited utilization data of the services system is presented,
3) NIMH Biometry data, providing ranges of mental health resources utilization across the nation in 1976[12] is used for basic estimates of need on Guam and compared with the CMHC utilization data,
4) Social indicators which also help define the context and hint at relative extent of mental health needs, are presented,
5) A summary of key informant perceptions of mental health needs and existing services is presented and discussed, and
6) All of the above are considered in the summary analysis.

12 Source: As presented by Harold Conrad, M.D., in the CMNI "1980, Combined Alcoholism, Drug Abuse and Mental Health" State Plan Needs Assessment, pp. 26-32.

The In-patient Unit of CMHC has had the treatment philosophy to provide short term, intensive psychiatric treatment for those individuals whose function is so severely impaired as to require protection for themselves, others or property. However, in practice the unit has provided approximately 29.4% of it's patient days to chronic long term clients and 6.1% to mentally retarded. This has been due to lack of alternatives for these placements. CMHC intends to change it's admission criteria for In-patient to the following:

"From:

Psychosis with or without suicidal/homicidal intent;
Severe depression;
Manic with poor behavior control.

To:

Dangerous to the self, others, or property."[13]

Implementation of this change is not likely to be approved until an alternative is found for the non-acute care patients. Other Units of CMHC do not report admission criteria. Besides internal referrals and requests from other agencies for diagnostic workups, it must be assumed that self-perceived mental health problems is sufficient for admission to any of the outpatient modalities. Mental Health and Substance Abuse Agency has not yet established SSA policy definition of the various mental health cohorts. This will be done over the next year, based on national standards but reviewed and amended to assure local relevance. This work will be in cooperation and with input from CMHC and the private providers.

A. Area and Population

1. The Island (description of the catchment area), the Community Mental Health Center and Single State Agency serve the Territory of Guam, comprising the island of Guam. An organized, but unincorporated territory of the United States, Guam is the most populous of the western islands known as the Mariana Islands. Guam is 32 miles long, ranges form 4 to 8½ miles in width and has a total area of approximately 209 square miles. The island lies 1,350 miles from Hong Kong; 1,499 miles from Manila; 2,006 miles from Sidney; 3,318 miles form Honolulu and 5,060 miles from San Francisco.

The climate is tropical, with a mean annual temperature of 81 degrees. The warmest months are May and June, while most of the average yearly rainfall of 80 to 100 inches falls from July to September. Guam enjoys tradewinds throughout the year and abounds with beautiful beaches, exotic flowers and tropical fruits. The Northern half of the island is a high rolling plain reaching to a height of 400 feet with steep cliffs abruptly forming the coastline. In the central/western part of the island is Agana, the capital city. This section is level, with low hills rising into rough mountains of 700 to 1,344 feet above sea level in the South. At the Southern end of the island are colorful villages and good boating and fishing areas.

Guam is located on the fringe of the Pacific typhoon belt and is threatened 4 to 5 times a year by major typhoons. Historically, major typhoons (with the eye passing over Guam) have occurred on the average of every 6.6 years. The last one, Typhoon Pamela, devasted the island in 1976.

13 June 23, 1980 Financial Distress Grant, page 159.

Military bases compose 1/3 of the island's land area. Major military installations of the Navy and Air Force are located in Northern and Middle Western parts of the Island. Older residents state that the military bases occupy some of the richest farm land on Guam.

There is no public transportation on the island. Taxis and tourist shuttle buses are available. However, the primary means of transportation is privately owned cars.

Because the bulk of Guam's building materials, food clothing, and transportation are imported from the United States or Asian countries, the cost of living is extremely high.[14]

The People

The people of Guam have witnessed significant changes in their island society since Ferdinand Magellan landed here in 1521. The population has experienced Spanish domination, an American Naval government, and Japanese occupation before the current U.S. territorial status. Each event has left its mark upon the people. The Spanish brought Catholicism to Guam. The precepts of this Church are now integral parts of Guam's culture. The Navy's reign initiated the process of "Americanization", while cementing a close U.S. territorial relationship. Events of WWII emphatically domonstrated the strategic importance of Guam's position as "Gateway to the Orient." That military role is still the over-riding fact of Guam's existence. It dictates the increased U.S. involvement in local affairs which touches the lives of everyone on Guam. Tourism, primarily Japanese, has become the second major industry for Guam and is continuing to grow.

The "Americanization" or "urbanization" on Guam, while by no means complete, has proceeded at a break-neck pace during the last 40 year period. The Chamorro culture has been propelled from it's agrarian, "familia" system to a job-oriented system of individualistic values. Now agriculture has declined to the point where Guam imports nearly all of its food primarily from the U.S. mainland.

This transition to modern, western society, which took the Western Civilization hundreds of years, has occurred within a 40 year period. That period also witnessed two major demographic changes. First, there was an extraordinary jump in Guam's civilian population. In 1940, it stood at 22,290 and by 1980 it had risen to 84,800.[15] Second, while Chamorro population continues to be the largest ethnic group, immigration has greatly increased Guam's cultural heterogeneity. In 1940, the Chamorro comprised 90.5% of the total population. By 1977[16] that percentage had declined to 62.1% while the

14 A June, 1978 Study by Cost of Living Office, Guam Department of Commerce, reveals food prices on Guam are 12.5% higher than Honolulu and 44.4% higher than Los Angeles. The January-March, 1980 "Quarterly Economic Review" published by the Economic Research Center, Department of Commerce, Government of Guam, on page 29, compares the Consumer Price Index on Guam across categories of items. All appear to follow similar pattern to "Food" with the exceptions of transportation increasing dramatically (probably due to oil and probably proportionate increase with Stateside) and "Appeal, Entertainment". and "Other Goods and Services" rising more slowly. In the case of "Apparel," Guam may be better off that Stateside in terms of recent price increases due to Asian imports.

15 Non-immigrant aliens and Active-duty military and their dependants living on base are not included in this figure. While active-duty personnel are served by military facilities, their dependants utilize civilian services.

16 Bureau of Labor Statistics, Department of Labor, Government of Guam.

Caucasian group has grown from 3.5% of Guam's total population to the 1977 level of 8.1%. The Filipino population, meanwhile, has grown from 2.6% to 21.2% of the total. In view of this population shift, Chamorro have reason to fear that their race may become like the Hawaiian, a minority in their own land.

Along with these dramatic changes, the insular nature of the island poses an on-going challenge for service providers. The island's small, isolated population cannot financially support a wide range of specialized services. Guam's Community Mental Health Center is responsible for all the public mental health needs of it's catchment area. It must offer broad-based services to address the majority of the island's service needs.

One example of the implications of this small, insular status is that the CMHC in-patient unit has been the only supervised, residential setting available for chronic care, care of the mentally retarded who cannot be cared for by family, and other inappropriate placements.

An issue worth special note here concerns geo-political temperament of the people of Guam. The 40 year transition is not over. Something which is coming to an end is the patient acceptance of U.S. influence, which has often involved major policies made by people in Washington D.C., who have little awareness of Guam. The patient acceptance has been dominant in large part because the vast majority of Guam's leaders had vivid memories of Japanese occupation and American liberation. A rapid change of leadership to individuals without these memories and who also have most strongly felt the cultural transition, is in rapid progress.

In this culture, characterized by much reserve concerning public expression of feelings, political status is a hot issue with much public expression of strong feelings. While Guamanians are acutely aware of the economic implications of independence from the U.S. political sphere, sentiment is high for considering alternatives to U.S. domination if equal political status, first class citizenship and respect, cannot be gained.

U.S. policy-makers should not allow themselves to be falsely lulled by the soft-spoken nature of Guam's protest compared with Stateside social protest. The pride and basic unity of the Chamorro is strong. It is reflected in the little realized fact that the Chamorro enlistments and casualty rates per capita for Guam, since World War II, lead all ethnic groups in America. The underlying pride and political tension will have significant impact, in the context of the cultural transition, on Guam's mental health status considered in the broadest sense.

The signs of this impact will probably not be clear before preparation of the next Five Year Plan. Issues like the high herion prevalence compared with low prevalence of other drugs (excluding alcohol) and the high rate of homicide might be at least partially explained by these issues.

Social stress, accepted as closely correlated with incidence of mental health problems, is and will be high on Guam.

B. Capacity and Utilization Data

1. Overview

By far the most significant fact concerning Guam's mental health services system is that the Guam Community Mental Health Center (CMHC) is the only public provider. The inpatient unit of CMHC must serve as State Hospital as well as the community acute care

facility. Historically, this [illegible] also served Guam's needs for chronic care, those mentally retarded who [illegible] placed with family, temporary confinement of the criminally insane and those [illegible]g and/or alcohol induced problems involving dangerous behavior. Alternatives do not now exist for these groups.

By lack of alternative resources, the other elements of CMHC services are corresponding expected to respond to needs which in larger and less insular communities are handled by other agencies.

2. Private Providers

For a number of reasons, Guam's private service capactiy has been small. Before June, 1979, the only active private provider was the Behavioral Clinic with D. Kanaiapuni, Ph. D., a tests and measurements specialist and a medical consultant.

In June, 1979, Catholic Social Service opened its doors, with a contract to provide residential treatment for substance abusers, and the Order of Sisters of the Good Shepherd providing crisis counseling and other services. The Executive Director is Father David Quitugua, M.S.W. Pending proposals would allow CSS to provide comprehensive services for women with alcohol related problems (including a general alcohol awareness campaign) and transportation for the elderly.

In July, 1980, Human Services Corporation (HSC), a non-profit corporation, became active under Executive Director Phyllis Luminelli. It is currently conducting a study, "Barriers of Employment for Displaced Homemakers," a CETA project sponsored by the Government of Guam Agency for Human Resources Developement. Other employment and human behavior related services and training proposals are pending. HSC has also begun individual and group counseling on a limited basis, with emphasis thus far on the special needs of women.

The former Director of the CMHC, E. Woodyard, Ph.D., returned to Guam in late 1979, opening a private practice of psychotherapy and consulting.

Each of these private providers are involved in mental health or mental health related services. The Behavioral Clinic has focused on individual psychotherapy and psychological assessment with a children's specialty. The others are new, growing and changing. Each of these new providers appears flexible and likely to be responsive to community need within funding limitations. Except for the CSS residential treatment for substance abusers, the only public funding is in the form of third-party payments and thus utilization data is not reported. (However, a quarterly survey for minimal information will be implemented in the first quarter of FY 1981.) Except for the Behavioral Clinic, capacity information at this state of the providers' development, capacities cannot be projected.

3. Public Provider- Community Mental Health Center

A central issue of CMHC at this time is the lack of fully functioning system for compilation of programmatic and fiscal information. In both cases, most of the needed information has been and is being collected and stored. What has been lacking is the mechanism for extracting and reporting critical data in useful formats. For lack of such mechanism in the past, much historical data is realistically unretrievable at this time.

For FY 1981, the manual programmatic and fiscal management information system designed by Edward Rudin, M.D., during his June, 1980 D.H.H.S. Region IX sponsored visit has

been implemented, with July, 1980 programmatic data summarized in Table III-A.[17] While admittedly a short duration, this one month of comprehensive data allows calculations of estimated annual episodes and caseloads expanded proportionately to annual data that is available. Also, these expansions are made from data collected by uniform format from the service components. The episode (admission) data allows comparative analysis with national data Table III-D, and gives meaning to care days/patient visits data. The caseload data allows analysis of staffing pattern related to utilization by service component, (Table III-B).

Inpatient data is presented as reported and also reduced ot reflect the approximate 64.5% acute care portion of total patients[18], particularly in order ot compare utilization with national figures. For other service components, data is selected from various sources to be most comparable to the new MIS data and adjusted as necessary to reflect day-to-day direct service staff for each component in order to facilitate caseload analysis. Staffing presentations for fiscal, administrative and medical considerations of analysis have been separately presented in the FDG and other addendums.

Table III-C is presented to indicate the level of impact on mental health services from a need perspective (who will no longer be served) with one-year Financial Distress Grant Support and without. The critical issue is the numbers of what kinds of clients will be served with one-year support beyond the support period (beyond 10/1/80) who would not be served in FY 1982 (beyond 10/1/81) if the one-year support is not provided. These figures are by necessity approximations, considering all the complex variables involved, especially the vagaries of federal funding. If future federal support for human services on Guam were known, a reasonably accurate impact statement could be made.

The Needs Assessment "Analysis and Summary" looks at the implications of the capacity and utilization data in relation to the other needs assessment factors.

C. NIMH Biometry Data Compared With CMHC Utilization

In assessing service requirements, NIMH biometry data from 1976 Stateside utilization statistics have been applied to Guam's actual 1980 and projected 1985 and 1990 population figures. While Guam differs in many respects from the mainland U.S., these figures offer a starting point for our analysis. They are presented in Table III-D.

Even with the dramatic drop in inpatient days, the FY 1980 rate is still 2½ times that fo the high end of the Stateside range. However, until these figures are compiled separately for acute mental illness, a conclusion is difficult to reach. Both the mentally retarded (approximately 6% of the caseload) bias CMHC inpatient days upward, even if data were available in average days per episode.

Outpatient visits at CMHC are running about 25% higher than the high end of the Stateside range. The main factor which probably contributes to this high figure, is the fact that the Methadone program generated daily visits (charged at 15 minutes) for dispensing. In FY 1979, the Drug Program alone generated approximately 2/3 of all outpatient visits; almost all of these were visits for dispensing of methadone. If these are deducted, that all other outpatient contacts by CMHC total approximately 80% of the

17 The complete MIS report for July, 1980 is included as APPENDIX E, Item 3.
18 Financial Distress Grant p. 157
June 23, 1980 FDG Submission, page 157

TABLE III - A

GUAM COMMUNITY MENTAL HEALTH CENTER
CENSUS REPORT

MONTH JULY YEAR 1980

	ADMISSIONS	DISCHARGES	ACTIVE CASES	PATIENT VISITS	PATIENT CARE
EMERGENCY SERVICE	4	4		8	
MH IN-PATIENT UNIT	13	12	18		483
PROGRESS HOUSE	0	4	5		253
PARTIAL CARE SERVICE	4	12	49		524
AFTERCARE SERVICE	4	3	48	155	
PROGRAMMAN PATGON	5	3	40	87	
ADULT OUT-PATIENT	6	12	60	178	
ELDERLY SERVICE	0	3	17	20	
DRUG RX SERVICE	0	2	20	554	
ALCOHOL RX SERVICE	0	3	3	1	
MONTH-TOTALS	36	58	260	1,012	1,260

TABLE III - B

CMHC CAPACITY AND UTILIZATION
BY SERVICE COMPONENT (MODALITY)
FY 1980

Service Component	FTE Clinical Staff Total/Direct Only*	Utilization Projected FY 81 Caseload/Visits or Days	Expanded FY 80 Caseload/Days Care or Pt. Visits**	Capacity Caseload One hr. Visits or Days***
Emergency	1.0/ 1.0	225/450	126/217	650 - 1300
In-Patient +	20.2/19.3	17/6205	17.9/6490	17/6205
Partial Hospitalization	10.9/10.3	61/4884	58.5/4990	61/4884
Progress House +	2.5/ 2.3	- 0 -	7.7/3224	8/3000
Aftercare	2.5/ 2.0	N/A/2338	48.7/1457	N/A/1752
Adult Outpatient	5.6/ 4.0	N/A/4674	73.5/2648	80/4672
Alcohol Service	2.6/ 2.0	N/A/2103	11.0/ 761	20/2336
Drug Program	5.4/ 4.0	N/A/5259	26.8/5934	40/4672
Programman Patgon ++	4.5/ 4.0	N/A/3506	51.8/2222	80/4672
Forensic	0.8/ 0.8	- 0 -	N/A	350/1400
Elderly (Included in Adult Outpatient Consultation and Education)		-	25.1/1366	----

*** Estimated by MHSAA if not clear from page 219, June 80 FDG or Feb. 80 FDG, page 99
* Based on Financial Distress Grant of June 23, 1980 staffing pattern and page 219, Direct staff are best count of caseload staff
** Data for October, 1979 through July, 1980 is expanded to give an annual figure.
+ Care-Days (otherwise, Patient Visits)
++ Children's Services

TABLE III-C

IMPACT ON GUAM COMMUNITY MENTAL HEALTH CENTER CLIENTS WITH AND WITHOUT ONE-YEAR FINANCIAL DISTRESS GRANT FUNDING

SERVICE COMPONENT	ADMISSIONS Expanded FY80	Projected FY81 W/FDG	Projected FY81 W/O FDG	Projected FY82 W/ FY81 FDG	Projected FY82 W/O FY81 FDG	POTENTIAL FOR ALTERNATIVE GIVEN ONE YEAR DEVELOPMENT TIME
Emergency	126	126	126	126	126	
In-Patient	139	90[1]	90	90	90	Change of Progress House Purpose
Progress House	5	11[2]	0	20[3]	0[4]	Progress House can be justified w/expanded function.
Partial Hospitalization	52	52	52	52	52	
Aftercare	28	28	28	28	28	
Programman Patgon	125	125	60	?[5]	?[5]	Dept. of Education and Federal Education $$. With time and training this unit can perform valuable functions for the public interface, patient return to community, etc. MH Systems Act, NIDA, NIAAA funding are all possible for this.
Adult O/P	132	132	120[6]	132	100[7]	
Elderly	4	4	---[8]	---[8]	---[8]	Other agencies are beginning to fill the gaps in services for the elderly.
Drug Program	23	23	10	25[9]	15[10]	Outreach support through MHSAA Drug Training and Prevention.
Alcohol Program	32	?[11]	0	?[11]	0	Catholic Social Services, Human Services Corp. and MHSAA through various categories of NIAAA $$$.
Forensic	N/A	0	0	0	0	Court
Consultation & Education	---	---	---	---	---	MHSAA through consolidated Training and Prevention federal $.

TABLE III-C

Footnotes

1/ Based on admitting only acute care patients which now comprise 64.5% of inpatient per FDG application page 157.

2/ This is based on FY 80 discharges since Progress House Utilization has been stable and factors can explain the low admission figure for FY 80. It could be anticipated that the changes in In-Patient admission criteria could result in greater utilization of Progress House.

3/ This makes two assumptions: a) with time, and with impact of In-Patient changes apparent, continued funding can be found, and b) Progress House would begin serving some additional short-term housing needs as well as the predominant long-term caseload now served.

4/ It is not easy to get a program started when an existing one has recently been shut down.

5/ MHSAA requires more knowledge of this program and DOE priorities in order to make these projections.

6/ With the low staff/patient ratio, capacity should be sufficient for current caseload. The change, however, would probably have adverse impact to some degree.

7/ MHSAA feels that current problems at CMHC are and will be most felt in the outpatient programs. This area is planned to experience a large cut and increased responsibilities. While the numbers would indicate that this is viable, morale, image, change and weak sense of purpose issues in relation to the other services, can be expected to have long-range impact. FDG funding would provide sufficient feedback of worth and the time necessary to adapt with spirit.

8/ Elderly will be included in Adult Outpatient caseload.

9/ MHSAA has noted lack of outreach activity and poor morale in this program. With security of full functioning and the time for MHSAA to assist outreach, the potential clientele which seems to exist will moderately increase utilization.

10/ Loss of FDG funding at this time would probably not kill the program, but would create significant setback.

11/ Caseload has declined steadily since the early months of this program a year ago. Communication has not been good and the reason for this decline is not known. Projections cannot be made.

12/ Services distributed among components. Not included as case data.

NOTE: ALL PROJECTIONS WERE MADE BY MHSAA BASED ON IMPLICATION OF THE FDG OBJECTIVES. AND FY82 PROJECTIONS DO NOT REFLECT POPULATION OR POTENTIAL UTILIZATION GROWTH. THESE ARE BY NECESSITY, HIGHLY SUBJECTIVE PROJECTIONS.

Expected Annual Utilization Based on National Averages and Guam's Population Projections

	Biometry Figures	FY 1979 Actual	FY 1980[1] Actual Expanded	1990	1985[2]	1990[2]
Inpatient Episodes	2-3.6/1,000/yr.	142	139	170-305	184-332	196-354
Inpatient Days	5.7-30/1,000/yr.	8256	6490	483-2,540	523-2,750	560-2,950
Average days per episode	12-20	36[3]	N/A[4]	12-20	12-20	12-20
Inpatient Beds (acute care)	.15-.24/1000/yr.	17	17	13-20	14-22	15-22
Total persons served by comprehensive mental health programs	20-27/1000/yr.	N/A[5]	N/A[5]	1,700-2,300	1,800-2,500	2,000-2,700
Partial care episodes	1-2/1000/yr.	N/A	52	85-170	92-180	98-200
Partial Care Days	33-83/1000/yr.	5239	4878	2,800-7,600	3,000-7,600	3,200-8,200
Average days per episode of partial hospital care	30-49	N/A[4]	N/A[4]	30-49	30-49	30-49
Outpatient Episodes	19-27/1000/yr.	400[6]	Due 8/8/80	1,600-2,300	1,700-2,500	1,900-2,700
Outpatient Visits	87-137/1000/yr.	15,262	15,262	7,400-12,000	8,000-13,000	8,500-13,000

Continue on next page for Footnotes.....

TABLE III-D

Footnotes

1. Figures from October, 1979 through July, 1980 were multiplied by 12/10 for the expansion to all FY 1980.
2. Expanded based on the 1975 Quinton-Budlong population projections
3. Based on the average of 1976, 1977 and 1978 average length of stay reported in the "Guam Community Mental Health Center, Operation Grant Application, Fiscal Year 1980".
4. Average length of stay for FY 1980 has not been reported.
5. An unduplicated count is not available.
6. Admissions are assumed to be equivalent to episodes.

low end of the national range. A look at outpatient episodes reveals that episodes are only 25% of the low end of the national range. The fact that outpatient visits are approximately three times as numerous per episode than nationally, needs to be looked at closely. There may be a reasonable explanation, or treatment time to discharge needs to be reduced. Low caseloads in outpatient services could explain the high visits per episode as unconscious willingness by clinicians to draw out treatment. In fact, based on outpatient episodes, CMHC falls far behind Stateside experience. The Key Informant report addresses this issue directly.

One of the issues to be discussed in the Key Informant section of this Needs Assessment is the reluctance of people to use CMHC services. With the methadone program generating almost 2/3 of outpatient visits and many of the 17-20 inpatients on the grounds each day, (partial care patients probably should be included for this issue) activity at CMHC is dominated by two groups: groups who are generally identifiable as shunned social groups. It would be naive to assume that this factor does not have its negative effect on potential users of other CMHC services, as unfortunate as that may be. Consideration should be given to providing other outpatient services in a different location.

D. Social Indicators

While it is clear that Guam's 40 year process of urbanization has dramatically changed the lifestyle of its people, the more subtle impact of this development on their social relationships is difficult to assess. A series of social and economic indicators were analyzed as an initial approach to that assessment. They are listed below:

Social Behavior

- Divorce rate trend
- Abortion trend
- Child Abuse trend
- Crime
- Substance Abuse

Social Conditions

- Housing
- Mean Family Income
- Unemployment trends
- Ethnic Composition
- Public Assistance Caseloads

Social Behavior

Divorce Rate - Table-E presents Guam's divorce rate from 1955 to 1978. During that period, Guam's divorce rate tripled from 1.0 per 1,000 civilian population to 3.1 per 1,000. While Guam had not, as of 1978, reached the 1977 U.S. rate of 5.0 divorces per 1,000, it can be expected to do so within the 5 years of this plan, if the current trend continues.

With the Chamorro tradition of strong extended families and predominantly Catholic population, Guam's rising divorce rate highlights a 2-pronged problem. First, in any area an increase in divorce highlights the stress families undergo and suggests an inability to cope with that stress. For Guam, rapidly changing values play an important role. Single parent families can be viewed as an "at risk" population

DIVORCE: DATA FOR GUAM

YEAR	DIVORCES	RESIDENT MARRIAGES	DIVORCE RATE	MARRIAGE RATE
1955	55	339	2.0	9.0
1960	47	443	1.0	11.0
1965	60	471	1.0	10.0
1970	105	726	1.2	8.4
1975	233	767	2.4	7.8
1976	313	694	3.5	7.7
1977	331	747	3.6	8.2
1978	361	1,115	3.1	15.1

O - MARRIAGE RATE

X - DIVORCE RATE

--- Continuation

1977 U.S. divorce rate: 5.0

1977 Guam divorce rate: 3.6

Dept. of Commerce

Source Office of Vital Statistics

which may need increased public support services. In addition, this trend has unique implications for the Chamorros. It is contrary to the familia system which represents the fabric of Guam's traditional social protection structure. An increase in divorce indicates that this system may be collapsing under the island's increasing westernization.

Child Abuse - Between 1975 and 1979, reported cases of child abuse have increased by 94%, from 109 cases to 211. (See Table III-F) (Earlier data is not available) That trend is expected to continue in 1980, with 103 cases reported as of June 1. The staff of Guam's Children's Protective Services views this sharp increase as the result of growing community awareness rather than a rise in incidence. Nonetheless, this increase places a demand upon, and importantly, demonstrates an increasing public reliance upon, the services of the public system, and it particularly highlights the need for family programs. In 1979, 52% of the 211 reported cases involved actual abuse, rather than neglect. Where neglect may suggest a need for educational or support services, cases of abuse generally are expressions of dysfunctional coping skills, viewed here as a mental health problem. A national study conducted by the American Humane Society last year linked child abuse with family stress, citing 3 major causes of abuse: stress due to insufficient income, broken homes, and family discord.

TABLE III-F
CHILD ABUSE DATA

YEAR	TOTAL REFERRALS	PERCENT CHANGE
1975	109	-
1976	154	+46%
1977	122	-21%
1978	157	+29%
1979	211	+34%

Source: Children's Protective Services

TABLE III-G
ABORTION DATA

YEAR	TOTAL VOLUNTARY ABORTIONS	TOTAL VOLUNTARY ON CAUCASIANS	TOTAL VOLUNTARY ON GUAMANIANS
1973	0	0	0
1974	14	3	4
1975	47	10	12
1976	115	26	42
1977	197	50	43
1978	65	15	21

Source: Guam Memorial Hospital

Abortion - Table III-G presents the total number of voluntary abortions performed at Guam Memorial Hospital between 1973 and 1978. (Earlier data are not available) A review of the ethnic background of women receiving these abotions shows that Caucasians tend to be over-represented as expected by religious affiliation. In 1978, 23% of the abortions performed involved Caucasian, 18% involved Filipino, and 32% involved Chamorro women. (The total civilian population as estimate for 1977 p. 5 of Needs Assessment) is comprised of: 8.1 Caucasian, 21.2% Filipino, and 62.1% Chamorro. The striking fact is

the increase in non-Caucasian voluntary abortions.

Crime - Youth crime on Guam does not appear to have increased significantly in the past 3 years. (Comparable data are not available before 1977). This is illustrated by Table III-H below.

TABLE III-H
DELINQUENCY DATA

YEAR	TOTAL CASES RECEIVED
1977	453
1978	267
1979	362
1980	270 (as of the end of June)

Source: Superior Court
Division of Probation Services
Juvenile Probation Section

A review of the ethnicity of juvenile offenders shows that Filipino group under represented, the Chamorro group slightly over-represented, and the percentage of Caucasian offenders parallels that group's population percentage. In 1979, 9% of the youth offenders were Filipino, 63% Guamanians and 8% Caucasian.

Ethnicity of adult offenders presents a somewhat different picture. In 1978 Caucasians made up 18% of the total arrests, while Filipinos comprised 10.1% and Guamanians were 56.8% of the total. In part, the over-representation of Caucasians could be due to arrests of military personnel stationed on Guam. This is not clear, however, from the data provided.

As of 1978, 12% of the total arrests made were for crimes against persons (murder, forcible rape, assault). The rest of the arrests were for crime against property. This ratio has remained fairly stable since 1975.

While these data do not offer immediate insight into Guam's need for mental health services, it is hoped that in the future, data will become available which would enable us to compare Guam's situation with the national average and ultimately to analyze the trend on the island.

The Department of Public Safety does report that the total number of reported offenses between 1974 and 1978, rose by 27%, from 7045 to 8949. Should that trend continue, Guam's offenses could total as much as 11,385 by 1983.

Social Conditions

Ethnic Composition

As noted earlier, the ethnic composition of Guam's people has grown much more heterogenous in the past 40 years. The Chamorros are no longer clearly the dominant ethnic group as Caucasian and Filipino populations continue to grow. This trend is illustrated in Table III-I below:

TABLE III-I
Total Population of Guam by Ethnicity[1]
(in percent)

YEAR	Chamorro	White	Filipino	Others
1920	92.0	2.1	3.0	2.9
1930	88.6	6.5	2.0	2.9
1940	90.5	3.5	2.6	3.4
1950	*	*	* .	*
1960	86.2	6.2	3.3	4.3
1970	76.9	9.2	8.9	5
1977	61.2	8.1	21.2	9.5

* DATA NOT AVAILABLE

Sources: Bureau of Labor Statistics, Department of Labor, Government of Guam

The percentage of white residents has doubled in the past 40 years while the Chamorro percentage has declined from about 90% to 60%. The most dramatic shift in ethnic proportions of the population is the growth of the Filipino community from it's 1940 level of 2% to the 1977 figure of 21%. Much of this growth occurred due to post WWII immigration.

Housing

While the housing stock on Guam continues to improve, the island faces serious problems which hinder the achievement of the goal to provide decent, safe and sanitary housing to all its residents. Typically, mental health needs have been associated with crowded housing conditions. Subjective opinion of the staff of the Guam Housing and Urban Renewal Authority, however, is that crowding is not a problem on Guam. To a large extent, this is because family living patterns are adapted to small dwelling. More pressing concerns focus upon the growing cost of a home and the needs of low-income residents. Because materials, and often labor, must be imported, building costs on Guam are extremely high. G.H.U.R.A. estimates that "over 60% of future households will not be able to enter into the home purchasing marker."[1] This means the demand for rental housing can be expected to rise. Currently 36% of Guam's occupied units are rented.

Currently U.S. averages are not available to enable us to compare Guam's housing situation with other parts of the country. However, the trend for Guam clearly indicates a growing rental population.

Family Income

According to latest available figures, the average household income on Guam for 1978 was $19,309. This represents a 20% increase over the previous year. However, the 1979 Annual Governor's report notes that, "total personal income in Guam has grown twice as fast as on the mainland, from $142 million in 1970 to $299 million in 1975..."[2]

The mean family income on Guam increased by 37% between 1975 and 1978 (from $14,114 to $19,309.) At roughly the same time (1976 - 1979), the percent of families receiving under $7,000 per year declined from 25% to 21%.

Although the mean family income on Guam has risen steadily since 1975, it still was

1 "Guam's Need for a Housing Program" 1980 publication
2 Page 6, Annual Report.

below the U.S. average as the 1977. That year the U.S. mean was $18,264 while Guam's mean stood at $16,405. However, families on Guam tend to be larger than on the mainland so the per capita income may be much lower. Household size on Guam in 1975 was 4.7[1] compared to the national figure just under 4.0.

Like the rising mean income level Guam's average wages are increasing. In 1979 the average wage of workers in the private sector was $4.87 per hour. This represents an increase of 22% in one year. This is still 23% below the U.S. average. (Cost-of-living information, comparative food costs: Guam, Hawaii and Los Angeles, Department of Commerce).

Public Assistance Caseloads

Between 1975 and 1980 the number of people receiving General Assistance grew by 119%, from 46 to 100. Growth of the local resident population during the same period was much slower, showing a 10% increase. So, in 1975, .06% of the population received GA. By 1980, that percentage was up to .12% . Other Public Assistance programs showed similar increases, with AFDC most notably growing from 3, 284 clients to its July 1980 level of 6,128. Again, the increasing reliance upon public services in a short period of time emphasizes a potential substantial increase on demand for mental health services, unrelated to common projection techniques.

Data summarizing U.S. average Public Assistance caseloads are not currently available to permit comparison.

Unemployment

Table III -J presents civilian unemployment data on Guam and the United States for December, 1979 (The most recent available). However, a couple of interesting facts emerge. While the unemployment rate of adult men is lower than the rest of the country, the overall unemployment rate is considerably higher. On Guam, unemployment of women and youth in the work force is very high compared with the United States generally.

TABLE III-J
Civilian Unemployment, Guam and United States[2]
December, 1979

	GUAM		U.S.	
	Participation Rate	Unemployment Rate	Participation Rate	Unemployment Rate
Total, 16 years & older	63.8	6.5	63.9	5.9
Males	78.3	4.6	*	*
Females	50.6	9.1	*	*
Adult Men (20 & over)	86.2	2.9	79.5	4.2
Adult Women (20 & over)	54.5	7.8	51.1	5.7
Teenagers (16-19)	33.9	23.1	58.6	16.0

* Data not available

1 Quinton-Budlong
2 U.S. Department of Labor, Bureau of Labor Statistics

Social Indicator Summary

Examination of Guam's economic indicators and the number of people receiving public assistance offers an intriguing paradox. Guam's families have more money now than ever before, yet the number of people receiving assistance is higher, as well. This perhaps suggests that the breakdown of the familia system places a burden on public support programs. The traditional form of social protection on Guam was linked to the strength of extended families. Commitment breaks down, individuals in need must seek help elsewhere. The public sector bears the brunt of this increased demand. It's impact can be expected to be felt in the mental health services, as well.

E. Key Informant Information

From January through April, 1980, a number of interviews were conducted and written responses to a questionnaire were received by the state plan consultant to, and several staff of Mental Health and Substance Abuse Agency. The respondents (ACKNOWLEDGMENTS, front of this plan) represent many of the key individuals and agencies concerned with mental health and substance abuse problems and other significant members of the community.

Two themes emerged from this input:

1. Many individuals with mental health problems avoid the services of the Community Mental Health Center, and
2. The extended family and "Natural Provider" systems are heavily relied upon as informal providers of mental health services on Guam.

Several factors are involved in the avoidance of CMHC services:

1. Cultural values of both Chamorro and Filipino people include strong feelings that personal problems are a private affair, even embarrassing. Within the social system, it is only appropriate to discuss one's problems with individuals in specific relationships to oneself, including God-parent, village commissioner (formerly the role of Chief), an uncle or aunt, a friend, one's parents, a suruhanu or certain Village elders with specialties of wisdom. The last person to share a problem with a stranger, though there are exceptions to this. Each individual, following a social pattern, will take one kind of problem to one or several of these people; for another kind of problem, different individuals will be selected as the confidant. With this last statement, those of Stateside heritage can identify with the subjective, pre-conscious selection of certain individuals with whom to share certain problems. It is a natural system, similar in general, different in specifics, from patterns of all human groups. Mainland American patterns have, more than for most human groups, emphasized formalization and professionalization of helping relationships. Many factors are involved in creating these differences. The insular nature of Guam and limited size of the human group are forces of resistance to the American pattern of depersonalized help. As we have seen with the indicators of social change on Guam, a rapid shift to the choice of depersonalized help is taking place.
2. There is a lack of faith in CMHC services. This issue alone involves several issues, including:
   a) In this relatively small community, the chance of a relative or known individual working at CMHC or seeing one enter or leave CMHC, is great. Confidentiality is not likely to be maintained despite the best of system safeguards. And, where there might be many reasons to speak with a God-parent, there are few reasons to be at the CMHC.
   b) There are many stories of someone close having had negative experiences at CMHC. The bureaucratic nature of services at CMHC is frequently mentioned. The best of Stateside model CMHC's would be likely to receive this criticism, though in some cases, it would appear that the criticisms are justified. The lack of resources necessary for Guam to provide a variety of specialized services is obviously a major factor in much of the criticism. Confusion of roles between humanness and professionalism, a lack of synthesis of these elements, seems to be a problem for significant segments of the organization.
   c) A common element of service provider Key Informant comments was reluctance to refer individuals to CMHC for mental health services.
3. CMHC suffers from problems of stigma. Much of the community lacks understanding of the variety of services available. Frequent comments include the perception that any CMHC services equates one with inpatient individuals. In other words, to go to CMHC means that one is "crazy".

The "natural" system of mental health care is still highly utilized. Besides family resources, recognized and respected village figures and the village commissioners, the parish priest (and increasingly, ministers of other faiths) and other Church figures, play a large role in community mental health. The Confessional alone, must have significant impact. The Suruhanu, encompassing spiritual and mystical elements, also includes cultural, medicinal and wisdom elements. Though a diminishing resource, the Suruhanu still is seen as a unique source of certain kinds of help.

At first glance, one might ask "Why a formal mental health system at all?" There are two strong answers to this:

1) Many mental health problems can be relieved in whole are in part by application of scientific knowledge by professionals, and
2) The culture is changing and adopting modern, industrial values with corresponding breakdown of the natural system, at the family level and most clearly at the village level. Formal services are becoming increasingly the choice. With the composite of many individual choices involved in these changes, a return to earlier patterns is unrealistic.

However, a synthesis of the formal and informal systems, responding to the choices people are tending to make, might comprise a service system which operates with the advantages of both formal and informal services. In other words, might the community best be served by the informal and formal ways of helping people, working together? This question is further explored in the "Analysis and Summary" of the Needs Assessment.

F. Analysis and Summary

1. Administrative Needs

The two key issues of the Financial Distress Grant application efforts of 1980, have

been Management Information System (MIS), including fiscal information and management, and third-party funding. These issues are discussed in detail elsewhere. To summarize, steps have been and are being implemented to construct a good MIS. The data exists in raw form and in the input to the GMH computerized Financial Management System. The task is one of establishing manual compilation systems and new output routines for the computer system, in order to provide the most useful summary data.

Most of the third-party and income identification concerns will be addressed by the above efforts. In addition, the crucial issue of inclusion of mental health services in health insurance coverage on Guam has taken an important position in the many CMHC discussions involving all CMHC Task Force members, including Guam Memorial Hospital, Guam Health Planning and Development Agency, Mental Health and Substance Abuse Agency and most importantly, the Governor's Office. The fact that this issue will be seriously discussed in Government of Guam Employee health insurance package negotiations coming up soon, represents great progress. With the importance of this issue to many of those involved, a sustained effort can be expected with eventual success.

2. Overview of Need for Services

Our analysis begins with the expected need for mental health services based on 1976 NIMH reported national utilization. This data gives fairly broad ranges. The rapid cultural change documented in the area and population description suggests that stress, changes in values, and other factors would give Guam relatively high need for services.

The social indicators give evidence both of significant rapid social change and rapidly increasing reliance on public, formal human services. Of interest, though, is that delinquency data, an expression of youth problems, has remained steady. It has not followed the pattern of the adult indicators. The needs assessment of the recently completed Alcohol and Drug Abuse Five Year Plan shows a decrease in youth drug incidence, though subjective material suggest a marked increase in youth alcohol abuse. An explanation for this stability in youth's expression of problems is not apparent. This area requires a closer examination over the coming year.

The data on the elderly is not clear: Utilization from FY 1979 to the first half of FY 1980 has increased by about 50% but FY 1979 was the first full year that services was offered. The increase may be entirely involved with increased public awareness that the services exist. The problems of the elderly also require closer examination in the coming year.

Close to half of admissions have been women. Specific programming to address the unique problems and stresses of women do not now exist and this area needs to be a programmatic concern of the service system. Human Service Corporation's recent emphasis in this area may have significant impact on the system over the next few years. Catholic Social Service has also proposed specific programming for women and both private practice Ph.D.'s are women.

In short, low utilization figures are explained by the cultural and community perception of CMHC discussed in this needs assessment. At the same time, the documented cultural transition and attendant stresses suggest that the community need for

mental health services is high, though somewhat hidden. Also, cultural change in terms of utilization of other public human services is rapidly increasing.

Simple mathematical projection of service needs based on utilization would entirely miss the larger, overriding issues. In the same way, need for service capacity must be reviewed in a larger context. It is clear that an acute care inpatient facility is needed. It is equally clear that partial care services, which facilitate movement of acute care patients from expensive inpatient services back to the community is economically justified.

The plan to close Progress House and delete this half-way house service is short-sighted in view of a lack of alternatives. The Legislature should take a government wide view of half-way house types of services possibly providing a variety of consolidated functions including acute care transitional housing, minimal service housing needs for the chronically mentally ill and developmentally disabled (mentally retarded, physically handicapped). This broadbased need for minimal care housing could be administered by one entity in one location with the various specific service needs provided by the appropriate agencies. GHURA, with an experienced human service professional to administer it, might be the ideal agency to provide such a housing service.

Existing drug and alcohol services should be continued and expanded. CMHC has advantages and disadvantages for continuing provision of the methadone services. Outpatient drug-free services should be restricted to an intervention service, which is almost the case now. The outpatient alcohol services of CMHC, as a new and small service, can be eliminated without much loss to the community. GMH is mandated to continue to handle alcohol induced medical problems including medically complicated alcohol detox. Catholic Social Service or another provider could pick up the slack, though this service area is not likely to grow without both third-party insurance coverage (proven to be economically sound) and federal support from NIAAA. The form such programming should take is discussed in the Alcohol and Drug Abuse Five Year Plan for the Territory of Guam, published in July, 1980 by Mental Health and Substance Abuse Agency.

The dropping of forensics services to force the Court to realistically assess the need and fund such services, is justified.

Outpatient services can be substantially reduced (50%) on the basis of caseload alone. But here, and with Consultation and Education services for CMHC provided by the services rather than a separate unit only being sufficient within the limited context of CMHC, larger issues become the major concern.

Probably the most important mental health need identified in this Needs Assessment, is the need for effective interface between the public, and specialized professional mental health service providers. There is a need and it is not now being met.

The best and most cost-effective alternative to meet this need is expansion of the "Natural Provider" concept generated by the Training and Prevention Division of the Mental Health and Substance Abuse Agency. This concept is centered in the people's tendency to seek help from village commissioners, the clergy, doctors, village and

and family elders, Suruhanus, and increasingly from Public Health and Social Services social workers and nurses, educators and police officers. The thrust is to train the "Natural Providers" in prevention, crisis intervention, preliminary assessment, basic counseling and referral skills. Thus trained, many crisis and situational mental health problems could be handled at the community level. Those circumstances requiring specialized professional services would more often, more appropriately, be handled in terms of effective referral made possible by the trained and trusted Natural Provider.

The other major alternative for satisfying the need for interface should be considered and perhaps utilized to some extent. The reduced, but still highly effective, home visit philosophy emphasized in the early years of Public Health and Social Services, has the advantage of professionals working at the "grass roots" level. People have been, and with the home visits services of Public Health Nursing still are, very responsive to services. In addition, the professionals experience at this level is grounded in the actual living experience of those in need. The importance of this is difficult to document but should not be underemphasized.

Prevention has become a priority of federal authorities in the areas of mental health, alcohol and drug abuse. It should be a priority for Guam also. Much of the need for mental health services is based in emotional rather than organic or genetic factors. Environmental factors can be documented but are extremely difficult to influence and are often involved with broad social issues. However, there is growing evidence that individuals can be better prepared to cope with and make effective decisions about their circumstances and to a less extent, that family functioning and relationships can be positively affected. The schools, with tools such as the Prevention Curriculum jointly developed by the Department of Education and the Mental Health and Substance Abuse Agency, and the family through several contact points including the media, augmented by general community education efforts, are the focal points of prevention activities. Need for funding is apparent. However, funding is so uncertain at this time, that it difficult to discuss. Local support seems likely to be maintained at least at its current level. The only alternative to the cutbacks planned in the CMHC Financial Distress Grant (FDG) identified at this time is emergency, supplemental appropriation by the Guam Legislature. At this time, considering Guam's overall fiscal situation, this alternative does not seem hopeful and cannot be relied upon. With either FDG support for one year of emergency supplemental appropriation, the possibility of available mental health funding through the likely Congressional passage of Mental Health Systems Act (involving major revision of the federal mental health funding mechanisms) does provide hope for the future.

Third-party funding also provides hope of substantial increase in funding availability in the next year and a half. Emphasis on development of a "Natural Provider" component of the mental health system could mean expansion of services and service availability to those in need, at relatively nominal cost.

PART IV. PROGRAM ACTION PLAN

A. Administration

1. Planning - Resource Assessment

Planning Division is subdivided into three major sections, Research and Development, Program Design and Management Information System. Each major section consists of specific responsibilities which functions as an integrated system within the network of MHSAA.

The Chief, Division of Planning is responsible for all three major sections. This responsibility is comprised of Administrative, Programmatic and Personnel Supervision.

The division's staff consists of a Division Chief, Planner II and a CETA Trainee. Additional positions were identified by the division to support the expansion of activities anticipated in the next fiscal year and thereafter.

Staff development is encouraged by the division. An assessment of training needs is performed on an individual basis in determining the division's priorities as related to staff requirement.

The Research and Development Division, within a year and a half, completed five major studies in the field of social research.These consist of the following:

1. Youth Survey on drug and alcohol abuse
2. Government of Guam Employees Alcohol Survey
3. "Alcohol Consumption" from retailers
4. Mental Health Needs Assessment
5. Title XX, Social Security Act

These studies were done with very limited resources, but adequately performed and accomplished.

The five year plan projection based on existing and anticipated manpower will address the issues of needs assessment studies on mental health services, drug and alcohol incidence and prevalence of special population groups, e.g., women, the elderly and handicapped.

2. Management Information System - Resource Assessment

The current Management Information System consists of the following components as a functional system network:

a. Client Oriented Data Acquisition(CODAP)
b. State Alcoholism Profile Information System(SAPIS)
c. National Drug and Alcohol Treatment Utilization Survey(NDATUS)
d. Client Management by Exception Report(CMER)
e. Statewide Services Grant Program Evaluation Review Manual(SWSG)
f. Information based on Needs Assessment Studies
   - Alcohol and Drugs (Youth)
   - Alcohol and Drugs (Govt. of Guam)
   - Mental Health Biometry Data
   - Alcohol Consumption (Retailers)
   - Title XX, Social Security Act
   - Resource Directory
   - Drugs - Chung Survey

g. Federal Programs Design
   - Drug-free Residential
   - Drug Methadone Program
   - Prevention Program
   - Drug and Alcohol Five Year Plan (1981-1986)
   - Mental Health and Substance Abuse Plan (1976-1981)
   - 1980 Drug and Alcohol State Plan Update
   - CMHC, FDG Application
   - Statewide Services Grant(SWSG)
   - CMHC Revised FDG Grant Application (Including Dr. Rudin's comments)

h. Quality Assurance and Evaluation Criterias
   - SWSG Program Review Criteria.
   - Federal Funding Criteria
   - NIMH, CMHC Operations Review Manual
   - NIMH, Services Annual Inventory Report
   - Mental Health Systems Act, as amended
   - Confidentiality Review Guide

As the system develops, it shall continue to provide for the considerations of internal and external needs of the agency and its programs.

The expansion and sophistication of the existing MIS will be included in the next five years. As a resource base, the MIS shall constitute a Data Base Management for needs assessment study in alcohol, drugs and mental health. Within the MIS system there will exist integrated sub-systems such as:

a. Clinical Reporting - Consisting of clinical data capture, socio-demographics data capture, client profile reporting, clinical reporting, general planned event reporting, direct service activity reporting, clinical data inquiry, indirect service activity, reporting case management, follow-up and review processing, client tracking.

b. Financial Reporting - Client and third party billing, financial reporting, general accounting, fund accounting, cost accounting, payroll labor/staff distribution and grants management.

c. Management and Evaluation - The elements in this component address federal, state, and local agency reporting, statistical analysis and reporting, emphasis on program evaluation, and historical data storage and retrieval.

d. System Control - Identifies system utilization monitoring, data base management, data sorting, communication control, data back-up and recovery, data security protection, data code management and data validation and control.

This anticipated expansion and sophistication of the current MIS will evidently mean the facilitating of a computer terminal and two modums, which are currently being negotiated with Department of Administration, pending availability of fund from MHSAA (either federal or local).

Meanwhile, the MIS system will continue to consider external resource either from Bureau of Planning, DOA's DATA Processing Office, or University of Guam for computer assistance. The semi-manual computer process will adequately fill the transitional needs of the agency's operational requirements.

The Program Design section of planning facilitates the agency and other users with MHSAA plans for mental health, drug and alcohol as seen by the Territory of Guam.

This section reviews, modifies, recommends, and enforces standards for a community-based oriented plan, which addresses the concerns of service users, seekers, needers and providers in the field of mental health, drugs and alcohol.

The plan, under the auspices of MHSAA must meet federal, state and local planning guidelines. To ensure that this activity is carried out, MHSAA under its SSA mandate, through this section, will appraise all related mental health, drugs and alcohol plan, provide technical assistance in its implementation and evaluate the plan based on stated objectives versus outcome performances.

To perform the task required of this section of planning, the division coordinates all planning functions relative to each division's specialization and monitor through quarterly submissions report each activity performed.

The planning division formulated its guidelines based on the five-year plan in alcohol and drug and mental health, including each annual update which defines the Annual Implementation Plan(AIP) for the following year.

The following illustration is Planning Division's breakdown of its resources including anticipated needs.

CURRENT		PROJECTED	
Existing Resources	Annual Cost	Anticipated Resources	Annual Cost
I. Personnel		I. Personnel	
1. Planner IV	$20,000*	1. Research Analyst IV	$15,214*
2. Planner II	14,500	2. Research Analyst III	13,869
3. CETA-Lmtd term	n/a	3. Program Coordinator	15,000
		4. Planner IV	20,000
		5. Planner II	14,500
II. Contractual		II. Contractual	
Equipment -		Equipment	
Computer Terminal + 2 Modums	-0-	Computer Terminal + 2 Modums $1200 X 12 mos. = $14,400	14,400**
Off-island Training		Off-Island Travel	
ASTI	n/a	1. ASTI	2,500
		2. NDATUS-BOP, NCHS	2,500
Local Training		Local Training	
1. NIDA-Prevention		1. NIDA-Prevention	
MHSAA-Affiliate	n/a	MHSAA-Affiliate	n/a
2. Other Health Depts.	n/a	2. Other Health Depts.	n/a
III. Supplies and Materials		III. Supplies and Materials	
1. Printing and Dup. Copies (Xerox)	Local Costs shared by Division	1. Printing and Dup. Copies (Xerox)	Local costs shared by Division
2. Miscellaneous	" "	2. Miscellaneous	" "
TOTAL***	$34,500+		$97,983+

* Cost identified includes personnel and fringe benefits.
** Computer terminal plus two modums with allowable maximum of computer installation, programming and monthly computer time allotment.
*** Total column identifies existing basic resource cost plus additional cost not itemized.

This resource assessment is detailed in the action plan portion of this five year plan.

MINI PLAN

PLANNING

OBJECTIVES	PLANNERS	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNDS
	Div. Chief 1) Program Coordinator 2) Research Staff II & III	C C	March of each year beginning FY81-FY85	1) Collect, tabulate, and analyze statistical data/information to include updates on needs assessment study. 2) Gather data on social and economic indicators relevant to and highly correlated with the need for mental health services.	1) AST 2) AST 3) AST 1) AST 2) AST	1)State 2)State 3)State 1)State 2)PAF
	1) Chief Planner 2) Research Staff	C	March of each year beginning FY81-FY85			
	Div. Chief	C	Semi-annual Mar., Sept. of FY8l-FY85	B. Assess each area of service, monitoring program impacts to service users. Relate the outcome of services to stated objective and establish program efficiency thru evaluation mechanisms provided by NIMH, ADAMHA, in addition to operations manual for CMHC and annual inventory report for Mental Health. Identify levels of disparity between provision of services and needed services. Submit recommendations to SSA director for implementation and inclusion to update and revision of Five-Year Plan.	1) AST 2) AST	State 1)PAF 2)PAF
Complete functional comprehensive database management system which will consider the inclusion of data updates, accessibility, confidentiality, storageability, evaluation capability, correlation analysis, and other features by Oct.1,1985	Div. Chief MIS Staff systems spec.	U	Jan. 1, 1982	A) Support system of semi-automated efforts will be established between MHSAA and possibly UOG and/or Dept. of Administration by Oct. 1982. B) By Jan. 1, 1982, system model on semi-manual operations will be developed by research staff in Planning Division.	1) AST 2) $28,000	State 1)PAF
	Div. Chief 2) Research Staff	U	Feb. 1, 1982	C) By February 1, 1982, transitional efforts in program filing system will be effectuated utilizing research staff in planning to coordinate the project.	2) AST	State 2) PAF

PAF - Pending Availability of Funding
Status - C = Continuing Service Activity, N = New Service or Activity, U = Unmet Need

PLANNING

OBJECTIVES	PERSONS	STATUS	TIME FRAME	METHODS/PROCEDURES	COSTS	SOURCE OF FUNDS
	Chief Planner	N	Jan. 1983	3) By Jan. 1983, Program/Clinic Operations Manual for CMHC and annual inventory report for mental health will be programmed as parts of the Research Data Base System.	1) AST 2) AST	State 1) PAF 2) PAF
Cont'd	Chief Planner 1) MIS Staff 2) Research Staff	N	Oct. 1982	4) By Oct. 1982, base management system for research will be a developed component of MHSAA's management information system.	1) AST 2) AST	State 1) PAF 2) PAF
Cont'd	Chief Planner 1) MIS Staff 2) Research Staff	N	Jan. 1983	5) By Jan. 1983, Program/Clinic Operations Manual for CMHC and annual inventory report for mental health will be instilled, coded, and programmed as parts of the Research Data Base System.	1) AST 2) AST	State 1) PAF 2) PAF
Cont'd	Chief Planner 1) MIS Staff 2) Research Staff	N	Oct. 1, 1983	6) By Oct. 1, 1983, program management policies and procedures from CMHC will be programmed into the data base and made parts of the system.	1) AST 2) AST	State 1) PAF 2) PAF
Cont'd	Chief Planner 1) MIS Staff 2) Research Staff	N	Oct. 1, 1984	7) By Oct. 1, 1984, program files on organization management, treatment process, financial management and general management will have been programmed into the systems and functionally operating.	1) AST 2) AST	State 1) PAF 2) PAF

B. Treatment, Rehabilitation, and Diversion

1. Resource Assessment

For reasons described in the Introduction to, and Needs Assessment section of, this plan, the MHSAA Treatment and Rehabilitation Division devoted substantial time in cooperation with the Planning Division in developing the Needs Assessment. The Needs Assessment addresses most of ADAMHA's concerns in the area of this specific Resource Assessment. The division has also been represented on the Governor's Inter-Agency Task Force on CMHC since January. Major insufficiencies in the CMHC Management Information System(MIS), has been a major focus of the CMHC and all others involved. The division will continue to assist in the process of attaining useful information. It needs to be reemphasized that CMHC represents 100% of Guam's mental health services. The following list indicates the major data items pertinent to this plan thus far obtained from CMHC:

-- July, 1980 CMHC "Management Report" produced by the MIS recommended by Dr. Rudin during his June 1980 visit; Appendix E, Item 3
-- "Census Report, July 1980;" Table III-A.
-- "CMHC Capacity and Utilization;" Table III-B.
-- "Census Report, FY80;" Appendix E, Item 5.
-- "GCMHC FY1981 - Projected Unit of Service to be Rendered;" Appendix E, Item 6.
-- "GCMHC, FDG Budget and Staffing Information;" Appendix E, Item 7.
-- CMHC Patient Characteristics from June 1980 FDG; Appendix E, Item 8.

ADAMHA Concerns

Outcome data are not available. The MIS and Quality Assurance sections of this part of the plan present the actions by which MHSAA will establish an outcome evaluation mechanism over the next year.

The problems for MHSAA center on the fact that MHSAA is just beginning to grasp the whole picture of SSA functioning for the discipline of mental health. There is no direct, substantial tie to services in this discipline, as there is for alcohol and drug. The link through the Drug Program has provided essential, positive contacts with services delivery, as has the SSA Training efforts. A specific, and important ADAMHA concern in State Planning is "changes intended in the system." With the potential loss of $517,000 of federal funding for a $2.2 million program (in this case, entire system), in a context of adverse state fiscal situation, with rushed decision making in the absence of good data -- the problems for SSA functioning also center on the fact that substantial changes can happen to the system in the next few months, without intent. This division has analyzed the most recent "CMHC Operations Grant" application and the three major versions of the Financial Distress Grant. Careful study of these documents reveals much information. The reader is referred to these documents for questions not answered her. Table IV - A summarizes the reductions intended for CMHC.

"Pre-admission screening" and "Alternatives to Hospitalization" are addressed for the In-Patient unit. In the pending Financial Distress Grant, it is planned to limit In-Patient to 64.5% of the current case load. The other 35% of the patients are mentally retarded and chronic care Patients. The underutilized Progress House, in close relationship to In-Patient expertise, could be modified to effectively cope with those patients to be eliminated from the acute care program. However, the question arises: Where else to cut in order to continue funding Progress House? Perhaps a bit more squeeze needs to be placed on outpatient sevices. Progress House seems

PLANNING

ont'd	Chief Planner 1) MIS Staff 2) Research	N	Sept. 1985	8) By Sept. 1985, comprehensive research and needs assessment study data-base system will be operational in a systematic, continuing process	1) AST 2) AST
evelop MHSAA's anagement informa- ion system to a omprehensive de- ailed design stage o serve the manager administrator) -	Chief Planner 1) MIS Staff	N	Oct. 1, 1982	1) By Oct. 1, 1982, the detailed design model for the agency's management information will be completed.	1) AST
	Chief Planner 1) MIS Staff	N	Jan. 1, 1982	2) By Jan. 1, 1982, the MIS transitional phase of a semi-automated system will be completed.	1) AST
	Chief Planner 1) MIS Staff	N	Oct. 1, 1982	3) By Oct. 1, 1982, the MIS and inclusion of one terminal and two modern units will be contracted between Department of Administration and MHSAA	1) AST 2) Unit lease quote from Dept. of Administration approx. $15,000; includes unit and computer time.
ser (MIS service iser) in a systema- ic manner in the ecision making rocess by 1985	Chief Planner 1) MIS Staff	N	Oct. 1, 1983	4) By Oct. 1, 1983 the use of MIS by the agency will be servicing programs as well as other departments	1) AST
ont'd	Chief Planner 1) MIS Staff	N	Oct. 1, 1985	5) By Oct. 1, 1985, all components of the MIS will be integrated within the system and shall not be limited to the following: fMS Program/Clinic data, research and statistical data, agency and program policies and procedures, agency's divisional requirements.	1) AST

an essential component for transition to maximized self-sufficiency for acute care patients, and can be the basis for an essential service to "inappropriate placement" of In-Patient. With the lack of data, success in the areas of foster-type and family placements is not known. It is supposed by this division that stronger outreach by an underworked outpatient staff in conjunction with MHSAA's Prevention and Training Division "Natural Provider" program might be quite helpful. This type of program might facilitate the assistance provided by Public Health, Social Services and housing services of government.

As to the ADAMHA issue of "Public Mental Hospitals," there is just the one facility, living conditions are sometimes quite poor. Treatment, social and recreational stimulation is an integral part of the full program. The two person"Aftercare" staff, both nurses, are dedicated to the success of aftercare services. Administratively, they have recently returned to direct contact and supervisor by the Partial Care Program.

The island of Guam is the one catchment area for the jurisdiction. The CMHC is the only available resource.

Criminal justice interface for mental health is limited to the recently terminated Forensic Service and the new Dept. of Corrections program. It is felt that the court must become aware of CMHC's problems and participate in solutions to the current problems. The DOC program, funded by MHSAA, provide for payment for services requested from and provided by CMHC to DOC inmates.

There are positive factors existing. The Prevention and Training Division of MHSAA has grown to the point where important aspects of outreach activity can be assumed by MHSAA without additional burden to State revenues. The Outpatient services of CMHC can be cut substantially without turning people away from services. The transition can be made much more smoothly and effectively for Guam and the staff involved with the assistance of one year FDG funding, however. CMHC was able to achieve a full model of services capable of passing JCAH review. By having this experience, Guam is able to establish priorities of services with some confidence, in terms of today's expressed community desire for services.

And, as stated in the Introduction of this Plan, the current crisis has created a climate of true community planning. For instance, the Third Party Payment issue has been raised so strongly, that with the commitment key people have, third-party coverage for mental health services in the major group insurance plans seems inevitable by 1982, if not 1981.

The priorities for the Treatment and Rehabilitation Division become the following based on current circumstances:

-- Assist development of a good MIS for SSA so that informed decisions and evaluation can be made,
-- Identify and pursue funding for mental health services, both to relieve fiscal pressures of services to be continued and to fund service gaps which would be created by the planned CMHC service reductions,
-- Provide the interface between current Prevention and Training Division programming as it can supplement the service system in outreach transitional aftercare areas.

TABLE IV - A

SUMMARY OF BUDGET REDUCTIONS PLANNED AS PRESENT IN THE CMHC FDG APPLICATION BY SERVICE COMPONENT

Service Component	Direct Cost Reduction	Disposition
Emergency	0	Continue full service, improve GMH capabilities to manage and assess emergency mental health cases
In-patient	0	Limit to and improve acute care services. Eliminate
Partial Hospitalization	10%	Absorb the two Aftercare Nurses and reduce budget by 10%. No reduction of patients anticipated but some quality reduction inevitable.
Progress House	100%	Though Progress House has seemed to serve a number of long-term clients, continuity of acute care patients can be expected to be hurt, resulting.
Aftercare	100%	The two nurses will be incorporated into the Partial Care service.
Adult Outpatient	50%	Even with incorporating elderly and alcohol services, without specific outreach activities no impact is expected for clients.
Alcohol Service	100%	With only 3 patients reported in July, this first effort at alcohol programming has not created a demand on the system and is expected to have little impact by being closed. In addition, MHSAA feels NIAAA funding will be available for establishing needed programming in alcohol abuse for Guam.
Drug Program	100%	With SWSG funding and local commitment to at least minimal programming, it is expected that this service will service. It is an MHSAA priority.
Programman Patgon	50%	It appears that this specialized children's service for DOE will survive through funding provided by DOE.
Forensic	100%	The Court and community are being confronted with the need for and funding requirements for these services.
Elderly	100%	The caseload will be picked up by Outpatient Services.
Consultation and Education	------	As through FY1980, these functions will be distributed throughout the service units, will concentrate on clinical issues and will be supplemented by MHSAA Prevention and Training Activities.

MINI PLAN

TREATMENT, REHABILITATION, AND DIVERSION

OBJECTIVES	MANPOWER	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNDI
Objective: Develop and contract out the Govt. Guam Employees Assistance Program, including supervisor training, intervention counseling and short-term intensive treatment (residential or basi-residential approx. weeks)	Chief, T&R a. Chief,T&R Planning b. Chief,T&R Planning c. Chief,T&R or other Provider	N	7/1/81-6/30/84 a. Dec. 1, 1980 b. Oct. 1, 1981 c. Thru FY81 and on	3.a. Design program, prepare and submit proposal to NIAAA. b. Negotiate with one or more Govt. of Guam departments to begin implementation. c. Continue and expand implementation of program.	AST $505,000 275,000 20,000 20,000 $820,000	STATE NIAAA PAF Third-Party PAF (increasing each year) Self-pay PAF State (Third PAF year
Objective: Identify potential mental health funding sources under the Mental Health Systems Act when passed.	Chief, T&R	N	a. Oct. 1, 1980 b. Nov. 1, 1980	4.a. Talk to NIMH officials at Rockville, Maryland during Sept. 1980 trip concerning the various NIMH monies available, ranking them, and get necessary application guidelines as well as contact persons. b. Establish priorities for which funding possibilities to pursue in cooperation with other divisions and with GMH/CMHC. Set time frame.	AST	STATE

PAF - Pending Availability of Funding
Status - C = Continuing Service Activity, N = New Service or Activity, U = Unmet Need

C. Quality Assurance and Evaluation

Resource Assessment - The Quality Assurance/Evaluation section has received annual technical assistance from Touche Ross Company relevant to the development and implementation of monitoring and evaluation tools and methods. Division Chiefs of Treatment/Rehabilitation, Quality Assurance, Evaluation and Planning joint quarterly site monitoring visits which yield a variety of information for evaluation purposes, i.e. compliance with local and federal regulation and law, client/staff ratio, client records, confidentiality, administration including fiscal and personnel, primary substance of abuse, aftercare activities, outreach and intake. All site visit reports are submitted to the individual programs for review and if necessary, action. No alcohol formula dollars presently go into alcohol treatment and rehabilitation. Programs within the purview of the MHSAA are judged on quality of services based on information gathered at the site visit. Various reports, SAPIS, CODAP, etc., and information are gathered, as required, and reviewed and forwarded to the appropriate agency.

Guam is just beginning to consider the issue of licensure, accreditation, and certification. Presently, the Division Chiefs of Treatment/Rehabilitation, Prevention/Training, and Quality Assurance/Evaluation are all jointly considering this issue. Licensure and certification standards from other states are being reviewed and considered. Discussions are underway with the Guam Community College regarding credits for national courses. We are very concerned with developing criteria that will assure quality of care while not being bureaucratically cumbersome.

Internal SSA evaluation activities are conducted by joint meetings between the Administrator, Deputy Administrator, and Divison Chiefs with input from the ADM Consultant. Planning activities receive input from the GHPDA. Fiscal and administrative monitoring is handled by other government agencies.

All programs contracted by MHSAA have established clear measures of functioning. Site visits also gather effectiveness data for analysis and feedback. Judgement as to degree of effectiveness is in large part within the responsibility of the Chief, Treatment and Rehabilitation.

Quality Assurance & Evaluation - It is essential to note that the "end results" evaluation of the mental health program at CMHC go far beyond mere counts of activities, services rendered or achievement of specified goals to measure the effect of the program or project on the improvement of the mental health program for the community.

In recognition of the present level of development and the lack of information and relevant data from CMHC in the area of mental health, the Division of Quality Assurance and Evaluation is seeking new tools and resources in order to effectively implement its program evaluative function specific to mental health.

Although Q.A.&E. is primarily geared toward the evaluation of program in an institutionalized setting it should also be flexible enough to handle program setting afforded by "Natural Providers" accepted and approved by the community.

TREATMENT, REHABILITATION, AND DIVERSION

OBJECTIVES	MANPOWER	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNDS
5. Objective: Support inclusion of mental health services in Government of Guam employee group health plans.	Chief, T&R		Sept. 10, 1980 Oct. 1, 1980 Oct. 20, 1980	5.a. Develop list of key negotiators, both of the Government of Guam and of GMHP and FHP. b. During Sept. 1980 trip, seek documents which support the economics of insuring mental health services, from NIMH staff. c. Prepare presentation for key negotiators. d. If it appears that the plans will not include mental health coverage for CY1981, develop strategy and time frames for gaining coverage in CY1982.	AST	STATE
6. Objective: Work with Prevention and Training, and Planning Divisions, to develop strategy for MHSAA providing outreach assistance to CMHC.	Chief, T&R		Oct. 1, 1980	6. Meet with Planning and Prevention and Training Chiefs to agree on actions MHSAA can take in the area of outreach to assist CMHC.	AST	STATE

AST - Agency Staff Time - Staff salaries plus administration

PAF - Pending Availability of Funding

Status- C = Continuing Service Activity, N = New Service or Activity, U = Unmet Need

MINI PLAN

QUALITY ASSURANCE & EVALUATION DIVISION

OBJECTIVES	MANPOWER	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNDIN
To provide a comprehensive systematic process for discovering new operating capacity potential for Mental Health Research Specialist services annually.	1. Chief Div. of Q.A.E. 2. Program Planning Evaluation & Research Specialists	C	FY'81 - FY'85	1) Each year starting FY81 thru FY85, the Quality Assurance Section will continue to Systematically inquire, observe and study each phase of all factors affecting functional capacities of Mental Health services.	1) $19,080 2) $17,457 3) $14,000	STATE PAF PAF
				a) Quality Assurance Section of SSA will implement quarterly Quality Assurance relevant to Mental Health methodologies by utilizing Quality Assurance Staffs. It will monitor the status changes in factors affecting: client needs, service utilization program, infrastructure, target population served, their age, sex, ethnicity, geographic origin, opinions and attitudes, of clients, program personality factor, modality, discipline, treatment process, organizational structure, program management general management. These data will be gathered through the use of various methodologies appropriate to the data being collected.	1) AST 2) AST	STATE PAF
Con't	Same	U	Con't		1) AST 2) AST 3) AST	STATE PAF PAF

PAF - Pending Availability of Funding
Status - C = Continuing Service Activity, N = New Service or Activity, U = Unmet Need

MINI PLAN

QUALITY ASSURANCE & EVALUATION DIVISION

OBJECTIVES	MANPOWER	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNDIN
				survey instrumentalities and currently established external reporting requirements o.e. CODAP, NDATUS, SAPIS, CARL. In addition, SSA will continue to conduct program interviews and quarterly site visits		
Con't	Same	U	Con't	b) Quality Assurance Division will implement appropriate practical application of inductive or deductive findings to each program/clinic/center. This is manifested by the discovery of new facts in treatment process, patient rights, program funding policies, etc.. Enforcement procedures will be conducted under controlled conditions to test or discover alternative functional capacities of each service modality for mental health program.	1) AST 2) AST	STATE PAF
Con't	Same	C	Con't		1) AST 2) AST	STATE PAF

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QUALITY ASSURANCE & EVALUATION DIVISION

OBJECTIVES	MANPOWER	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNDING
				f. Acquire appropriate legislation 82 - 83. g. Final - October 1983.		
SA will implement a ystematic process of etermining the effectveness and efficiency of xisting functional capcities to meet total eeds and stated objectves from program recipents and services users y 1981.	1) Chief Q.A.E. 2) Program Planner/ Evaluation Research Specialist	U	FY'81 thru FY'85	The Evaluation Division if SSA will implement the following process; - Establish a quarterly updating Evaluative criteria and required or disired area and applicable SSA program structural guidelines for Mental Health programs. - Sensing and recording system performance and environmental condition study from division of Planning SSA. Information input thru survey mechanism will also support findings. - Comparing program performance records, Environmental requirements and performance standards acceptable to NIDA's SWSG, NIAAA, and NIMH program review manuals.	1) AST 2) AST	STATE PAF

PAF - Pending Availability of Funding
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QUALITY ASSURANCE & EVALUATION DIVISION

MINI PLAN

OBJECTIVES	MANPOWER	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNDING
Con't D	Con't D	N	Con't D	- Data deductions tabulations and transmissions to validate, quantify, and qualify findings as evidenced by reporting mechanism required by SSA, NIDA's CODAP, SAPIS, NDATUS.	AST	PAF

PAF - Pending Availability of Funding
Status - C = Continuing Service Activity, N = New Service or Activity, U = Unmet Need

D. Prevention and Education

Resource Assessment - The Guam Mental Health and Substance Abuse Agency (MHSAA) has adapted the definition of the National Association of Prevention Professionals (NAPP) of prevention as being a proactive process, utilizing an interdisciplinary and multi-cultural approach designed to empower people with resources necessary to constructively confront stressful life conditions.

It is proactive in that it spans the deliberate activity before the onset of a problem. It is interdisciplinary in that it spans the traditional human service delivery systems (mental health, alcohol, drug abuse, juvenile delinquency, education, etc.). The approach is multi-cultural as it recognizes the diversity of values and customs of the multi-ethnic population of this and neighboring Pacific Islands. In empowering people, it enhances their natural support system or, when this support is absent, provides a means of enabling them to help themselves, moving them from dependency toward personal autonomy in ways that are acceptable to them.

Prevention differs from treatment in that it addresses the needs of that segment of the community who are not yet experiencing mental illness or substance abuse, and those who are just beginning to experience these stressful life situations. The prevention acitivites the MHSAA wishes to pursue are those which promote personal growth and may be broken down as follows:

Information - Centers on the function of providing accurate and up-to-date information on the nature of mental illness and substance abuse, prevention strategies and resource announcements to the general public. The aim is to heighten awareness, healthy and rewarding living.

Education - This function involves promoting deeper knowledge of mental illness and substance abuse and the problems that accompany them. It differs from public information in that it focuses on specific populations like youth, parents, service providers, etc.

Intervention - These activities are aimed at providing services to individuals at risk, i.e., those whose life situation makes them prone to experience episodes of mental illness or to be involved in substance abuse.

Alternatives - These activities are targeted primarily at substance abusers. The premise is that if individuals are provided with fulfilling and rewarding activities then they will be less prone to engage in substance abusing behavior.

Since prevention has just recently been recognized as a priority in the Mental Health and Substance Abuse fields, there are virtually no programs on Guam whose primary focus is prevention.

The Mental Health and Substance Abuse Agency's Prevention and Training Division is one of the only entities offering prevention programming. The division has taken the lead in this area and will aggressively pursue this goal. Major steps have already been taken to sell the concept of prevention on Guam by MHSAA's sponsorship of two prevention workshops in as many years. A product of the last

MINI PLAN

OBJECTIVES	MANPOWER	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNDING
1. Organize and provide the annual Prevention Workshop for direct service providers	Prevention Staff	C	Yearly	a. Identify and obtain funds for Workshop b. Create organizing committee c. Develop workshop agenda and format d. Invite appropriate direct services providers e. Implement workshop, to include evaluation and follow-up mechanisms	1) AST 2) $ 1,800	1) STATE STATE-PAF
2. Expand MHSAA Prevention Newsletter to include all school and health counselors, all libraries on island and 100 additional teachers	Prevention Staff	C	By Dec. '81	a. Increase funding for newsletter b. Increase publication by 200 more issues	1) AST $ 150	STATE STATE Local
3. Continue prevention coordination efforts with other agencies and groups on island	Prevention Staff	On-going	C	a. Maintain Prevention Task Force's representative membership	1) AST	1) STATE
4. Assist DOE in developing Health Education curriculum for grades K-12	Prevention Staff	On-going	C	a. Meet with DOE Drug Coordinator to identify assistance b. Provide technical assistance as indicated	1) AST	1) STATE
5. Recruit and hire a permanent Agency Librarian.	Training and Prevention Supervisor	By Sept. 1981	C	Request (1) one additional employee slot for MHSAA Librarian from Legislature Recruit according to standard Government of Guam hiring procedures	1) AST 2) $ 12,000	1) STATE 2) STATE-PAF

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Status- C = Continuing Service Activity, N = New Service or Activity, U = Unmet Need

MINI PLAN

OBJECTIVES	MANPOWER	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNDI
6. Develop library into Mental Health/ Substance Abuse Clearinghouse for the Island	Training and Prevention Supervisor	By Sept. 1983	C	a. Continue to obtain all available literature on mental health and substance abuse prevention, treatment, research, training, etc.	1) $ 8,000	1) STATE
7. Increase utilization of MHSAA library by teachers, counselors, students, and other "providers" by 50%	Prevention Staff	By 1981	C	a. Continue inserts in the Agency's Newsletter on reading materials available in the MHSAA Library b. Identify informational needs of teachers, counselors, students, and other "providers". c. Establish liason with Main Library (Nieves Flores) for the purpose of increased utilization of MHSAA library by students, teachers, counselors, and the public. d. Utilize the Nieves Library van to disseminate pamphlets and brochures on substance abuse.	1) AST 2) $ 500	1) STATE 2) STATE

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workshop was the formulation of a prevention task force to implement the recommendations generated by the participants in the workshop. Another workshop is planned in May 1981.

The Consultation and Education Service of the Guam Community Mental Health Center also does limited prevention activities. These activities at present are limited to speaking presentations before various group promoting the services they have available and the types of persons they service. Plans are underway to expand this role by using the media to promote good mental health. Contacts will be made to coordinate their efforts with those of the MHSAA.

The MHSAA has a library which contains numerous materials (films, pamphlets, books, etc.) on mental health and substance abuse and is committed to expanding this resource and making it more accessible to the public and service providers.

In addition, MHSAA has actively assisted the Department of Education in the formulation of its Drug Education Curriculum. Although the curriculum is labeled "Drug", it is more an affective education curriculum which focuses on such things as self-concept, values clarification, decision making and problem solving skills, in the hope that this will promote an all around healthier individual.

Per ADAMHA subdivision of consolidated services, the prevention efforts of MHSAA are integrated. However, federal grants management standards are maintained and monies separately accounted for.

E. Manpower and Training

Resource Assessment - The Training and Prevention Division of MHSAA is responsible for manpower and training activities for mental health, alcohol and drug abuse. In the past, the bulk of the resources for training have come from the National Institute on Drug Abuse. Therefore, the major focus has been to train drug abuse workers. This does not mean, however, that mental health and alcohol workers have been ignored. On the contrary, whenever courses or training events are scheduled, a wide variety of service providers are invited to attend. The nature of courses usually can be applied by workers in any of the human service fields. Some of the courses offered include: group facilitation, basic counselling skills and interviewing and assessment skills.

The Consultation and Education Section of the Guam Community Mental Health Center also does mental health related training primarily as in-service to their staff. They also offer courses to staffs of other agencies. The following is a description of GCMHC's in-service training program.

a). Mandatory Programs - have continued on a monthly basis throughout the year and has covered such subjects as:

(1) Schizophrenia - new approaches and medications. Legal aspects of Mental Health, Confidentiality, Violent Patients (control of), Managing the sexually provocative patient, Aspects of Health Planning, Child Abuse, and Violence Against Women.

(2) Orientation - new staff members complete an orientation program specific to the Center.

(3) Abnormal Psychology - (an ongoing course) - all Psychiatric Technicians and RNs who have not completed this course in college or university are required to complete the CMHC Program as well as write a comprehensive

exam. A 70% average is considered the acceptable score.

(4) Selected staff members are trained in the operation of all new equipment.

(5) Vital Signs - for staff members required to perform this service.

b. General Inservice Programs - General Inservice Programs remain consistent with the immediate needs of the Center. The following courses are offered:

(1) Goal Oriented Charting
(2) Psychopharmacology
(3) Suicide Prevention
(4) Seclusion Room
(5) Restraint Use (correct procedure)
(6) The Adolescent Patient
(7) Cardiopulmonary Resuscitation - will continue to be offered. This course will be taught by a certified American Red Cross Instructor.
(8) Secretaries and Receptionists will be trained in the following areas:
  (a) Dress Code
  (b) Telephone Manners
  (c) Conversing with the Public
(9) Introduction to Psychology - a 12 part course (multi-media)
(10) Behavior Modification - a 5 part course (multi-media)
(11) Micro-Counseling will continue to be offered as needed.

c. General Inservices Open to Outside Agencies

(1) Peer Counselor for Rape Victims - a 12-week course (36 hours)
(2) Childhood Development and Mental Illness in Childhood - a 4-week course (12 hours)
(3) Child Abuse Workshops - presented twice during the year to:
  (a) Emergency Room Staff
  (b) Pediatrics Staff
  (c) Private Clinic RNs
(4) Psychiatric Nursing Classes
  -- primary for student nurses
  -- graduate level for RNs
  -- tutoring State Board applicants

The primary goal of the MHSAA in the area of mental health training and manpower is to develop a comprehensive system which can effectively deal with these issues on a regular basis. We lack, however, the resources to accomplish this goal. One objective then, that we will pursue is to secure an NIMH Manpower Development Grant. With the financial resources and technical assistance provided by this grant we feel we can achieve this goal within the next five years.

MHSAA's main focus in the development of training resources on Guam is to build an in-house trainer capacity, so that a self-sufficient internal capability may be achieved. This capability will enable trainers to design and implement culturally relevant training programs. This is important in that most training courses are

designed towards mainland needs and although MHSAA thinks that similarities between Guam and U.S. abound, the past practice of transplanting social service programs and practices to Guam on the assumption that what is good for the mainland will benefit Guam, also has sometimes proven disastrous in terms of utilization and effectiveness. Training courses, films and literature developed on the mainland must be modified and where appropriate developed locally to suit unique local needs.

Key individuals from social service agencies will be identified and trained through a phasing system. The aim is to develop a cadre of local trainers using the generic approach as much as possible. These trainers will subsequently train others from within their own agencies and select potential persons whom they will train through all phases. This training cycle would continue until each agency develops their own cadre of trainers. We will have totally developed our own training resources, that dependence on bringing in off-island trainers would be significantly reduced and eventually become unnecessary.

Another group upon which MHSAA intends to focus training needs are the "natural providers". These are leaders within the community such as the family, village commissioners, priests, folk practitioners and civic leaders who have always been throughout Guam's history the caregivers and advisors for those who seek help with their problems. Interviews with priests and commissioners have evidenced their desire to enhance their effectiveness in counseling and in general helping families cope with today's problems. The "natural providers" concept underscores further the need for modifying training courses or even the development of new ones.

Finally, another group we would hope to impact are the service providers in the Northern Mariana Islands. We would like to do joint planning with them in the area of training and manpower and share our resources. This is a logical move as the people of Guam share a common language and culture with their neighbors to the north.

Again, training services should be considered as integrated per ADAMHA's definition. Again, strict fiscal accountability by discipline is maintained for all federal grants. However, in the area of training and personpower development, some efforts are funded for, or appropriate for workers of one or two of the disciplines. With the current lack of specific mental health monies for these areas, the majority of CMHC staff are minimally served by current efforts.

MINI PLAN

OBJECTIVES	MANPOWER	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNI
1. To secure funding for training and manpower development	T&P Supervisor	U	March 1981	a. Contact NIMH to acquire details of the Manpower Development Grant and to secure a grant application kit b. Prepare grant application and forward to NIMH c. Implement program	1) AST	1) STATE
2. To develop a Manpower Development System for Mental Health on Guam	Training Staff	U	Sept. 1981	a. Secure Manpower Development Grant b. Request Technical Assistance and training relative to the development of a Manpower Development System c. Draft write up of components of the system d. Receive input from persons who may be impacted e. Implement System	1) AST 2) $ 30,000	1) STATE 2) NIMH (PAF)
3. Assess the training needs of direct service providers in mental health	Training Staff	C	Feb. 1981	a. Correspond with NIMH relative to securing assessment instruments b. Modify instruments as necessary c. Conduct assessment d. Compile results	1) AST	1) STATE
4. Arrange for UOG credits to be given for MHSAA sponsored training	Training and Prevention Supervisor	N	By Oct. 1981	a. Meet with UOG extension services b. Determine criteria to be met and arrangements necessary c. Arrange crediting for each training event as indicated.	1) AST	1) STATE-PAF
5. To provide assistance to GCMHC in their in-service training program	Training Staff	N	On-going	a. Initiate communication with Consultation/Education staff of GCMHC b. Identify needs c. Provide assistance as required	1) AST	1) STATE/NIMH (PAF)

PAF = Pending Availability of Funding
Status- C = Continuing Service Activity, N = New Service or Activity, U = Unmet Need

PART V: GENERAL CONSIDERATIONS

A. Accounting Procedures - As an added information we do maintain separate accounts for all federal grant awards based on the grant award period. All records are available for audit and are being kept at Division of Account, Department of Administration. This is described on page 74 .

Presently we have no funds available to be awarded to other public or private non-profit Agencies and we do not foresee the Agency awarding funds in the immediate future. If however the time comes where the Agency is in a position to award funds, item (1) through (4) of the ADAMHA Guidelines, page 29-30 will be incorporated in one (1) Agency's policies and procedures.

B. Reports and Records - All reports are submitted as requested on forms provided in a timely manner. Records of Advisory Council meetings as well as fiscal and other official records of the Mental Health and Substance Abuse Agency are maintained and access afforded to authorized federal authorities.

MINI PLAN

OBJECTIVES	MANPOWER	STATUS	TIME FRAME	METHODS/PROCEDURES - ACTION STRATEGY	COSTS	SOURCES OF FUNDS
6. To assess the role of natural providers in the provision of services to the mentally ill	Training Staff	N	Jan. 1981	a. Secure a list of natural providers in the community b. Make visits to assess needs c. Provide assistance as indicated	1) AST	1) STATE/NIMH (PAF)
7. To develop a formal agreement with the Northern Marianas Islands Mental Health Dept. relative to sharing training resources	Agency Administrator	N	March 1981	a. Make contact with NMI Mental Health Dept. b. Arrange for joint meetings to discuss needs and resources c. Draft agreement d. Secure endorsement of agreements with proper officials	1) AST 2) $ 400	1) STATE 2) STATE(PAF)

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GOVERNMENT OF GUAM
AGANA, GUAM 96910
FINANCIAL MANAGEMENT SYSTEM
DEPARTMENT OF ADMINISTRATION
FMS - MANUAL

FORWARD

This publication is issued for information, guidelines and compliance of all personnel administering or accounting for Financial Resource in the Annual Operating Budget, Continuing Appropriation, Federal Grant-in-Aids, General Funds, Special and Trust and Agency Funds and Revenue Accounts.

The System is an integrated system, fully automated, handling a financial transaction once and automatically updating their respective accounts and files. This is a Uniform Budget and Accounting Information System (BACIS) which affects all departments and agencies whose accounts are accounted for and maintained by the Department of Administration. Accordingly, all are enjoined to comply to the Procedures and Accounting Methods Outlined in the Financial Management System Manual.

The System is effective 1 October 1979, commencement of Fiscal Year 1980. For further information or clarification, please call the Accounting Division on 472-6230/6240/6508. Each department and agency is assigned a Section Leader who maintains the accounting records and are to provide continuing assistance to their assigned departments and agencies. We encourage the department and agency Directors to avail themselves to this additional service.

FRANK G. BLAZ
Director of Administration

The Financial Management System Manual documents the fiscal policies, accounting principles, internal controls, operating procedures and reporting requirements comprising the Financial Management System of the Government of Guam. This system is designed to:

1. Establish adequate financial control to ensure compliance with statutory requirements;
2. provide organizational units of the Government with accurate and timely financial information for effective management of the financial affairs under their jurisdiction;
3. control the detail financial records maintained in approved departmental sub-systems; and
4. integrate data requirements of the many governmental functions into a single comprehensive system.

The Financial Management System manual is intended to be a working guide for all levels of personnel to use in accomplishing their financial responsibilities. The manual will be of particular value in assuring continuity of operations in the event of personnel turnover, as well as aiding in the training of new employees. This manual encompasses the entire central government accounting operation through the inclusion of many separate, but integrated procedures. The employees assigned the responsibility for performing their tasks should be the most qualified to recommend changes and improvements in data processing methods; consequently, it is anticipated that they will propose additions

and revisions to the manual.

Manual Format to facilitate their, the employees and other users of the manual, participation in the maintenance of the manual, it is important that the structure of the manual be thoroughly understood. Also familiarity with the contents of each section encourages those concerned to use the manual to its maximum potential. The manual consists of twenty-two (22) major sections & four (4) appendixes in addition to the bale of contents:

Each section begins with an introductory paragraph explaining the contents and, ordinarily, presents the more general information before progressing to specific and detailed procedures. Supporting exhibits and attachments are provided, when necessary and where applicable, and follow the narrative of the section. Sections are numbered with Roman numerals and alphabets. The page numbers commence on the first page of each section and reflect both the section and page number of the section, respectively. Exhibits accompanying the procedures are identified by the section number and a numeric code identifying the exhibit. For example:

(a) Page "A-10" would be the tenth page of Section A.
(b) Exhibit "A-1" would be the first exhibit of Section A.

SECTION TITLE: INTRODUCTION

A page number is also assigned the exhibit according to its page location within the section.

Manual Maintenance - The Systems and Standards Office, Division of Accounts, Department of Administration is the organization responsible for coordinating, reviewing and distributing all revisions to the Financial Management System Manual.

All requests for changes will be directed to this organization. Upon receipt of change request, a schedule for review will be made and concerned organization's supervisor will be notified of the date and time when review is to be made, and what related date and information will be required to adequately perform the review on the change request. The review findings and recommendations will be fully documented for review and approval by the Director of Administration. Budgeting changes are identified and addressed in the review. The requestor will be notified if and when the requested changes have been approved or disapproved and the effective date of approved changes.

Copies of the manual will be maintained in loose-leaf form to facilitate the insertion and removal of pages. All new and revised pages will be numbered to properly conform with the remainder of the manual. Revision and additions are to be incorporated into the manual immediately upon receipt and superseded pages removed and destroyed.

All revisions will be sequentially numbered beginning with "1" and will be distributed under a letter of transmittal (see

Exhibit I-1). Introduction for [illegible] the manual changes is [illegible]s is outline on the transmittal form Exhibit I-1.

C. Assurances

LEGISLATIVE APPROPRIATION for

A. Mental Health and Substance Abuse Agency

B. Community Mental Health Center

C. Department of Education

D. Department of Public Safety

cannot be certified at this time since the Budget Act for Fiscal Year 1981 has not been passed. Upon passage of the Budget Act for Fiscal Year 1981 certification of Legislative Appropriation will be completed and forwarded in the form of an "Addendum" to the State Plan submitted. Additionally, a revised State Appropriation and Financial Summary will be forwarded.

1. All services provided under the Plan will be made available without discrimination on account of race, color, national origin, sex, creed, duration of residence, or ability or inability to pay for such services.

2. Drug and alcohol abusers and alcoholics who are suffering from medical conditions shall not be discriminated against in admission or treatment solely because of their drug or alcohol abuse or alcoholism by any private or public general hospital or outpatient facility which receives support in any form from federal funds available to the State for services provided under the Plan.

3. All services provided under the Plan shall be publicized as to be generally known to the population to be served and shall be so located as to be readily accessible, available and responsive to the needs of the population to be served.

4. The Mental Health and Substance Abuse Agency has developed and will maintain, to the extent feasible, a current and complete inventory of all public and private resources available in the State, including but not limited to programs funded under State laws, occupational programs, voluntary organizations, education programs, military and Veteran's Administration resources, and available public and private third party payment plans.

5. The Mental Health and Substance Abuse Agency will coordinate its planning efforts with other State planning agencies.

6. Federal funds received for services under the Plan will be used to supplement State and other non-federal funds, but will not be used to supplant such funds.

7. Equal Employment Opportunity is assured by the State Merit System. Discrimination in any aspect of personnel administration because of political or religious opinions or affiliations, or discrimination because of age, sex, race, national origin or physical disability will be prohibited except where age, sex or physical requirements constitutes a bona fide occupational qualification. All personnel employed by the Mental Health and Substance Abuse Agency who have authority for supervising the development and administration of the State Plan, must and do conform to the rules

and regulations of the Government of Guam Merit System. In addition, the Mental Health and Substance Abuse Agency has developed a tailored Affirmative Action Plan and will take positive action to implement that plan and take any action consistent with merit to assure equal employment opportunity.

8. The Mental Health and Substance Abuse Agency established policies and procedures to ensure that treatment or rehabilitation projects or programs supported by formula grant funds will provide to the the Agency a proposed program performance standard, or standards to measure, or research protocol to determine, the effectiveness of such treatment or rehabilitation programs or projects.

9. State certification, accreditation and licensure requirements applicable to alcohol abuse and alcoholism treatment facilities and personnel take into account the special nature of such programs and personnel, including the need to acknowledge previous experience when assessing the adequacy of treatment personnel.

10. The Mental Health and Substance Abuse Agency has assessed the need for prevention and treatment of alcohol abuse and alcoholism by women, by individuals under the age of eighteen and by the elderly; prevention and treatment programs within the State will be designed to meet such need.

11. In addition, all requirements as presented and/or referenced in the "ADAMHA COMBINED STATE PLAN GUIDELINES" of the Office of Program Coordination, July 1978 presented in Part V, Section C, are followed by the Mental Health and Substance Abuse Agency including the following areas of compliance: 1. Nondiscrimination, 2. Accessibility, 3. Maintenance of Effort, the Administrative Requirements, 4. Merit System Personnel, 5. Performance Standards, 6. Specific Needs, 7. Review and Approval issues and 8. Funds for Administration.

I do hereby certify that these assurances are made in good faith and will be maintained by the Mental Health and Substance Abuse Agency as a condition of continuing funding.

Peter A. San Nicolas

PETER A. SAN NICOLAS, Administrator
Mental Health and Substance Abuse Agency
Government of Guam

7-14-80
Date

STATE: Guam
AGENCY: Mental Health and Substance Abuse Agency
X ORIGINAL
REVISION NO.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

STATE HEALTH PLAN OR APPLICATION BUDGET

FUND SOURCE	TITLE V-SOC SECURITY ACT SEC 503 MCH A	SEC 504 CC B	C	D	LEGISLATIVE ADJTM SEC 409 EPDA	SEC 20 FACILITIES	E	F
STATE PUBLIC								
LOCAL PUBLIC								
PRIVATE NON-PROFIT								
SUB-TOTALS								
FEDERAL SPECIAL ASSISTANCE (FUNDS A)								
FEDERAL DIRECT ASSISTANCE (FUNDS D)								
PREVIOUS FISCAL YEAR (s) CARRYOVER	A.				60,000	29,546	1 191,048	
	B.					140,653	2 114,693	
TOTALS								
NON-FEDERAL SHARE REQUIREMENTS								
MAINTENANCE OF EFFORT								
AMOUNT OF MATCHING PROPOSED BY STATE								
DIRECT COMMUNITY SERVICES								
TOTAL HEALTH FUNDS BUDGETED								

FUNDS BUDGETED TO OTHER AGENCIES		
PURPOSE	STATE PUBLIC AGENCIES	LOCAL PUBLIC AGENCIES	NON-PROFIT
PUBLIC HEALTH			
MENTAL HEALTH			
TOTALS			

PROGRAM DIRECTOR (Name and Title)
PETER A. SAN NICOLAS, Administrator
AGENCY HEAD (Signature)
Peter A. San Nicolas
TITLE
DATE 7-14-80

OFFICE OF GOVERNOR
JOSEPH F. ADA
TITLE
ACTING GOVERNOR OF GUAM
DATE 7/14/80

1-80.

1 Estimated formula grant award.
2 FY 1980 ends Sept. 30, 1980 - figure is an estimate of expended amount by 9-30-80.

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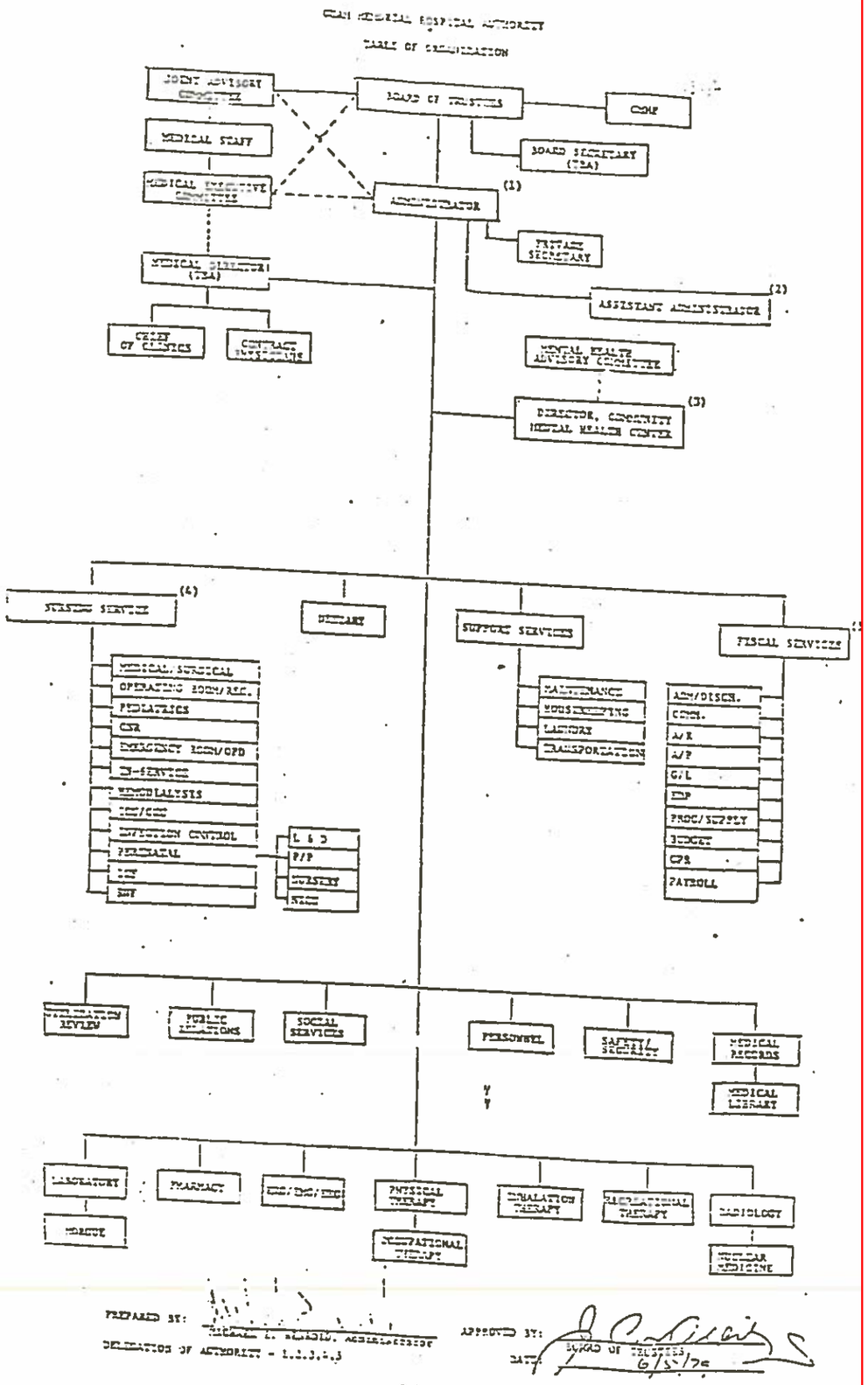
APPENDIX A - ITEM 7

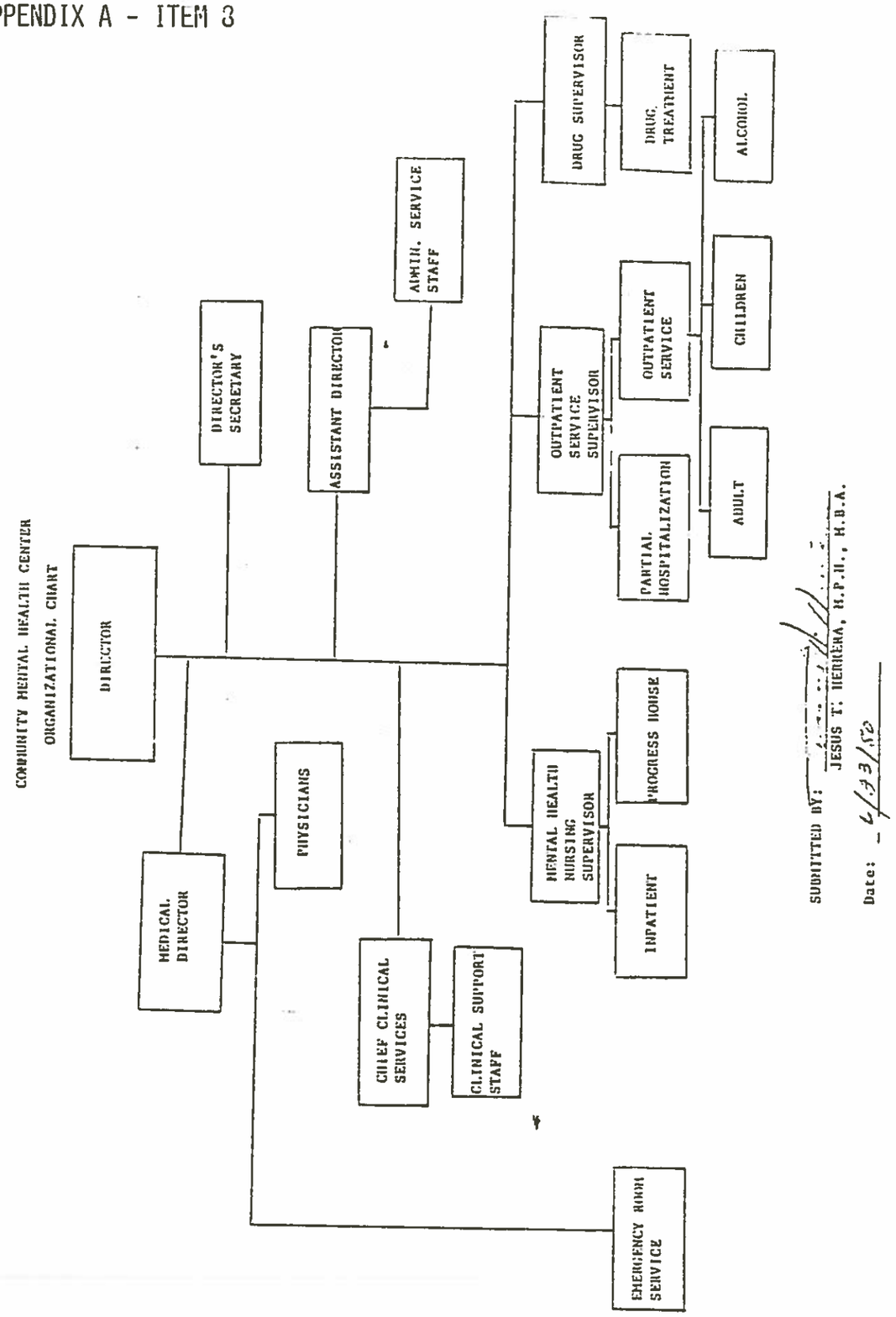


PREPARED BY: [signature] DELEGATION OF AUTHORITY - 1.1.1.1.1.3

APPROVED BY: [signature] BOARD OF TRUSTEES DATE: 6/15/72

APPENDIX A - ITEM 3

COMMUNITY MENTAL HEALTH CENTER
ORGANIZATIONAL CHART



SUBMITTED BY: [signature] JESUS T. HERRERA, M.P.H., H.B.A.

Date: 6/13/72

Canada losing faith in America

The writer specializes on Canadian affairs for the Financial Times of Canada and participates with International Writers Service.

By LES WHITTINGTON

OTTAWA — In an obscure Canadian government office here sit thousands of letters, plaques and other expressions of appreciation sent by grateful Americans after Canada helped six U.S. diplomats to escape secretly from Iran last winter.

But those messages are now gathering dust. The unprecedented burst of goodwill of eight months ago seems to have faded, eclipsed by changing Canadian attitudes toward the United States and growing irritants in the ties between this country and its giant neighbor.

When Kenneth Taylor, the Canadian ambassador to Iran, masterminded the Tehran "caper" in January, everyone here was thrilled to see Canada show its strength in the frustrating drama of the U.S. hostages.

Since then, however, the euphoria has been replaced by disillusionment as the Carter administration displays its incompetence to cope with the Iranian crisis. And this sense of disappointment has been exacerbated by increasing Canadian impatience with Washington's inability to act on a range of bilateral issues.

So, in short, Canadians are losing much of their faith in the United States at a time when unresolved differences could seriously damage relations between the two nations.

Though links between Canada and the United States have been remarkably close over the years, their mutual history has not been without its tempestuous moments such as two attempted American invasions back in the late 18th and early 19th centuries. Those events, however, have been relegated to the schoolbooks.

There has been a bright side, of course, in the Canadian alliance with the United States. Direct American investment here over the past three decades has resulted in jobs and prosperity. Many Canadians favor a free trade accord with the United States, especially since Prime Minister Pierre Trudeau's attempts to forge closer commercial bonds with Europe have fallen flat.

APPENDIX B - ITEM 2

Canadian cons end standoff

MONTREAL (AP) — Nine convicts at the maximum-security Laval prison laid down their weapons today released the last of thei hostages and surrendere ending a three-day standoff.

"It's all over," said G Verreault, manager of com munications for the federa penitentiary service. H statement came afte reporters monitoring police radio frequencies heard policemen report "they laid down their guns."

The end of the siege, which began Monday, came some six hours after the inmates had released three of the 12 hostages taken in an escape attempt. One hostage with a heart ailment was freed Tuesday.

Three hostages were released shortly before 4 a.m., after Montreal criminal lawyer Robert La Haye arrived at the prison at the request of the convicts, all but one of whom were serving life terms for murder.

APPENDIX E - ITEM 1

SORTING VOUCHERS: OUTPATIENT

1. Sort and batch vouchers by source of payment, i.e., CHAMPUS, Aetna, B/C-B/C, FHP, DOE, DOC, HMSA, etc.

2. Alphabetize service vouchers within appropriate service unit by source of payment.

3. Add voucher total by service unit within source of payment and enter total on the monthly charge summary (Exhibit I).

4. Distribution of Copies - Exhibit II

   a. Control Data Center (C.D.C.) - White copy

   b. Business Office - Yellow copy

   c. Service Unit - Pink copy

5. Attach yellow copy to "Patient's Bill" in patient's accounts receivable file and pull out jacket for manual posting.

POSTING CHARGES: OUTPATIENT

1. If "Patient's Bill" (Exhibit III) is available in patient's accounts receivable jacket, compare information shown on service voucher vs patient's bill.

2. Post charges shown on service voucher, i.e., date of service, service rendered, service code, standard price and total.

3. If there is no patient's accounts receivable jacket and patient's bill, prepare one. Use information available on service voucher to prepare patient's bill.

4. If required information is incomplete on the service voucher, contact the therapist who provided the service and obtain the required information.

5. Post charges shown on service voucher to patient's bill.

6. File vouchers in a letter size folder. Label folder with the date of service and service unit, i.e., "7/1/80 - 7/15/80, Adult Outpatient, Children, etc."

POSTING CHARGES: INPATIENT

1. Inpatient charges (room rate) should be posted to the individual "Patient's Bill" from the patient floor census report.

2. Room and board fee should be charged for the first day of admission. Extra one-half room rate should be charged if the patient is discharged after 12 noon or one full day if discharged after 6:00 PM.

3. Enter room and board total on the "Monthly Charge Summary" for Inpatient.

4. File patient's accounts receivable jacket to appropriate place.

PAYMENT RECEIVED AT MENTAL HEALTH: PAYMENT

1. Prepare list of all payment received at Mental Health.

2. Enter Business Office payment and on payment summary indicating payment made at Mental Health.

3. Forward copy of payment list to General Hospital Business Office, c/o Patient Affairs Manager.

4. Post payment to appropriate patient's bill.

PAYMENT RECEIVED AT BUSINESS OFFICE, GENERAL HOSPITAL:

1. Prepare list of all payment received at General Hospital.

2. Forward copy of payment list to Mental Health, c/o Mental Health Director.

3. Review and forward list to Business Office Mental Health.

4. Enter payment on payment summary indicating collection made at General Hospital.

5. Post payment to appropriate patient's bill.

[illegible] COLLECTIONS OF PROGRESS HOUSE CLIENTS:

1. Patient's accounts receivable jacket and patient's bill will be prepared for every Progress House client.

2. Patient will be charged every month and collection will be enforced.

3. Collection made will be posted to patient's bill to offset outstanding account.

4. Business Office staff will reconcile with Progress House staff and advise of all unpaid accounts.

5. Progress House staff will seek all possible source of third party payment if patient or family is financially unable to pay account.

6. Business Office staff will provide the Director with a list of clients who have not paid their accounts by the 10th of each following month.

JESUS V. HERRERA, M.P.H., M.B.A.
Director, OCMC

APPROVED AND FORWARDED:

[illegible]
EMERSON A. ESCHBACH, M.P.H.
Hospital Administrator

EXHIBIT I

CHEMICAL COMMUNITY MENTAL HEALTH CENTER
CLIENT REVENUE SUMMARY
JULY 1980

	SELF	L O L	OWING	V A	MEDICARE	MEDICAID PAP	MP PERSNL	MP PERSNL	MP LEGAL	GMP	COURT	D O E	D O [illegible]	MISC. INS.	MC	TOTALS
	12,009	9,581		4,069	1,181	33,075	1,706				1,838					63,459
	140					158										298
	6,120	14,427	1,365	720	1,915	6,150	960				540			350		32,547
	347	943			288	2,521	45			166				101		4,411
	330	660			128	178										1,295
	1,244	2,071	254			462	85			72	306		1,673	188		6,355
	572	1,000	465			80				390						2,877
	585	455			325	2,795	79				8	180		195		4,485
	2,052	3,221				526										6,309
	60	50														110
TOTALS:	23,459	32,359	2,134	4,789	3,836	45,944	2,830	868	130	628	2,692	180	1,673	834		122,226
	19%	26%	2%	4%	3%	38%	2%	1%	1%	1%	2%	—	1%	1%		100%

CHARGE VOUCHER

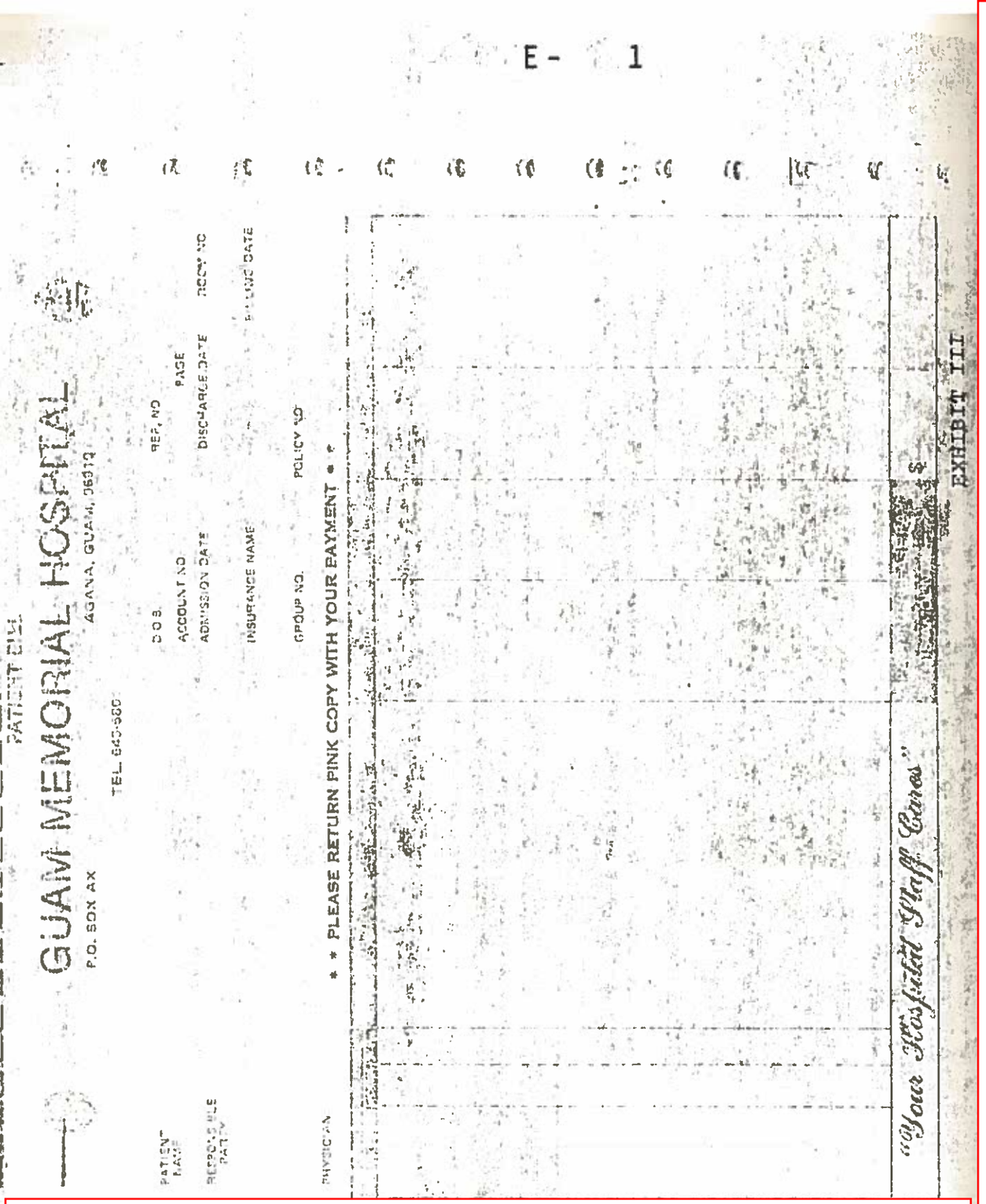
SERVICE RENDERED	CODE	MARK	AMOUNT	SERVICE RENDERED	CODE	MARK	AMOUNT
PARTIAL DAY WEEKLY	61900006			CONSULT/PSY REPORT	61906901		
PARTIAL EVENING WKLY	61900014			IND THERAPY 50 MIN G	61900034		
PARTIAL COMBINE WKLY	61900022			IND THERAPY 50 MIN H	61900056		
[illegible] ONE WKLY	61900030			IND THERAPY 25 MIN G	61900047		
[illegible] TWO WKLY	61900048			IND THERAPY 25 MIN H	61900053		
SPECIALIZED LAB TEST	61900055			IND THERAPY 15 MIN	61906117		
CONSULTED SERVICE/HOUR	61900063			GROUP THERAPY 50 MIN	61900216		
PATIENT MEALS	61900071			GROUP THERAPY 90 MIN	61900232		
PAR. TWEEN PROG. DAILY	61900089			CONJ MAR THERAPY 50	61906257		
PAT. DAY PROG. DAILY	61900097			CONJ MAR THERAPY 90	61900273		
MEDICATION	61900105			FAMILY THER./COUN 50	61906315		
[illegible] AND APP	61900113			FAMILY THER. COUN 90	61906331		
[illegible]ATE	61900155			PSYCHOLOGICAL TEST	61906414		
[illegible] EDUCATION DISP (Labor Only)	61900204			TELEPHONE CON 15 MIN	61900554		
[illegible] EMERGENCY SERVICE	61900154			DRUG PROG WKLY FEE	61906927		
CONSULT/PSY 15 MIN	61906304			DRUG PROG ENT FEE	61906935		
CONSULT/PSY 30 MIN	61906783			MISCELLANEOUS (See Remarks)	61900998		
CONSULT/PSY 50 MIN	61906202						
		TOTAL				TOTAL	

PATIENT'S NAME

PATIENT ID PLATE

DISTRIBUTION: DATA PROCESSING (White Copy), MH BUSINESS OFFICE (Yellow Copy, & Pink Copy)

EXHIBIT II



APPENDIX E - ITEM 12

The purpose of the [illegible] Information System (MIS) is to provide the Guam Memorial Hospital Health Center with the sufficient fiscal and caseload data to enable the Director to make targeted decisions in the implementation of medical health services within the allotted fiscal and clinical resources. This data will also serve as a planning tool in determining the utilization of the various services, the direct patient contacts made by professional and semi-professional staff, charges, expenditures, and other vital information. Each collection data will be provided as per Board of Trustees Resolution [illegible] dated 2/25/86 by the GMH Accounting Department.

The following forms will be used in the MIS:

1. Caseload Information Report (CIR)
2. Admissions Demographics (AD)
3. Discharge Information (DI)
4. Daily Floor Census (GMH 6000/15)
5. Monthly Revenue Summary by Source of Payment (MRS)
6. Monthly Performance Report (MPR)

MONTHLY PERFORMANCE REPORT

1. Caseload Information Report (CIR).
   A. Staff
      (1) Each staff will daily complete those items applicable to his/her caseload/workload and discipline on the Caseload Information Report (CIR) form.
      (2) Each staff will, at the end of each week, summarize the CIR, and signed completed CIR, on Monday for the previous week to the Service/Unit Clerk. (Definition of Week - Sunday through Saturday but to include only those days of that month, i.e., 1st week of July - Tuesday, July 1, through Saturday, July 5, is one week.)
   B. Clerk
      (1) Service/Unit Clerk will:
      - prepare a folder for each staff
      - identify folders by affixing staff's name
      - label folders as "Caseload Information Report Forms"
      (2) On receipt of CIR's, file in appropriate staff's folder.
      (3) By the 3rd day of each month, pull staff's folders, compile and prepare a monthly Caseload Information Report for each staff for the previous month, i.e., July 3 prepare report on June.
      (4) Compile and prepare a Service/Unit monthly CIR Summary Report by the close of work on the 4th of each month.

(b) [illegible] Supervisor for review and [illegible] by the 4th of each month.

(c) [illegible]

[illegible] all working copy handwritten.

For Mental Service/Unit Monthly Summary - Use Regular size typed for submission to Supervisor.

C. Service Unit Supervisor.

(1) On receipt of the Service/Unit monthly CIR summary from the Clerk, Service/Unit Supervisor will review, sign and forward original to Mental Health Business Affairs Accounting Clerk by the 5th day of each month (cc: to staff's folder).

(2) Review subordinate's monthly CIR.

(3) Discuss CIR with staff, verify, sign and return to Clerk.

(4) Use final CIR to maximize utilization of staff time, patient care, and financial viability.

(5) Monitor activities shown on CIR.

D. Mental Health Business Affairs Accounting Clerk.

(1) Compile all Service/Unit monthly CIR's and prepare a monthly Center CIR Summary and Summary of Admission Demographics (AD) form.

(2) Forward the completed Monthly Center CIR Summary Report to the Mental Health Business Affairs Accountant.

E. Mental Health Business Affairs Accountant.

(1) Prepare the Monthly Performance Report (MPR) for the GCMHC by extracting data from the Service/Unit monthly CIR's.

(2) Extract data to compute direct and indirect cost, General Hospital indirect cost, and other financial data from both Mental Health and General Hospital financial expenditure ledger.

(3) Forward MPR to the Director, GCMHC, no later than the 8th day of each month for the previous month's activities and fiscal information.

F. Director, GCMHC.

(1) Review and analyze the Center's MPR for any disposition necessary.

(2) Distribute copies of MPR to the Department Heads, Hospital Administrator, Mental Health Departments and Section Heads, Mental Health Advisory Committee, Hospital Board of Trustees, and others as appropriate by the 10th of each month.

(3) Use the MPR as a planning, projection, and implementation tool in the delivery of services and management of the GCMHC.

(Rev. 7/29/80)

APPENDIX E - ITEM 3

GUAM MEMORIAL HOSPITAL AUTHORITY

TAMUNING

August 13, 1980

Memorandum

To: Hospital Administrator

From: Director, GCMHC

Subject: Management Information System Report - JULY 1980

Forwarded for your review and analysis is the first report from the newly implemented Management Information System which seems to be working out as a good management tool.

Should you need any further information or clarification on the report, please do not hesitate to contact me.

JESUS T. HERRERA, M.P.H., M.B.A.

Attachment

Copy to:
Chairperson, Mental Health Advisory Committee
Manny Cruz, Special Assistant, Governor's Office
Administrator, SSA
Administrator, GHPDA
Director, BBMR
Administrator, Bureau of Planning

1.			491
			15
(a)			11
(b)			7
(c)			15
(d)	Transferred within Service/Unit (do not include in total)		0
2.	Number of b[illegible] during this month.		40
(a)	[illegible] (total)		27
(b)	[illegible]		13
(c)	[illegible] "new" within Service		15
(d)	Transfers within Service/Unit (do not include in total)		0
4.	Total of [illegible] caseload (1+2-3)		269
5.	Number of active cases (line 1) with no service rendered during this month.		39

Active case means not closed (close all cases without contact for 60 days, exception is made for those cases with specific recontact arrangements longer than 60 days).

JULY CASES SEEN = 230

6. Admissions/Demographics

Transfers "In"

FEMALES

Marital Status: S 4 M 8

D/S	3	W	2

Military Affiliation

1.		12.	
2.		13.	
3.		14.	
4.		15.	
5.		16.	
6.		17.	
7.		18.	
8.		19.	Guam 2
9.		20.	Yigo 2
10.		21.	None 1
11.		22.	Military Installation

Number of Residence

1.		12.	
2.		13.	
3.		14.	
4.		15.	
5.		16.	
6.		17.	
7.		18.	
8.		19.	
9.		20.	
10.		21.	
11.		22.	

MALES

Marital Status: S 13 M 1

D/S	1	W	

Military Affiliation

1.		12.	
2.		13.	
3.		14.	
4.		15.	
5.		16.	
6.		17.	
7.		18.	
8.		19.	
9.		20.	
10.		21.	
11.		22.	Military Installation 1

Number of Residence

1.	1	12.	
2.		13.	
3.		14.	
4.		15.	
5.		16.	
6.		17.	
7.		18.	
8.		19.	
9.		20.	
10.		21.	
11.		22.	

Military Dependent 1

FORM APPROVED
OMB NO. 68-R1222

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

STATE HEALTH PLAN OR APPLICATION BUDGET

STATE: Guam
FISCAL YEAR: 1981
AGENCY: Mental Health and Substance Abuse Agency
[X] INITIAL
[ ] REVISION NO. _____

FUND SOURCE	TITLE V-SOC. SECURITY ACT				PHS ACT		LEGISLATIVE AUTH. (See Instructions)				
	SEC. 503 MCH	SEC. 504 CC	SEC. 505 MCH	SEC. 1615 [illegible]	[illegible]	SEC. [illegible] [illegible]	SEC. 314(d) MENTAL HEALTH	SEC. 303(a) ALCOHOL	SEC. 409 DRUG	SEC. 237 FACILITIES	SEC. 163 FACILITIES
1.	A	B	C	D	E	F	G	H	I	J	K
STATE PUBLIC											
4. LOCAL PUBLIC											
3. PRIVATE NON-PROFIT											
4. SUB-TOTALS											
5. FEDERAL — FINANCIAL ASSISTANCE — FUND A											
FEDERAL — FINANCIAL ASSISTANCE — FUND B											
FEDERAL — DIRECT ASSISTANCE											
6. PREVIOUS FISCAL YEAR (s) CARRYOVER	A.	A.									
	B.	B.									
7. TOTALS							1 60,000	1 29,546	1 191,048		
8. NON-FEDERAL FUNDS REQUIREMENTS											
9. MAINTENANCE OF EFFORT								140,653 2	114,663 2		
10. AMOUNT OF MATCHING PROPOSED BY STATE											
11. DIRECT COMMUNITY SERVICES											
12. TOTAL HEALTH FUNDS BUDGETED											

FUNDS BUDGETED TO OTHER AGENCIES

PURPOSE	STATE PUBLIC AGENCIES	LOCAL PUBLIC AGENCIES	NON-PROFIT
13. PUBLIC HEALTH			
14. MENTAL HEALTH			

REMARKS:

[1] Estimated formula grant award.

[2] FY 1980 ends Sept. 30, 1980 - figure is an estimate of expended amount by 9-30-80.

PROGRAM DIRECTOR (Name and Title)
PETER A. SAN NICOLAS, Administrator

AGENCY HEAD (Signature) — DATE 7-14-80
TITLE

OFFICE OF GOVERNOR — DATE 7/14/80
JOSEPH F. ADA
TITLE
ACTING GOVERNOR OF GUAM

PHS-1233-2
(REV. 2-78)

No. of staff hours and contacts in C&E services - SUMMARY.

a. Psychiatrist hours _____ contacts _____

b. Medical hours _____ contacts _____

c. Psychological hours 32 contacts 19

d. Social Worker hours 114 1/4 contacts 120

e. R.N. hours 2 contacts 2

f. Psych Tech hours _____ contacts _____

g. ~~Graduate/Clinical/Trainee~~ Supervisor hours 6 contacts 3

h. Other support staff hours (clerical, etc) _____

TOTAL hours 154 1/4 contacts 144

SIGNATURE: _____

DATE: _____

	TOTALS		MISC. INS.		D O		D U E		COUNTY		CHP LOCAL		CHP FEDERAL		MEDICAID TMP		MEDICARE		V A		COUNTY		L O L		SELF	
	63,459								1,838						33,075		1,181		4,069				9,581		12,009	
	298														158										140.	
	32,547		350						540		166				6,150		1,915		720		1,365		14,427		6,120	
	4,411		101												2,521		288						943		347	
	1,295														178		128						660		330	
	6,355		188		1,673		180		306		72				462						254		2,071		1,244	
	2,877										390				80						465		1,000		572	
	4,485		195						8						2,795		325						455		585	
	6,389										190		85		526								3,221		2,052	
	110										130												50		60	
	122,226	100%	834	1%	1,673	1%	180	—	2,692	2%	628	1%	868	1%	45,944	38%	3,836	3%	4,789	4%	2,134	2%	32,359	26%	23,459	19%

GREATER COMMUNITY MENTAL HEALTH CENTER
REVENUE SUMMARY
JULY - _____ 1980

SERVICE/UNIT SUPERVISOR: OMIC SUMMARY

GUAM MEMORIAL HOSPITAL AUTHORITY
MONTHLY PERFORMANCE REPORT
MONTH July YEAR 1980

PREPARED BY: [illegible] Gonzales
DATE OBTAINED: August 8, 1980

	CURRENT MONTH – UNITS OF SERVICE 2,556 Patient hrs 19,4[illegible]				YEAR TO DATE – UNITS OF SERVICE 24,592			
	Actual	Budgeted	Variance Over/Under	Actual Per Unit	Actual	Budgeted	Variance Over/Under	Actual Per Unit
1. Direct Expense.								
a. Payroll	80,613	91,713	(11,100)		873,386	917,130	(43,744)	
b. Benefits	7,964	9,249	(1,285)		90,654	92,490	(1,836)	
c. Travel	198	798	(600)		12,964	7,980	4,984	
d. Contractual								
Professional Fees	225	2,167	(1,942)		2,050	21,670	(13,620)	
Purchase Services	2,005	3,715	(1,710)		32,587	37,150	(4,563)	
e. Supplies	333	2,640	(2,307)		14,566	26,400	(11,834)	
f. Utilities								
g. Others (Overseas Telephone)		67	(67)		243	670	(427)	
2. Total Direct Expense	91,338	110,349	(19,011)	35.73	1,032,450	1,103,490	(71,040)	41.98
3. Indirect Expense								
a. Mental Health	12,006	12,006	—		120,060	120,060	—	
B. GMH	57,840	57,840	—		578,400	578,400	—	
4. Total Direct Expense	161,184	180,195	(19,011)	63.06	1,730,910	1,801,950	(71,040)	70.39
5. Net Income (Loss)								
6. Gross Profit Percent								
7. Actual Hours Worked	8,381							
8. Billings Out	122,226							
9. Receipts	9,460				12,108			

APPENDIX E - ITEM 4

GUAM COMMUNITY MENTAL HEALTH CENTER

ADVISORY COMMITTEE

A P P O I N T E E S

1. TINA BLAS, R.N. - CHAIRWOMAN
2. JOHN BEANER
3. ROMANA MENDIOLA
4. NORBERT UNGACTA
5. GIL UNTALAN
6. LOLA PEREZ, R.N.

CONTACT ADDRESS:

MENTAL HEALTH ADVISORY COMMITTEE
GUAM MEMORIAL HOSPITAL AUTHORITY
POST OFFICE BOX AX
AGANA, GUAM 96910
(671) 646-9239/9378

(Rev. 7/11/80)

GUAM MEMORIAL HOSPITAL AUTHORITY
TAMUNING, GUAM

BOARD OF TRUSTEES

UNGACTA, NORBERT	CHAIRMAN
BLAS, TINA	VICE-CHAIRPERSON.
LEON GUERRERO, J.D.	TREASURER
TAINATONGO, ROSE	SECRETARY
SORIANO, SULPIANO (M.D.)	MEMBER
FISHMAN, H. (M.D.)	MEMBER
SULLIVAN, ROY	MEMBER

GOVERNING/ADVISORY BOARD REPRESENTING
CATCHMENT AREA

In each column in the table below, indicate the number of persons, according to the sex, race, age and income categories provided:

(a) Board composition refers to current membership.

(d) Catchment area population should be consistent with the Mental Health Demographic Profile System.

Category	(a) Board Members Gov.	Advisory	(b) Catchment Area
MALE	5	3	47,362
FEMALE	2	3	37,634
GUAMANIANS	4	5	52,400
STATESIDERS	2	1	6,428
FILIPINOS	1	0	10,172
MILITARY DEPENDENTS	0	0	19,037
OTHER (SPECIFY)	0	0	3,504
UNDER 25	0	0	52,020
25-44	3	3	22,843
45-64	3	2	8,653
OVER 64	1	1	1,480
Poverty Income	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE
Residents of Catchment Area	7	5	XXXXXXXX
Providers of Health Care	3	2	XXXXXXXX

SERVICE Summary

YEAR FY 82

	ADMISSIONS	DISCHARGES	ACTIVE CASES OR OCCUPANCY RATE	PATIENT VISITS	PATIENT CARE DAYS	PATIENTS/CLIENTS	YTD ADMISSIONS	YTD DISCHARGES	YTD PATIENT VISITS	YTD PATIENT CARE DAYS	YTD PATIENTS/CLIENTS
ER	64	60	388	1268	1281		64	60	1243	1432	
MBER	65	67	335	1349	1203		129	127	2613	2635	
MBER	45	53	340	1105	1152		174	180	3717	3787	
ARY	47	61	342	1330	1203		221	241	4347	4990	
DARY	51	70	393	1372	1166		272	291	5609	6155	
H	43	55	320	1319	1153		315	346	6762	7308	
L	70	55	353	1169	1216		385	401	7985	8520	
	51	63	334	1154	1116		436	464	9177	9685	
	62	58	354	1255	1197		498	522	10324	10934	
	31	51	343	1115	1210		529	573	11347	12095	
ST											
ENTER											
ALY											
AGE											

SERVICE Sh-pd

YEAR FY 82

	ADMISSIONS	DISCHARGES	ACTIVE CASES OR OCCUPANCY RATE	PATIENT VISITS	PATIENT CARE DAYS	PATIENTS/CLIENTS	YTD ADMISSIONS	YTD DISCHARGES	YTD PATIENT VISITS	YTD PATIENT CARE DAYS	YTD PATIENTS/CLIENTS
ER	1	2	0.4 / 0.4%	-	448		11	24	-	1428	
MBER	18	15	20 / 12.9	-	576		31	41	-	1834	
MBER	13	13	15 / 9.6	-	464		44	54	-	2298	
ARY	9	5	19 / 12.2	-	641		53	59	-	2939	
UARY	9	10	18 / 11.5	-	640		62	69	-	3579	
H	14	11	21 / 13.4	-	512		76	80	-	4091	
L	11	8	22 / 14.1	-	448		87	88	-	4539	
	12	15	20 / 12.9	-	496	-	99	103	-	5035	
	7	5	22 / 14.1	-	384	-	106	108	-	5419	
	12	10	24 / 15.4	-	480	-	118	118	-	5899	
ST											
ENTER											
ALY											
AGE											

Emergency
FY 80

	11	4	–	15	NA		11	4	15		
	12	5	–	17	NA		23	9	32		
	11	7	–	18	NA		34	16	50		
	5	11	–	19	NA		42	27	69		
	4	15	–	19	–		46	42	88		
	13	6	–	19	–		59	48	107		
	4	8	–	19	–		70	56	126		
	12	9	–	21			82	65	147		
	19	9	–	26			101	72	173		
	4	4	–	8			105	76	181		

Progress House
FY 80

	1	1	11	[illegible]	[illegible]		1	1	[illegible]	[illegible]	
	0	1	[illegible]	[illegible]	[illegible]		1	1	[illegible]	[illegible]	
	1	0	10	[illegible]	[illegible]		1	1	920	920	
	[illegible]	[illegible]	[illegible]	31 370	510		1	3	31	1380	
	[illegible]	1	7	–	203		1	4	31	1453	
	1	0	8	–	243		2	4	31	1674	
	[illegible]	[illegible]	[illegible]	–	[illegible]		2	4	31	[illegible]	
	1	1	3		245		5	5	31	2164	
	1	6	9	–	297		4	5	31	2454	
	6	6	5	–	353		4	9	31	[illegible]	

Partial
Fy 80

	2	9	57	5/6	5/6		2	9	5/6	5/6	
	7	1	12	9/6	9/6		9	10	19	19	
	3	2	64	3/2	3/2		12	12	1254	1354	
	5	5	60	23	506		17	20	23	1910	
	4	5	60	-	455		21	25	23	3345	
	5	5	56	-	445		24	30	23	3755	
	3	4	59	-	405		27	34	25	4150	
	5	5	59	-	368		32	39	23	4852	
	7	6	56	-	382		39	45	22	5134	
	4	5	56	-	3504		43	51	22	5638	

Aftercare
Fy 80

	1	3	46	112			6	3	112		
	4	3	43	90			11	5	202		
	1	0	49	104			11	5	306		
	3	1	51	185			14	6	445		
	2	1	52	132			16	7	577		
	0	1	53	115			16	8	692		
	0	3	46	90			16	11	812		
	2	3	41/45	123			18	14	942		
	1	1	41/44	137			19	15	1079		
	4	3	43	159			23	19	1214		

Programman Patgon

FY80

	ADMISSIONS	DISCHARGES	PATIENTS CARED FOR OR UNDER CARE	PATIENT VISITS	PATIENTS ON BOOKS	PATIENTS/CLIENTS	YTD ADMISSIONS	YTD DISCHARGES	YTD PATIENT VISITS	YTD PATIENTS ON BOOKS	YTD PATIENTS/CLIENTS	
	17	11	61	156			15	[illegible]	150			
	[illegible]	[illegible]	55 [illegible]	243			29	21	571			
	4	2	56	184			38	23	555			
	7	11	52	[illegible]			40	34	809 [illegible]			
	12	11	54	204			52	45	1016			
	14	13	54	204			66	58	1075			
	11	13	61	217			80	71	1472			
	6	11	55	165			91	82	1657			
	8	57	57	172			99	89	1765			
	5	3	59	91			104	92	1850			

Adult O/P

YEAR FY 80

	ADMISSIONS	DISCHARGES	PATIENTS CARED FOR OR UNDER CARE	PATIENT VISITS	PATIENTS ON BOOKS	PATIENTS/CLIENTS	YTD ADMISSIONS	YTD DISCHARGES	YTD PATIENT VISITS	YTD PATIENTS ON BOOKS	YTD PATIENTS/CLIENTS	
TOBER	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	264			
EMBER	[illegible]	4	44	193			15	7	459			
EMBER	7	4	21	172			29	18	628			
UARY	7	17	13	213			35	29	861			
RUARY	12	20	24	53			49	42	1134			
CH	5	4	5	238			45	51	[illegible]			
RIL	12	11	32	234			54	47	1360			
Y	11	15	30	214			95	82	1994			
NE	9	30	[illegible]	235			104	[illegible]	2309			
LY	[illegible]	12	[illegible]	111			[illegible]	[illegible]	2491			
GUST												
TEMBER												

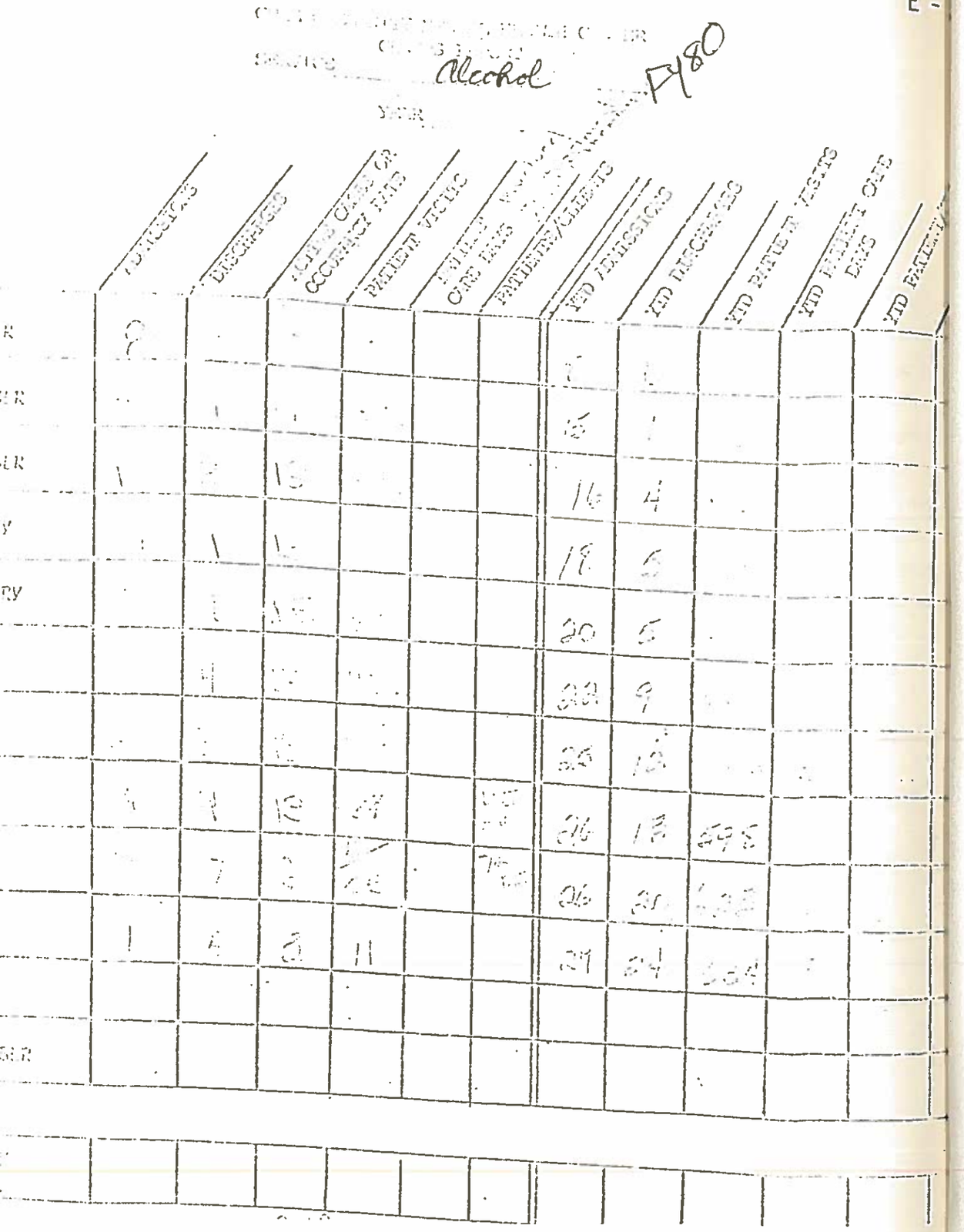
Elderly
FY 80

	1	1	32	134			1	6	134		
	6	11	21	154			1	11	360		
	0	0	32	90			1	11	350		
	6	1	21	156			1	12	508		
	8	6	23	163			2	13	671		
	0	2	21	107			3	14	775		
	6	0	23	63			2	14	582		
	6	2	21	141			3	15	979		
	6	1	20	139			2	17	1118		
	6	5	19	80			2	20	1158		

Drug Rx
FY 80

	3	3	25	328			3	5	683		
	6	1	23	156			3	10	1235		
	3	2	25	476			6	13	1769		
	4	4	25	594			10	16	2253		
	4	6	24	458			14	23	3165		
	6	6	24	450			14	27	3315		
	2	2	25	352			13	27	3605		
	1	1	25	401			19	30	4006		
	6	1	24	385			19	31	4291		
	6	5	20	754			19	33	4945		

Alcohol FY80



APPENDIX E - ITEM 6

9. [illegible]

Emergency Service - Based on historical data

225 Emergencies @ 2 hours average call = 450 hours

9 Staff "On Call" Status

Mental Health Day Unit - Based on 100% occupancy with

17 Pod capacity and 20 core staff

6,205 Patient Care Days

Partial Hospitalization Service With the Home Visiting Unit - Based on

historical data for Partial and in the Home Visiting Unit

66 2/3% of staff time in direct patient care with 1,752 hours

per annum per staff

Partial - 4,884 patient care days (6 hours)

61 patient capacity

9 staff

Home Visiting Unit - 2,338 patient visits (hour)

2 Staff

Adult Outpatient - Based on 66 2/3% of staff time in direct patient care with

1,752 hours per annum per staff

4,674 patient visits (hour)

4 Staff

Programmed Patron (Children's Program) - Based on 66 2/3% of staff time in direct

patient care with 1,752 hours per staff per annum

3,506 patient visits (hour)

3 Staff

Alcohol Drug Service - Based on 66 2/3% of staff time in direct patient care

with 1,752 hours per staff per annum

2,103 patient visits (hour)

1.8 Staff

CMHC Financial Distress Grant Application submitted June 23, 1980.

Rural Home Service - based on 66 2/3 of staff time in direct patient care
with 1,752 hours per staff per annum
5,259 patient visits (hour equivalents)
4.5 Staff

PART III – BUDGET INFORMATION

SECTION A – BUDGET SUMMARY

Grant Program, Function or Activity (a)	Federal Catalog No. (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1.	13,295	$	$	$ 443,705	$1,035,312	$1,479,017
2.						
3.						
4.						
5. TOTALS		$	$	$ 443,705	$ 1,035,312	$1,479,017

SECTION B – BUDGET CATEGORIES

6. Object Class Categories	– Grant Program, Function or Activity				Total
	(1)	(2)	(3)	(4)	(5)
a. Personnel	$ 379,591	$ 649,924	$	$	$ 1,029,515
b. Fringe Benefits	38,935	66,663			105,598
c. Travel	3,160	5,408			8,568
d. Equipment	369	631			1,000
e. Supplies	7,398	12,664			20,062
f. Contractual	13,957	23,894			37,851
g. ~~Construction~~ Utilities RCA	295	505			800
h. Other Inkind		275,623			275,623
i. Total Direct Charges	443,705	1,035,312			1,479,017
j. Indirect Charges					
k. TOTALS	$. 443,705	$ 1,035,312	$	$	$ 1,479,017
l. Program Income	$	$	$	$	$

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SECTION C – NON-FEDERAL RESOURCES

(a) Grant Program	(b) APPLICANT	(c) STATE	(d) OTHER SOURCES	(e) TOTALS
8. Financial Distress	$	$ 759,689	$ 275,623	$ 1,035,312
9.				
10.				
11.				
12. TOTALS	$	$ 759,689	$ 275,623	$ 1,035,312

SECTION D – FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 443,705	$ 110,927	$ 110,926	$ 110,926	$ 110,926
14. Non-Federal	759,689	189,923	189,922	289,922	289,922
15. TOTAL	$ 1,203,394	$ 300,850	$ 300,848	$ 300,848	$ 300,848

SECTION E – BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b) FIRST	(c) SECOND	(d) THIRD	(e) FOURTH
16. GCMHC Financial Distress Grant	$ 443,705	$	$	$
17.				
18.				
19.				
20. TOTALS	$	$	$	$

SECTION F – OTHER BUDGET INFORMATION

(Attach additional Sheets If Necessary)

21. Direct Charges:

22. Indirect Charges:

23. Remarks: + In-Kind Match - detail on Page 13

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PART IV PROGRAM NARRATIVE (Attach per instruction)

	(1)	(2)	(3)	(4)
SELECTION & WELLNESS CAMPS				
Chief - Jesus T. Herrera				
Assistant Director - Norma Cing (acting)	$51,000	12	100	$51,000
Administrative Assistant - Emily T. Pangelinan	18,000	12	100	18,000
Secretary/Secretary - Josephine Mesa	12,060	12	100	12,060
Psychologist - Norma Cing	12, 060	12	100	12,060
Social Worker - Richard Fejeran	15,180	--	---	------
Assistant I - Norma Gonzales	8,660	12	100	8,660
Planning Technician II - Janema Manavilla	15,700	12	100	15,700
Medical Transcriptionist - Betsie Leon Guerrero	12,810	12	100	12,810
	9,580	12	100	9,580
SUB-TOTAL				$119,900
BENEFITS				11,944
				$131,944
EMERGENCY SERVICE				
Psychiatrist - Aldo Cahue, M.D.				
Psychiatrist - Frances Reid, M.D.	55,000	12	20	11,000
Clinical Psychologist - Marcelo A. Ordonez, Ph.D.	45,000	12	10	4,500
Clinical Psychologist - George Kallingal, Ph.D.	21,000	12	10	2,100
Nursing Supervisor - Shirley Houha (Acting)	21,000	12	10	2,100
Patient Service Supervisor - Vincent Pereda	16,220	12	10	1,622
Outpatient Supervisor - Vicenta Duenas	19,860	12	10	1,986
Clinical Psychologist - Diane Cartland	17,260	12	10	1,726
Substance Abuse Treatment Supervisor - Dick Hartendorp (Acting)	14,660	12	10	1,466
	17,000	12	10	1,700
SUB-TOTAL				28,200
BENEFITS				2,809
				$31,009
MENTAL HEALTH INPATIENT UNIT				
Nurse Supervisor II - Rose Treltas	18,560	12	100	18,560
Staff Nurse III - Nelidad Gonzales	17,260	12	100	17,260
Staff Nurse III - Melourd Lagdamen	15,700	12	100	15,700
Staff Nurse III - Daisy Tydingco	14,660	12	100	14,660
Staff Nurse III - Joyce Apoenzeller	15,620	12	100	15,620
Staff Nurse III - (Vacant)	13,230	--	---	------
Staff Nurse II - Eugenia Aycock	11,748	12	100	11,748
Psychiatric Technician II - Evelina Caasi	12,060	12	100	12,060
Psychiatric Technician II - Linda Arciaga	12,060	12	100	12,060
Psychiatric Technician II - Joseph Viloria	10,052	12	100	10,052
Psychiatric Technician I - Emmanuel Perez	8,844	12	100	8,844
Psychiatric Technician I - Vacant	-	-	-	-
CARRIED TO BENEFITS (Page 00 617				

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CATEGORY TOTAL | $

NAME AND POSITION TITLE	ANNUAL SALARY RATE (1)	NO. MOS. BUDG. (2)	% TIME (3)	
PARTIAL CARE SERVICE (CONTINUED)				
Social Service Worker IV- Venancia Colet	$14,140	12	5	$2
Clinical Psychologist - Marcelo Ordonez, Ph.D.	$21,000	12	10	
Clinical Psychologist - George Kallingal, Ph.D.	21,000	12	10	2
Psychiatrist - Frances Reid, M.D.	45,000	12	20	9
General Physician - John Fleming, M.D.	12,000	12	5	
Mental Nursing Supervisor - Shirley Hauha (Acting)	16,220	12	20	3
Outpatient Service Supervisor - Vincent Pereda	19,860	12	5	
Clinical Psychologist - Diane Cartland	14,660	12	10	1
SUB-TOTAL				149
PREMIUM/NIGHT DIFFERENTIAL				21
				170
BENEFITS				16
				$187
AFTERCARE SERVICE				
Mental Nursing Supervisor - Shirley Hauha (Acting)	16,220	12	10	1
Staff Nurse III - Lourdes Gutierrez	16,740	12	100	16
Staff Nurse III - Jeanette Blas	15,180	12	100	15
General Physician - John Fleming, M.D.	12,000	12	5	
Psychiatrist - Frances Reid, M.D.	45,000	12	5	2
Clinical Psychologist - Marcelo Ordonez, Ph.D.	21,000	12	5	1
Clinical Psychologist - George Kallingal, Ph.D.	21,000	12	5	1
Clerk IV - Brenda T. Cruz	9,396	12.	(40)	5
Outpatient Services Supervisor - Vincent Pereda	19,860	12	2.5	
Psychiatrist - Frances Reid, M.D.	45,000	12	15	6
Clinical Psychologist - Diane Cartland	14,660	12	5	
SUB-TOTAL				50
PREMIUM DIFFERENTIAL				4
				55
BENEFITS				5
				$61,
OUTPATIENT SERVICE (ADULT)				
Outpatient Services Supervisor - Vincent Pereda	19,860	12	35	6,
Social Service Supervisor III - Vicenta Duenas	17,260	12	85	14,
Clinical Psychologist - Diane Cartland, M.A.	14,660	12	5	
Social Service Worker IV - Joaquin Guerrero	15,180	12	100	15,
Social Service Worker IV - Maria Luisa Benavente	14,140	12	100	14,
Social Service Worker III- Carmen O'Mallan	12,450	12	100	12,
Social Service Worker II - (Vacant)	11,436	--	---	---
Clinical Psychologist - George Kallingal, Ph.D.	21,000	12	5	1,
Clinical Psychologist - Marcelo Ordonez, Ph.D.	21,000	13	5	1,
Psychiatrist - Aldo Cahue, M.D.	55,000	12	25	13,7
Psychiatric Technician I - Maria F. King	9,028	12	100	9,0

FRINGE BENEFITS (Rate 99.617)

NAME AND POSITION TITLE	ANNUAL SALARY RATE (1)	NO. MOS. BUDG. (2)	% TIME (3)	
HOUSE TREATMENT SERVICE (CONTINUED)				
Nurse I - Lilian Peraigue	11,748	12	100	11,748
Psychiatrist - Aldo Cahue, M.D.	55,000	12	5	2,750
Clinical Psychologist - Marcelo Ordonez, Ph.D.	21,000	12	5	1,050
Nursing Supervisor - Shirley Hauha (Acting)	16,220	12	10	1,622
General Physician - John Fleming, M.D.	12,000	12	20	2,400
SUB-TOTAL				82,773
HOLIDAY PREMIUM DIFFERENTIAL				6,332
				89,105
BENEFITS				8,876
				$97,981
HUMAN PATOON				
Outpatient Services Supervisor- Vincent Pereda	19,860	12	35	6,951
Social Service Supervisor III - Marilyn Karolle	17,260	12	100	17,260
Social Service Supervisor II - Floyd Skinner	15,700	12	100	15,700
Social Service Worker IV - Vacant	14,660	12	100	14,660
Social Service Worker IV - Venancia Colet	14,140	12	95	13,433
Psychiatrist - Aldo Cahue, M.D.	55,000	12	5	2,750
Clinical Psychologist - George Kallingal, Ph.D.	21,000	12	5	1,050
Clinical Psychologist - Marcelo Ordonez, Ph.D.	21,000	12	5	1,050
Administrative Secretary - Albina Almeida	12,450	12	(50)	6,225
Clinical Psychologist - Diane Cartland	14,660	12	5	733
SUB-TOTAL				79,812
BENEFITS				7,951
				$87,763
(FORENSIC SERVICE)				
Psychiatrist - Frances Reid, M.D.	45,000	12	50	22,500
Clinical Psychologist - Marcelo A. Ordonez, Ph.D.	21,000	12	10	2,100
Clinical Psychologist - George Kallingal, Ph.D.	21,000	12	10	2,100
Clinical Psychologist - Diane Cartland	14,660	12	10	1,466
SUB-TOTAL				28,166
BENEFITS				2,806
				$30,972

FRINGE BENEFITS (Rate 99.617)

C - CASH REQUIREMENTS DETAIL (Continued)

	GENERAL FUND MIDA MATCH	MIDA FEDERAL	GENERAL FUND DISTRESS GRANT MATCH	DISTRESS GRANT FEDERAL	
PERSONNEL					
Alcohol Abuse Service					
Salaries			24,243	14,157	38,402
Holiday			2,439	1,425	3,864
Benefits			2,658	1,552	4,210
Sub-Total			29,340	17,134	46,476
Drug Abuse Service					
Salaries	10,687	19,848	32,977	19,261	82,773
Holiday	0	0	3,997	2,335	6,332
Benefits	0	0	5,603	3,273	8,876
Sub-Total	10,687	19,848	42,577	24,869	97,981
Forensic Service					
Salaries			17,781	10,385	28,166
Holiday			0	0	0
Benefits			1,771	1,035	2,806
Sub-Total			19,552	11,420	30,972
Administration					
Salaries			75,693	44,208	119,900
Holiday			0	0	0
Benefits			7,540	4,404	11,944
Sub-Total			83,233	48,612	131,844

III.D.

Source of Funds and Year	Federal $ Award	Local $ Required Match	Total Available	Local $ Authorized Appropriation	Federal $	Total Auth. to Expend	Total $ Expenditures	Expenditure Under-Over
FY 1977								
Local Funds	$ -0-	-0-	-0-	423,882	-0-	423,882	220,060	
Staff Grant A	197,174	65,725	262,899	65,725	197,174	262,899	261,594	
Staff Grant Part F	99,708	24,927	124,635	24,927	99,708	124,635	78,519	
Drug Formula	32,059	-0-	32,059	-0-	32,059	32,059	22,763*	
Alcohol Formula	33,735	-0-	33,735	-0-	33,735	33,735	*	
314(d)	60,000	30,000	910,000	30,000	60,000	90,000	90,000	
	$422,676	120,652	543,328	544,534	435,816	980,350	672,936	-32%
FY 1978								
Local Funds	$ -0-	-0-	-0-	382,201	-0-	382,201	425,993	
Staff Grant A	184,029	78,870	262,899	78,870	184,029	262,899	262,899	
Staff Grant-F	135,294	45,098	180,392	45,098	135,294	180,392	110,556	
314(d)	60,000	30,000	90,000	30,000	60,000	90,000	90,000	
NIDA Contract	40,000	10,000	50,000	10,000	40,000	50,000	50,000	
	$419,323	163,968	583,291	546,169	419,323	965,492	948,448	-8%
FY 1979								
Local Funds	$ -0-	18,000	18,000	18,781	-0-	18,781	-0-	
Operations Grant	517,409	776,112	1,293,521	776,112	517,409	1,293,521	1,149,439	
NIDA Contract	34,133	11,377	45,510	11,377	34,133	45,510	45,510	
314(d)	40,000	-0-	40,000	-0-	40,000	40,000	40,000	
	$591,542	805,489	1,379,031	806,270	591,542	1,397,812	1,234,949	-12%

APPENDIX E - ITEM 8

CHARACTERISTICS OF ADDITIONS		TOTAL ADDITIONS	SEX AND COLOR			
			MALE		FEMALE	
			White	Nonwhite	White	Nonwhite
		1	2	3	4	5
1. PRIMARY DIAGNOSIS: *(Codes indicated are from the second Edition of the Diagnostic and Statistical Manual, Amer. Psychiatric Association)*	a. Alcohol Disorder (291; 309.13, 303)	17	1	11	3	2
	b. Drug Abuse (294.3; 309.14; 304)	13	0	8	1	4
	c. Mental Retardation (310-315)	6	2	0	0	4
	d. Depressive & Affective Disorder (296, 298.0, 300.4)	19	3	5	4	7
	e. Schizophrenia (295)	57	2	36	2	17
	f. Organic Brain Syndromes excluding alcohol and drug, 290, 292, 293-294 (excluding 294.3), 309.0-309.9 (excluding 309.13, 309.14)	2	0	0	0	2
	g. Other Psychoses (297, 298.1-298.9, 299)	1	0	0	1	0
	h. Transient Situational Distrubances and Behavior Disorders of Childhood & Adolescents (307.0-307.2, 308)	32	3	10	7	12
	i. Other Nonpsychotic Mental Disorders (300.0-300.9 (excluding 300.4) 301, 302, 305, 306, 307.3, 307.4)	16	2	5	3	6
	j. Social Maladjustment (316)	2	0	0	1	1
	k. No Mental Disorder, Deferred Diagnoses, & Nonspecific Conditions (317, 318, 319.0)					
	l. Unknown	4	0	2	0	2
	m. TOTAL *(Should = figure reported in Question 13A2)*	169	13	77	22	57
2. AGE:	a. Under 15	16	5	3	5	3
	b. 15 - 17	10	0	5	2	3
	c. 18 - 24	40	3	20	5	12
	d. 25 - 44	75	3	35	7	30
	e. 45 - 64	23	1	12	3	7
	f. 65 +	5	1	2	0	2
	g. Unknown					
	h. TOTAL *(Should = figure reported in Question 13A2)*					
3. WEEKLY FAMILY INCOME: Not Available	a. Under $100 including no income					
	b. 100 - 149					
	c. 150 - 199					
	d. 200 - 299					
	e. 300 +					
	f. Unknown					
	g. TOTAL *(Should = figure reported in Question 13A2)*					
4. EDUCATION: *Highest grade completed* Not Available	a. None					
	b. Grade school (and/or special education)					
	c. High school (including vocational, business or tech. schools)					
	d. College or More					
	e. Unknown					
	f. TOTAL *(Should = figure reported in Question 13A2)*					

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TABLE II-2

66001000 E - 8

15 Referral Source of Additions During the Reporting Period

Indicate the referral source to your center for all clients added to the center caseload during the reporting period.

REFERRAL SOURCE TO CENTER	NUM
1. Self, Family or Friend	119
2. Clergy	
3. Private Practice Mental Health Professionals	
4. Nonpsychiatric Physician	12
5. Public Psychiatric Hospital	
6. Other Psychiatric Facility *(Including private psychiatric hospital; psychiatric services of general hospital; partial hospitalization, or outpatient facility)*	
7. Social or Community Agency	3
8. Medical Facility	25
9. School System	5
10. Court, Law Enforcement, or Correction Agency	4
11. Other	
12. Unknown	
13. TOTAL *(Should = figure reported in Question 13A2)*	168

TABLE II - 4

E - 8

PERCENTAGE OF UTILIZATION OF 169 DIAGNOSED AND CLOSED CASES BY SEX AND COLOR

DIAGNOSIS	Total Per Diagnosis %	SEX AND COLOR			
		% MALE		% FEMALE	
		White	Non-White	White	Non-White
Alcohol Disorder	10.05	5.88	64.70	17.05	11.76
Drug Abuse	7.69	-	61.54	7.69	30.77
Mental Retardation	3.55	33.33	-	-	66.66
Depressive & Affective Disorders	11.24	15.79	26.32	21.05	36.84
Schizophrenia	33.73	3.51	63.16	3.51	29.82
Organic Brain Syndromes excluding alcohol & drug	1.19	-	-	-	100
Other Psychosis	.59	-	-	100	-
Transient Situational Disturbances & behavior disorders of childhood and adolescents	18.93	9.38	31.25	21.87	37.50
Other non-psychotic mental disorders	9.47	12.50	31.25	18.75	37.50
Social Maladjustment	1.18	-	50	-	50
No mental disorder, deferred diagnosis, & non-specific conditions	0	-	-	-	-
Unknown	2.37	-	-	50	50
TOTAL	100%	7.69	45.56	13.02	33.73

SOURCE: Comprehensive Inventory of CMHC's - 6/80

APPENDIX F - ITEM 1

Taxonomy

93-641

Health System Enabling (Health Planning and Financing Services.)

Diagnosis and Treatment Services, Rehabilitation and Rehabilitation Services, Maintenance Services.

Health Service Enabling (Regulation and Research) Services.

Prevention and Detection Services, Community Health Promotion and Protection Services.

Health System Enabling (resource Development) Services.

Personal Health Care Support Services *

* Not included in the ADAMHA Taxonomy. If your HSAs wish to include this category, it would correspond most closely to Administrative services.

ADAMHA

1. Administrative Services
   - o Planning and Coordination
   - o Management Information System.
2. Treatment, Rehabilitation, and Diversion.
3. Quality Assurance and Evaluation.
4. Prevention and Education.
5. Manpower and Training.

FORM APPROVED
OMB NO. 68-R1222

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

APPENDIX G - ITEM 1

STATE PLANS:
Under Section 505 of the Social Security Act, as amended
Under Section 303 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, as amended
Under Section 237 of the Community Mental Health Centers Act, as amended
Under Section 1603 of the Public Health Service Act, as amended

APPLICATION FOR FUNDS:
Under Section 314(d) of the Public Health Service Act, as amended

CERTIFICATION

1. I hereby certify that Mental Health and Substance Abuse Agency (State Agency) of the State of Guam has been designated to administer or supervise the administration of, (check each applicable item) the:

   ☐ State Plan for Maternal and Child Health and Crippled Children's Services (strike out one if administered separately) under Section 505, Social Security Act, as amended. Regulations: 42 CFR Part 51a, Subpart A.

   ☐ State Plan for Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Services under Section 303(a), Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, as amended. Regulations: 42 CFR Part 54a, Subpart B.

   ☐ Funds made available for Public Health Services under Section 314(d), Public Health Service Act, as amended. Regulations: 42 CFR Part 51, Subpart B.

   ☒ Funds made available for Mental Health Services under Section 314(d), Public Health Service Act, as amended. Regulations: 42 CFR Part 51, Subpart B.

   ☒ State Plan for Community Mental Health Services and Facilities under Section 237, Community Mental Health Centers Act, as amended. Regulations:

   ☐ State Plan for Medical Facilities Assistance under Section 1603, Public Health Service Act, as amended. Regulations:

2. I further certify that each State Plan or application for funds (identified above) consists of the following mat rials which, in form and content, are those which are or will be utilized for the conduct of State health programs under the State Plan or application, and all of which are hereby incorporated by reference and made a part of such State Plan or application:

   (a) Those pertinent State laws, codes, regulations, administrative rules, surveys of need, published standards and criteria, and planning, organizational, information, reporting, and evaluating manuals and documents, contracts and interagency agreements which have been identified by authorized representatives of the Secretary and which they have stated, in writing, are acceptable as part of the State Plan or application, in accordance with the applicable Federal regulations. All documents so identified and the written statements of acceptance are on file in the office of the Above (State Agency)

   (b) The annual budget, which represents the best current estimate of financial resources available to support activities by each State Plan or application indicated above.

3. I further certify that all State Plans and applications covered by Section 1524(c)(6) of the Public Health Service Act, as amended, have been made available to the Statewide Health Coordinating Council (SHCC), in such detail as the SHCC may require, and have been approved by the SHCC in accordance with such Section 1524(c)(6).

4. I further certify that I am authorized to submit each such Certification and Budget on behalf of the above listed agency and to submit statement of needs, objectives, and resources, performance reports, and expenditure reports as may be required from time to time pursuant to the applicable regulations and policies and in accepting the responsibility for such program do hereby give each of the assurances required by the applicable Federal regulations.

OCT 07 1980
PAUL M. CALVO
(Signature)

10/7/80
(Date)

GOVERNOR OF GUAM
(Title)

PHS-5153-1
(REV. 7-76)