

Hawai`i Goal

Sub-Working Group (SWG) # 6 Workforce Development and Community Supports

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

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

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

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

SWG Guidance:

This SWG was specifically formed to address a pressing need in Hawai`i and it corresponds to the first portion of PFC Goal #5.3: Improve and expand the workforce providing evidence-based mental health services and supports.

Besides the overarching themes (cultural and rural Access as well as Evaluation) the SWG was referred the following charge:

Areas of focus include:

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

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

SWG Membership:

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

Members: Beth Ananda-Strout, Joan Apo, Kimberly Arakaki, Pauline Aranella, M. Paulani Basbas, Barbie-Lei Burgess, Frank Castagnetti, Steve Cheleniak, Michael Christopher, Lea Colter-Antczak, Nancy Dacosin, Jessica Davis, Richard DeTucci, Lynette Enriques, Sarah Eum, Jocelyn Grant, Lydia Hemmings, Barbara Hughes, Tiare

Kailiawa, Malina Kaulukukui, Barbara-Ann Keller, Lilli Kelley, Winston Kong, Wayne Law, Dee-Dee Letts, Leon Lure, Lisa Lynch, Nathan Marder, Michael McMullen, Abdel Mebed, Dawn Mendiola, Connie Mitchell, Gordon Miyamoto, Teru Morton, Bill Mousser, Steve Onken, Colleen O'Shea-Wallace, Michael Palazzo, Genevieve Parks, Anela Patterson, Charlene Ryerson, Jason Schiffman, Michele Scofield, Natividad Serran, Debbie Shimizu, Lesley Slavin, Kelly Stern, Eddie Suarez, Kathleen Sullivan, Robert Surber, Kelly Stern, Sharon Tamanaha, June Tavares, Steven Vanatta, Brent Whetstone, Cynthia Wicks, Jessica Wong-Sumida, Cliff Wright, Michael Zarate
MHTSIG Support: Rupert Goetz, Shar Chun-Lum, Carol Medina, Tercia Ku, Patrick Uchigakiuchi

SWG Meeting:

A total of eight meetings were held:

1. September 5, 2007 (Kickoff meeting) (N = Plenary meeting)
2. October 4, 2007 (N = 5)
3. October 18, 2007 (WICHE) (N = 12)
4. November 8, 2007 (N = 29)
5. December 13, 2007 (N = 17)
6. January 10, 2008 (N = 19)
7. February 13, 2008 (N = 16)
8. March 11, 2008 (N = Plenary meeting)

The number of attendees at each meeting is listed in parenthesis above after the meeting. At the Kickoff meeting, each SWG was also asked to complete a Charter that captured key information about the group. It was a plenary meeting and included all members of the SWGs in a large setting (Pearl City Cultural Center). This meeting oriented members to the task and presented critical information to be considered. Ellen Awai and Melissa Ortega were the primary co-chairs. Support to the SWG included attendance by MHTSIG Staff and an Evaluation Team member.

Consultations and Collaboration:

The Western Interstate Commission on Higher Education (WICHE) provided assistance. The October 18th meeting was primarily to allow SWG members to meet with the WICHE consultants, who had presented information on Hawaii workforce issues the previous day. (See WICHE Report.)

Description of Resources and Needs Inventoried:

- SWG information including NFC Goals relevant to each group:
- Ground Rules for Meetings
- MHTSIG fact Sheet
- Power Point Presentation introducing the MHTSIG SWG Process
- Power Point Presentation introducing the MHTSIG Evaluation
- Hawaii Government Organizational Chart
- AMHD Fact Sheet
- CAMHD Fact Sheet

- ADAD Fact Sheet
- DDD Fact Sheet
- Summary of Service Priorities from introductory Town Hall Meetings
- Technical Report summarizing Results of the Kickoff Meeting Evaluation Survey
- Stakeholder Questionnaire
- SWG Evaluation Form
- Fact Sheet on the Role of the Evaluation Team member
- ACAP Conference Workforce Subgroup information
- HRSA Hawaii Health Workforce Profile
- NA/RI Information on Workforce Issues (dated October 4, 2007)
- Power Point Presentation by WICHE on Hawaii Behavioral Health
- Muskie School of Public Service Working Paper #31: Are APRNs a Solution to Rural MH Shortages?
- Hawai'i Peer Specialist Training Information (dated March 15, 2007)
- Updates on MHT SIG activities
- Annapolis Coalition Paper
- "A Strategic Plan for the Improvement of Substance Abuse and Mental Health outcomes for Native Hawaiians, their Families and Communities" Developed for SAMHSA, 4th PAPA OLA LOKAHI Policy Academy on Co-occurring Substance Abuse and Mental Health Disorders for Indigenous Communities.
- Nā Honua Mauli Ola (Hawai'i Guidelines for Culturally Healthy and Responsive Learning Environments), which is a set of guidelines/framework to guide activities in various areas: learners, educators, schools/institutions, families and communities.
- Every consumer and family should be respected and the focal point of any action step relating to his or her care.
- Culturally competent services (this needs to be specifically defined-what does this really mean?)
 - Providers should appreciate and be aware of cultural differences, not just acknowledge the differences, but also truly grasp the significance of how culture plays an intricate part of life styles and every day decisions.
 - Providers should realize how relevant a relationship is for many consumers and colleagues alike.
 - Clinicians (all providers-health care included) require exposure to issues facing Hawaii residents (rural health, multicultural populations, specialty shortages and an aging population).
 - Develop a plan to increase the cultural competence of the workforce by developing standards and training models (Communities In Schools Hawaii, has provided a training called " 'Ohana Management System" which offers a value-based "system" that provides a beginning point across the board.)
- Values driven services that incorporate evidence based practices
 - A value is to esteem of regard highly, our values determine (consciously or unconsciously) the way we act in every situation.
 - Most cultures share some values, it is important to recognize that the way the value is practiced or prioritized may be different.

- The Adult Mental Health Division has a set of “core values”, these values should be expanded upon to identify the practice of how that particular value should be realized and accomplished.

Specific Recommendations:

Immediately address the critical mental health worker shortage

6.1 Immediately declare a state of emergency in hiring qualified mental health workers in the public and private sectors, urgently mobilizing resources to streamline the state hiring process and develop timely recruitment, training and retention strategies.

Additional Detail:

- The critical mental health workforce shortage requires immediate and long-term cross-departmental, interdisciplinary collaboration and solutions

Establish a Mental Health Workforce Development Collaborative

6.2 Appoint and convene an ongoing Mental Health Workforce Development Collaborative comprised of key stakeholders to develop and implement long-term solutions to produce a diverse, locally developed mental health workforce.

Additional Detail:

- Patterned on experience with the Bay Area Education and Workforce Collaborative. (<http://mhewc.org/>)
- Some of the projects this collaborative has inspired and/or supported include development of a web-site for students, providers, and educational programs about training, careers and job opportunities in mental health (<http://www.mhwee.org/>).
- Structure: The Hawaii Mental Health Workforce Development Collaborative would be comprised of representatives of the mental health service system including government and private providers, educational institutions at all levels, consumer and family advocates, family members and youth, professional and licensing organizations, Department of Labor and Industrial Relations, Department of Human Services, Department of Justice, and other interested parties. The collaborative would be an ongoing group that would meet regularly (at least monthly). The charge to the group would be to identify, prioritize, and promote the implementation of long-term workforce development strategies that foster a culturally competent recovery and resilience focused system of mental health care.
- Content: The initial expectation of the collaborative would be to review the strategies already developed by this Subgroup, WICHE, and the Annapolis Coalition to determine those that are most appropriate and feasible in Hawaii, and establish a long-range mental health workforce development plan for the state. The specific

focus of the collaborative efforts would be to promote activities that implement the “grow your own” approach to workforce development with an emphasis on addressing the needs of the rural areas of the outer islands, as well as any underserved populations in the state. This would necessarily involve strategies to inform, inspire, encourage, and prepare local residents to become providers of mental health services, and likely involve encouragement of professionals to serve in areas or with populations that are underserved. Approaches discussed in this Subgroup for the collaborative to consider could include

- Existing models that have empirical evidence supporting their effectiveness
- The “Alaska Model” (discussed by WICHE representatives) for preparing local residents to deliver mental health services in isolated areas and includes educational and career ladders for advancement for these providers.
- “Pipeline” strategies to encourage local residents to pursue careers in mental health from elementary school through professional training
- Best practices for consumer/family member employment as mental health providers, managers, and leaders in the system of care.
- Culturally derived healing practices into recovery and resiliency focused mental health services
- Support and incentives for the University of Hawaii system to increase involvement in training of professionals and paraprofessionals
- Incentives for University trained graduates to provide services in the public mental health system
- Removal of administrative barriers to recruitment and retention of providers at all levels (i.e. civil service and licensing/certification requirements)
- Articulated competencies for professionals and paraprofessionals in various settings in Hawaii, including but not limited to the following:
 - Clinical competencies for supervision and management of direct-care staff
 - Cultural competencies
 - Recovery, empathy and respect for consumers
 - Crisis response and trauma-informed care
 - Family driven, youth informed services
 - Resilience, evidence based treatments
- Credentialing/training for paid (e.g., Medicaid-reimbursed) paraprofessional providers (e.g., Ohana caregivers, peer support, etc.)
- Extension of professionals with prescriptive authority (e.g., psychiatrists, APRNs, psychologists with appropriate training) into underserved communities.
- Inter-state credential/license reciprocity
- Continuing education (CME/CEU) in licensing/credentialing requirements for all mental health professionals and paraprofessionals in coordination with local professional organizations and the state’s Division of Commerce and Consumer Affairs (DCCA)
- Coordination by the collaborative of services across agencies towards a model of wraparound care including intensive care coordination that cuts across systems for youth and families.

- Increased training and resources for mental health services in schools.
- Data sharing and coordination (i.e., pooled resources for recruitment, training etc) between agencies represented in the Collaborative.
- Use of data across agencies in the Collaborative to inform decisions.
- Community collaboration (this needs to be specifically defined-what does collaboration really mean?)
 - Develop a partnership with federal, state, and local departments of labor and professional organizations.

Strengths identified and/or efforts to showcase

- The agencies and individuals likely to constitute the Collaborative already exist. Each of these stakeholders likely has an existing infrastructure to support mental health services for their constituents. All stakeholders likely have guiding documents, requirements of providers, data infrastructure, and experienced leaders which would be shared with and perhaps integrated into the systems of other Collaborative members. The Collaborative therefore would not only provide a leadership body for future workforce development, it could also serve as a bridge to help create a more seamless and integrated system.
- The “Strategic Plan for the Improvement of Substance Abuse and Mental Health outcomes for Native Hawaiians, their Families and Communities” mentioned above, identifies many indigenous “best practices”

Issues or problems to be overcome by the recommendation

- The acute and likely long-term shortage of mental health service providers in Hawaii, particularly in the underserved areas and populations of the state. The Collaborative could transform MH system into an exciting, broad-minded and altruistic system that respects, appreciates and embraces ancient cultural healing practices. Also, it would give indigenous peoples “a seat at their own table” with a chance to reclaim their family “kuleana”, and all that comes with it.

Comments on the following cross-cutting themes

- Access: Accessibility is a must. Collaboration and access are part of the `ohana concept. Increased presence of culturally relevant mental health providers and services in underserved areas and will likely increase access to individuals in underserved areas/groups.
- Cultural Competency: Another must. At the very least the Collaborative would encourage all employees to develop an appreciation of the host culture at all levels, especially middle and upper management personnel. Local versus “implanted” training will help ensure cultural competency.
- Consumer/youth/family involvement: Another must. Again `ohana is the key to positive outcomes. Advocacy groups and representatives should be invited as members of the Collaborative and should be targeted as potential participants in the mental health workforce.
- Potential costs / Sustainability plan:
 - Personnel costs/time involved in attending regular meetings
 - Possible costs of changing systems are numerous

- Gains from the initiatives of the Collaborative should be both short and long term.
- Short term gains might help participants see immediate value and encourage sustainability.
- Other reinforcements as determined by the agencies should be supported
- Not a must. Quite often, natural supports in the indigenous community do not require compensation. As long as the `ohana concept is reinforced, sustainability is ensured.
- Potential numbers impacted:
 - All people who identify strongly with their ethnic heritage. The entire statewide mental health service system as well as potential mental health service providers and the educational, vocational rehabilitation, labor and credentialing/licensing systems that serve them.
- Evaluation/Accountability/Outcomes measure considered
 - The majority of progress indicators will be defined by the Collaborative but should include the following:
 - Increased number of providers,
 - Increased level of collaboration among provider agencies
 - Increased skills among the providers.
 - Decreased hospitalizations
 - Decreased use of chemical-type medications
 - Fewer “related” illnesses
 - Less social stigma.
- Identify potential Lead agencies/Community/Person(s)
 - *Representatives from Department of Health,(AMHD, CAMHD, DD), Department of Human Services, Department of Education, Veterans Administration, University of Hawaii, Schools of Psychiatry, Psychology, Social Work*
 - *PAPA OLA LOKAHI, O. H.A., Alu like Inc. and numerous other Hawaiian advocacy Programs.*
- What known players or potential players may need to be included?
 - Private Universities, non-governmental BEMH Provider Agencies (for AMHD, CAMHD, DHS, VA), Consumers, Advocacy Groups, DHS (i.e., DVR, TANF-Welfare to Work, MQD-PAS), DLIR - Workforce Development Council, DCCA, professional organizations, etc.
 - Any indigenous mental health professionals and practitioners.
- A short-term step: prior to convening the collaborative, the TWG assure government representation to provide the authority the collaborative will require to effect meaningful, substantial and lasting implementation of change.
- Intermediate steps will involve the actions of the established Collaborative to address acute needs of the mental health workforce.
- Long term steps involve the Collaborative developing into a self-sustaining, collaborative, inter-departmental, cross-disciplinary mental health workforce system with ongoing initiatives and mechanisms for self-monitoring and improvement.
- Next Steps:

- MHTSIG leaders invite agencies/participants to the Collaborative, creating a skeleton agenda from which the Collaborative can spring.
- Leaders should begin to test the “buy in” potential of some smaller community groups who will contribute at the grassroots level. For Hawaiians, it is the small rocks that prevent the big rocks from falling.

To articulate and instill core competency standards for all Behavioral Health Care Providers

6.3 Articulate and instill core competencies for professionals and paraprofessionals in various settings of Hawai`i.

Strengths identified:

- Acknowledgement by public and private providers that there is no agreement in the field as to what knowledge, skills, and attitudes are necessary to provide effective services
- Set the standards for providers across the system, eliminating the varied amount of knowledge, skills and attitudes when working with consumers (adult and children alike).
- Influence public and private providers to “adopt” a warm and welcoming approach in day to day practice (we may want to look at the Fatherhood movement checklist to identify “father friendly settings”; adapting it to reflect consumer friendly settings”)
- Assist in creating a curriculum for the university/college system to adopt when teaching new and upcoming mental health professionals and paraprofessionals. We may also want to share this with the substance abuse field and the medical field.
- Challenges the “system” immediately; it may ultimately turn the system “upside down”. The transformation effort, if true, should create in the long run a better system for consumers as a whole (both adult consumers and children consumers and their families). This will require practicing the following values:
 - kuleana (responsibility) understanding the importance of our responsibilities and how it affects those we come into contact with.;
 - laulima (working together) identifying how by working together and cooperating with each other will help strengthen the “system”; and
 - lokahi (balance) accepting that working as a whole and as individuals with the same purpose will make the challenge less of a burden to one department, one company, one organization or one person.
 - Creating interdependency between each other that demands responsibility for one another, colleagues as well as consumers
- Both adult and children providers will have a comprehensive competency standards, as well as a specific focus on their discipline (are there any research that compares children’s mental health issues in relation to adult mental health issues [whether or not diagnosed]?)
- Start with what competencies are in common, do not “recreate the wheel” (for example, the early childhood field has recently established preschool content standards for four-year olds; it is in a workbook format and takes into consideration

family and community, as well as the center-based preschools and other early educational opportunities for preschoolers-they may be working on the three-year old age group set of standards -check with Good Beginnings Alliance).

Develop mental health training centers on each island

6.4 Establish and sustain mental health training centers on each island that supports culturally competent and consumer and family driven recover, resilience and early intervention. The centers will honor indigenous knowledge and practices of the host and other local cultures.

Implementational Detail:

- Establish a collaborative committee of representatives from all Behavioral Health Care stakeholders to set minimal competency standards for all providers across the system (adult, children, forensic, substance abuse, professional associations, etc.).
- Assist in creating a curriculum for the university/college system to adopt when teaching new and upcoming behavioral health professionals and paraprofessionals.
- Develop a training module of core attitudes, values, and beliefs that are necessary for staff providers to adopt in order to deliver recovery friendly and consumer empowering services.
- Training centers provide opportunities and/or access to supervised practicum training for various mental health providers.

Specific Comments on each of the following points:

- There is no agreement by public and private providers in the field as to what knowledge, skills, and attitudes are necessary to provide effective services.
- There is a wide disparity in the level of competence found among current deliverers of service.
- Academic curriculums between the different professions inconsistently prepare providers to embrace the concept of recovery from the consumer's perspective and needs.