JOSH GREEN, M.D.
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

KENNETH S. FINK, M.D., M.P.H., M.G.A.
DIRECTOR OF HEALTH
KA LUNA HOʻOKELE

STATE OF HAWAI'I
DEPARTMENT OF HEALTH
KA ʻOIHANA OLAKINO
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

January 16, 2025

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Thirty-third State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Nadine K. Nakamura,
Speaker
and Members of the House of
Representatives
Thirty-third State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Nakamura, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the Annual Report to the Governor and the Legislature on the Implementation of the State Comprehensive Integrated Service Plan, pursuant to Section 334-10(e), Hawaii Revised Statutes.

In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:
https://health.hawaii.gov/opppd/department-of-health-reports-to-2025-legislature/

Sincerely,

Kenneth S. Fink, M.D., M.P.H., M.G.A.
Director of Health

Enclosures

c: Legislative Reference Bureau
Hawaii State Library System (2)
Hamilton Library

REPORT TO THE THIRTY-THIRD LEGISLATURE
STATE OF HAWAIʻI
2025

PURSUANT TO SECTION 334-10(e), HAWAIʻI REVISED STATUTES, REQUIRING THE HAWAIʻI STATE COUNCIL ON MENTAL HEALTH TO SUBMIT AN ANNUAL REPORT TO THE GOVERNOR AND THE LEGISLATURE ON THE IMPLEMENTATION OF THE STATE COMPREHENSIVE INTEGRATED SERVICE PLAN

PREPARED BY:
HAWAIʻI STATE COUNCIL ON MENTAL HEALTH

SUBMITTED BY:
STATE OF HAWAIʻI
DEPARTMENT OF HEALTH

EXECUTIVE SUMMARY

Hawai'i law requires the State Council on Mental Health ("Council") to report to the Governor and State Legislature on the implementation of the State Comprehensive Integrated Service Plan ("SCISP"). This report addresses this in four sections: State Council on Mental Health, State Plan Implementation, Implementation Landscape, and Looking Ahead. Like the last two annual reports, this report reflects information, insights, discussions, and decisions at Council meetings.

State Council on Mental Health. The Council successfully met quorum in all its monthly full Council meetings and seven additional ad hoc committee meetings. There was a net gain of one member with the addition of four new members and a departure of three. The remote method, with the support of the Zoom platform, made it convenient for members, guests, and the interested public to come to meetings. However, the Council met in person for the first time since the COVID-19 pandemic for a facilitated strategic planning retreat to foster camaraderie and creative brainstorming.

State Plan Implementation. The Mental Health Block Grant (MHBG) plan continued to serve as the SCISP. The MHBG FY24-FY25 Plan Year 1 performance results show that the State met its targets in priority areas measured by more established performance indicators. The areas are (1) community tenure (forensic population), (2) community-based services, and (3) resilience and emotional health for children, youth, and families. The State made progress, but missed targets, where newly established performance indicators were used. The areas are (1) enhancing access to suicide care and crisis services, (2) strengthening the behavioral healthcare workforce, (3) commitment to data and evidence, and (4) integrating behavioral and physical healthcare. Like in previous years, the stories behind the results remain anecdotal, but data collection and analysis are improving. The State also submitted an MHBG FY25 mini proposal that required Council recommendation and a public comment period. The Council endorsed the mini proposal and recommended that the State planning workflow be more transparent in the future and have a more apparent role for the Council. There is guidance from the federal level that State Councils should be engaged in selecting priorities, goals, strategies, and performance indicators based on data analysis. To address data needs, the ongoing AMHD and CAMHD improvement of their electronic health record systems and/or documentation of evidence-based practices are valuable.

Implementation landscape. The extraordinary year of response and recovery from the Maui wildfire disaster stood out. Disaster mental health lessons uphold the value of trauma-informed care, the reframing of mental health along with wellness, and survivor-to-survivor peer support. Workforce issues remain key threats to a seamless continuum of care. Legislation addressed some long-term solutions, such as the approval of provisional licensing, while community dialogues fostered stopgaps to urgent situations, such as the reopening of the Kona Paradise Clubhouse. Meanwhile, federal supplementary funds increased preventive capabilities, including piloting a behavioral health crisis center, expanding On-Track Hawai‘i to address first-episode psychosis, and resiliency training for first responders.

Looking forward. The Council looks forward to unpacking forecasts and uncertainties as part of advancing five goals in the next three years-- (1) increasing Council effectiveness, (2) increasing access to care equity, (3) more complete mapping of mental health challenges and resources, (4) attacking workforce development challenges, and (5) improving care coordination.

STATE COUNCIL ON MENTAL HEALTH

Vision Statement

A Hawai'i where people of all ages with mental health challenges can enjoy recovery in the community of their choice.

Mission Statement

To advocate for a Hawai'i where all persons affected by mental illness can access necessary treatment and support to live full lives in the community of their choice.

The State Law

Hawai'i Revised Statutes 334-10 State council on mental health. (a) There is established, within the department of health for administrative purposes, a state council on mental health. The council shall consist of twenty-one members appointed by the governor as provided in section 26-34. In making appointments to the council, the governor shall ensure that all service area boards of the State are represented, and that a majority of the members are non-providers of mental health or other health services, and that a majority of the members are not state employees. The number of parents of children with serious emotional disturbances shall be sufficient to provide adequate representation of such children in the deliberations of the council. The council shall be composed of residents of the State, including individuals representing:

(1) The principal state agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, medicaid, and social services;

(2) Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(3) Adults with serious mental illnesses who are receiving, or have received, mental health services;

(4) The families of such adults or families of children with serious emotional disturbances; and

(5) The Hawai'i advisory commission on drug abuse and controlled substances who shall be a person knowledgeable about the community and the relationships between mental health, mental illness, and substance abuse.

(b) The council shall elect a chairperson from among its members. All members shall serve without compensation but shall be paid their necessary expenses in attending meetings of the council.

c) The council shall advise the department on allocation of resources, statewide needs, and programs affecting two or more service areas. The council shall review and comment on the statewide comprehensive integrated service plan and shall serve as an advocate for adults with serious mental illness, children with serious emotional disturbances, other individuals with mental illnesses or emotional problems, and individuals with combined mental illness substance abuse disorders.

(d) If the department's action is not in conformance with the council's advice, the department shall provide a written explanation of its position to the council.

(e) The council shall prepare and submit an annual report to the governor and the legislature on implementation of the statewide comprehensive integrated service plan. The report presented to the legislature shall be submitted at least twenty days prior to the convening of each regular session.

f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins.

(g) If a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes. [L 1984, c 218, pt of §1; am L 1993, c 210, §2; am L 2004, c 79, §3; am L 2018, c 137, §1]

The State Council on Mental Health had 19 distinct individuals serving in 2024. They are:

Katherine Aumer
Chairperson
Family member

Kathleen Rhoads Merriam
1st Vice Chairperson
Behavioral Health Sector

John Betlach
2nd Vice Chairperson
Hawai'i Service Area Board

Mary Pat Waterhouse
Secretary
Ad Hoc Committee Chairperson for 2024 Legislation
Family member

Tianna Celis-Webster
Youth, appointed September 2024

Charlene "Naomi" Crozier
Family member

Lea Dias
Vocational Rehabilitation Sector

Jon Fujii
MedQUEST, HACDAC

Heidi Ilyavi
Family member

Jackie Jackson
O'ahu Service Area Board

Eileen Lau James
Family member, until June 30, 2024

Christine Montague-Hicks
Education Sector, term starting July 1, 2024

Jean Okudara
Family member, until June 30, 2024

Ray Rice
Social Services Sector (Adult Protection Services)

Richard Ries
Immediate Past Chairperson, until June 30, 2024
Provider

Asianna Saragosa-Torres
Consumer Advocate, appointed September 2024

Forrest Wells
Provider, appointed August 2024

Kristin Will
Judiciary Sector

Marian Tsuji
Ex-Officio, DOH BHA Deputy Director

In 2024, the long-vacated seats for education, youth, and consumer advocates were filled. However, three other seats were hard to fill, those for housing and the Maui and Kauai service area boards. Three members completed their terms in 2024. Richard Ries completed two full terms totaling eight years of service. He served as chairperson and championed resiliency, especially among first responders. Eileen Lau James completed her four-year term appointment. She served as Secretary and chairperson of several ad hoc committees, including legislative advocacy. She led the Council's closer look at the issue of stabilization bed shortage. Jean Okudara completed her brief interim appointment and reported on the plight of individuals living with co-occurring conditions. The Council successfully held twelve (12) full Council meetings and seven committee meetings, a testament to collective efforts. The three ad hoc committees are for 2024 Legislation, MHBG Planning and Performance, and Planning Retreat Workforce and Care Coordination. The Council meetings featured 16 invited presenters (Appendix 1) and had five individuals who provided substantial oral testimonies (Appendix 2). All meetings were remote and proved convenient to all. However, the May 14, 2024, strategic planning retreat meeting was held in person along with the best practice of fostering camaraderie and creative brainstorming.

IMPLEMENTATION OF THE STATE PLAN

Per Hawai‘i Revised Statutes, the State Council on Mental Health needs to report on the implementation of the State Comprehensive Integrated Service Plan ("SCISP"). In the last decade, the Council's annual reports on the SCISP have been on the Hawai‘i's Mental Health Block Grant ("MHBG") plans.

MHBG Plan FY24-FY25 Year 1 Performance. The MHBG FY24-FY25 Plan Year 1 covers the period, July 1, 2023 to June 30, 2024. The Plan had seven priority areas and a combination of old and new performance indicators (Appendix 3). Year 1 performance show that the State met or exceeded targets in three priority areas where the indicators have been technically vetted and improved on in previous planning years.

The State met the targets in the following areas and based on better-established indicators:

- *Community Tenure (Forensic Population).* Decrease in readmission rate of discharged patients.
- *Community-Based Services*. Increase the number of clients served.
- *Resilience and Emotional Health for Children, Youth and Families*. Increase the number of clients served by the On-Track Hawai‘i program for First Episode Psychosis.

The State progressed and/or missed its targets in areas with new and untested indicators:

- *Commitment to Data and Evidence*. Improve data quality and contracted service providers' access to the DOH Adult Mental Health electronic health records system.
- *Enhancing Access to Suicide Care and Crisis Services*. Provide stabilization beds in all service areas (counties) and have beds available for placement of persons in crisis.
- *Integrating Behavioral Health Care and Physical Health Care*. Have at least one SAMHSA-Certified Community Behavioral Health Clinic (CCBHC Maui).
- *Strengthening Behavioral Health Care Workforce*.
    - Reduce vacancy rates at the Adult Mental Health Division (AMHD) and Child and Adolescent Mental Health Division (CAMHD).
    - Grow the number of Substance Abuse and Mental Health Services Administration- or SAMHSA-certified trainers in trauma-informed care.
    - Employ more graduates of the Hawai‘i Certified Peer Specialist program

Like in previous years, the stories behind the performance numbers continue to be anecdotal. The Council supports continuing improvement in data to improve performance measures, targeting, and analysis. The story in the inbox elaborates on the story of On-Track Hawai‘i program.

MHBG FY25 Mini-proposal. The mini-proposal is SAMHSA’s way of asking, albeit limited, whether States have changed their two-year plans. The public comment period, a required part of the process, and the Council discussion did not lead to any changes in the State’s final mini-proposal. Still, they did provide opportunities to consider prevention, social determinants of (mental) health, and a seamless continuum of care in future planning. In its endorsement letter, the Council recommended a more transparent planning workflow and a more apparent role for the Council in the future (Appendix 4). As a matter of early feedback, SAMHSA announced that the guidelines for the FY26-FY27 MHBG Plan will be released in April 2025 instead of the usual July. An older technical guide from the National Association of State Mental Health Directors (NASMHD) encourages State Planning Councils to be engaged in prioritizing goals, selecting measures, and setting targets.

Spotlight: CAMHD's First Episode Psychosis (FEP) for Youth aka On-Track Hawai'i
Prepared by CAMHD staff

CAMHD serves youth diagnosed with FEP using MHBG funds through its On-Track Hawai'i (OTH) progra. OTH provides coordinated specialty care, including psychotherapy, medicine management, employment and education, and peer supports for optimal treatment outcomes. According to the National Institutes for Health (NIH), 15-100 people out of 100,000 develop psychosis annually. Given that as of 2023, there were approximately 323,473 youth under 20 years old, the need for FEP services exceeded the number of youths served, highlighting the current challenges. OTH is in Honolulu on the most populated island of Oahu. OTH staff meet with youth with FEP who live on islands other than Oahu through telehealth and occasionally fly to these clients' home for treatment resulting in suboptimal access. To better meet the needs for youth with FEP, OTH received a game-changing SAMHSA Technical Assistance to obtain Medicaid reimbursement for FEP services. CAMHD is now in negotiations to expand OTH services through additional funding statewide.

Reference: https://www.nimh.nih.gov/sites/default/files/documents/health/publications/understanding-psychosis/23-MH-8110-Understanding-Psychosis.pdf

Beyond MHBG Planning and Performance. Informational exchange and discussions have led to legislative advocacy with promising outcomes. The Council joined other groups in seeking information and reviewing bills on workforce needs, crisis services, youth and families, forensic population, assisted community treatment, Hawaii State Hospital, and others. In 2024, the Council saw four of the bills it tracked and testified become laws (Appendix 5), marking a significant step forward in collective efforts. The members look forward to their implementation with optimism and hope for the future of mental health services.

THE IMPLEMENTATION LANDSCAPE

The extraordinary year of response and recovery from the Maui wildfire disaster stood out. The various presentations and reports to the Council have emphasized enough that the paths to recovery will be long. The past year of response and recovery emphasized that certain practices are crucial in disaster mental health—trauma-informed care and warm handoffs, reframing mental health along wellness, survivor-to-survivor peer support, well-trained researchers and service providers, and resiliency of first responders and "boots on the ground."

Almost every report and discussion on any part of the continuum of care brought up a part or two of the workforce shortage. Legislative actions provided some long-term solutions, such as approving provisional licensing for various mental health professionals and supporting peer specialists. Community dialogues on urgent situations led to stopgaps, such as the reopening of the Kona Paradise Clubhouse. Significantly, federal supplementary funds bolstered preventive capabilities, enabling the piloting of a behavioral health crisis center, the expansion of On-Track Hawai'i to address first-episode psychosis, the provision of resiliency training for first responders, and others.

The shortage of workers protracted efforts to address issues, but breaking silos allowed the leveraging of the limited resources of different stakeholders. Implementing resiliency training for first

responders, which the Council actively advocated for and received substantial community input in 2022, is a case in point.

Retaining a Critical Workforce: Resiliency Training for First Responders
Prepared by AMHD and CAMHD staff

First responders play a crucial role as the first point of contact for individuals in mental health crises. Their health and well-being are paramount to their ability to provide effective assistance. The end of the COVID-19 pandemic saw several Hawai'i Emergency Medical Technicians (EMTs) sharing their experiences at a Hawai'i State Council of Mental Health (SCMH) meeting. Their compelling testimonies underscored the critical need for EMT resiliency training. The toll of serving the public during the pandemic was evident, with mental and emotional strain leading to concerns about suicide. Consequently, AMHD and CAMHD received an MHBG supplement fund under the Bipartisan Safer Communities Act (BSCA). They explored how the modest fund can support resiliency training. Another branch of the DOH, the Emergency Medical Services and Injury Prevention System Branch, guided with the criteria to use the one-time funding to provide resiliency training more sustainably. Originally, Kapiolani Community College (KCC), the only EMT training program in the state for new trainees and continuing education, was targeted to include resilience training. However, after Hawai'i's devastating and deadly Maui Wildfires, the various groups of first responders expressed the urgency for resiliency training. Needs were assessed further through consultations with the different groups of responders in the different counties and assurances that there would not be duplication of efforts with other disaster-related grants that also supported training.

The decision to use the International Critical Incident Stress Foundation, Inc. (ICSFI) or Critical Incident Stress Management (CISM) and psychological crisis intervention certification training was a collective one. This choice reflects the shared commitment of key first responder groups-police, firefighters, and EMTs-to support each other and those affected by critical events. The shared resilience training will enable them to work together more effectively during emergencies and disasters. Hawai'i had only two people certified to teach ICISF courses before BSCA-funded training was administered. The strategy for the best use of funds was to have more certified ICISF instructors, preferably at least one in each county of the state of Hawai'i. These instructors may, in turn, train others and may be a part of the peer support groups within each discipline of police, EMTs, and firefighters. Using the BSCA funds, the two instructors taught prerequisite courses required to be eligible to take ICISF-approved instructor training. This training includes a series of courses and an exam to become a certified instructor. Funding was also used to pay for training manuals, per diem, and exams for eventual certification. In addition to didactic courses, first responders must have experience as instructors with positive student reviews and critical incident experience before applying to be a certified ICISF instructor. Through BSCA funding, 114 persons were trained as of October 16, 2024, and 10 are estimated to be eligible for training to be ICISF-approved instructors.

LOOKING FORWARD

Amidst many ongoing lessons and future uncertainties to be analyzed, the Council looks forward to addressing its mandates, mission, and vision by advancing five goals in the next three years. These

goals are (1) increasing Council effectiveness, (2) increasing access to care equity, (3) complete mapping of mental health challenges and resources, (4) attacking workforce development challenges, and (5) improving care coordination (Appendix 6). The objectives for the next year are modest and foundational, like inviting subject matter experts for a deeper understanding of details.

The Council members look forward to reviewing recommendations relevant to the above goals. Legislatively, this review will be guided by the Council's focus on bills that the Mental Health Task Force collaborative may be considering, as well as those that fall under workforce development, supportive housing, employment (clubhouses, vocational rehabilitation), family and youth, crisis services, assisted community treatment, AMHD and CAMHD bills, forensic-related, disaster-related, and general policy (e.g., Sunshine Law).

Appendix 1. 2024 Full Council Meetings – Invited Presenters and Topics

January 9
Behavioral Health Crisis Center
Dr. Chad Koyanagi
AMHD Medical Director for Crisis Continuum

February 13
Meet and Greet, Talk Story on Breaking Silos
Governor Josh Green
State of Hawai'i

March 12
Mental Health Support and House Bill 1906
Fern Yoshida & Ayada Bonilla, DOE

July 9
Kona Paradise Clubhouse and Oahu Clubhouses
Steve Pavao, Branch Manager, Hawai'i CMHC
Troy Freitas, Branch Manager, Oahu CMHC

Assisted Community Treatment: Then & Now
Connie Mitchell, Executive Director
Institute for Human Services

August 13
Maui Wildfire Disaster: Response a Year After and Beyond
Trever Davis, Project Director
Maui Behavioral Health Response

Transcranial Magnetic Simulation (TMS) Essentials: An Overview for Professionals and the Public
Dr. Erik Jul & Dr. Brandon McNichols
Hawai'i Depression Clinic

September 10
Maui Wildfire Disaster: A Year After and Beyond
Keli Acquaro
CAMHD Administrator

October 11
Electronic Health Records System
Dr. Courtenay Matsu
AMHD Medical Director

November 12
Overview of the State Department of Human Services' Division of Vocational Rehabilitation Program
Lea Dias
DVR Administrator

Department of Education -Behavior Threat Assessment and Management
Sheri Taketa
Lead -Project AWARE 2

December 10
Observations on the Impact of the Lahaina Wildfires have had on Individual and Community Mental Health
Dr. Christopher Knightsbridge
Director- Hawai'i Community Health

The Medicaid Perspective: Care Coordination Services
Jon Fujii
Branch Administrator, Med-QUEST

Note: There were no invited speakers at the Council's meetings in April, May and June.

Appendix 2. 2024 Council Full and Committee Meetings –Substantive Public Input

March 12
Pauline Aralano, seeking thyroid testing before psychotropic medicines as administered. Seeking support for SCR 34 and HCR 144.

April 9
Carrie Ann Shirota, ACLU, on House Bill 2159, opposing it because it strips away legal representation of indigent subject to ACT.

June 18
Aliza Gebin and Mona Trena, including a written testimony with 35 additional signees and 14 additional comments on the urgency and need to re-open the Kona Paradise Clubhouse

October 8
Poha Sonoda-Burgess, Hale Naʻau Pono closing of 6 of 15 houses, and placement of affected consumers.

December 10
Christopher Au, service provider, on a major insurance company not paying peer support services, and limited billing codes.

Note: No substantial community input received on other months.

Appendix 3. MHBG FY24-FY25 Plan Performance Indicators and Year 1 Results[1]

Prepared by DOH AMHD and CAMHD

PRIORITY AREA 1. COMMUNITY TENURE (Forensic Population)

Goal

Decrease the percentage of individuals discharged from the Hawai'i State Hospital (HSH) readmitted within six months.

Performance target

The first-year target is a five percent decrease in readmission rate. In FY25, the second year is aimed at an additional five percent decrease.

The numbers

Of the 33 readmissions within 180 days in FY 2023, there were 487 distinct patients.
Of the 450 readmissions within 180 days in FY 2024, there were 26 distinct patients.
FY24 readmission is 21 percent lower than FY23

The narrative for FY24 result

AMHD aimed to strengthens the continuum of care for all individuals across the system. AMHD made strides among the population known to be homeless or with co-occurring substance use disorder. Of those readmitted back, seventeen consumers self-reported to be homeless, compared to 27 in FY23, a 37 percent decrease. Also, 23 consumers were reported with co-occurring substance use disorder, compared to 28 in FY23, an 18 percent decrease.

PRIORITY AREA 2. COMMUNITY-BASED SERVICES

Goal

Increase the number of consumers served by community mental health services.

Performance target

The first-year target is a 5 percent increase in consumers served by community mental health services. In FY25, the second year is aimed at an additional 5 percent decrease.

The numbers

FY23 Count = 7,599 unduplicated counts of individual consumers.
FY24 Count = 9,118
FY 24 Count is a 20 percent increase in consumers served compared to the FY23 data.
Note: The FY23 count reflects a correction to the data reported in last year's report.

The narrative for FY24 result

The increase comes from the pilot Certified Community Behavioral Health Clinics in Maui, launched this fiscal year.

[1] Find the 2025 Mental Health Block Grant report at https://bgas.samhsa.gov/Module/BGAS/Users. USERNAME CitizenHII PASSWORD Citizen

PRIORITY 3. COMMITMENT TO DATA AND EVIDENCE

Goal

Improve mental health outcomes, including reducing disparities among priority populations. The goal aims to achieve two key performance targets.

Performance target 1

Obtain 4 contracted providers using Provider Connect NX. The second-year target is to obtain 50 contracted providers. The first-year target was not achieved.

The narrative for FY24 result

AMHD had a delay in AvatarNX implementation. This is attributed to several factors, including renewal delays, loss of staff, and diverting resources to other pressing issues. After this late start, about 44 connections are expected at report-writing time. Most factors contributing to the late start will not carry over in Year 2.

Performance target 2

Achieve a minimum percentage of encounter-level records that contain complete (non-missing and usable) data across all demographic and health equity-related fields in the Electronic Health Record (EHR). The target for the first year is at least 75 percent, while the target for the second year is at least 90 percent. The first-year target was not achieved.

The narrative for FY24 result

In the first year following the rollout of EHR, a late start resulted in only 35 percent of encounter-level records containing complete and usable data across all demographic and health equity fields. However, like the ProviderNX initiative, AMHD anticipates that data collection will improve with the enhancements introduced in the recent EHR upgrade. The key variables under assessment include age, sex, race, ethnicity, living situation, employment status, gender identity, and marital status.

PRIORITY AREA 4. PROMOTING RESILIENCE AND EMOTIONAL HEALTH FOR CHILDREN YOUTH AND FAMILIES

Goal

Increase and expand accessibility and reduce health disparities for all youth in need of intensive mental health services.

Performance target

For the first year, the target is to expand the OT-Hawai‘i program by increasing the number of monitored clients from 18 to 21—welcoming an additional 3 clients into our care. The first-year target was achieved. Looking ahead to the second year, we aim to further the program by accepting referrals for up to 25 clients.

The numbers

FY23 18 clients
FY24 25 clients

The narrative for FY24 result
During FY24, the OT-Hawai'i was fully staffed with primary clinicians, a psychiatrist, a supported education and employment specialist, and a youth partner. This increased the opportunity for youth to receive services from OT-Hawai'i and a youth partner.

PRIORITY AREA 5. ENHANCING ACCESS TO SUICIDE PREVENTION AND CRISIS CARE

Goal
Retain and expand the workforce in managing crisis support services, focusing on recruiting more staff to meet the needs of rural communities and improve the flow of care for people facing behavioral health crises. This workforce particularly provides services that help stabilize people and build consumers' resilience. The goal aims to achieve two key performance targets.

Performance target 1
Expand the number of service areas with stabilization beds (Licensed Crisis Resident Services and others). The first-year target was to procure LCRS for 4 counties or service areas. This target was not achieved. The FY25 target, the second-year target, will be reduced to two service areas, and alternative goals will be re-set for the service areas of Maui and Kauai.

The numbers
During the reporting period, LCRS services were offered in 3 areas: Oahu, Big Island, and Maui. However, it is important to note that the Maui location experienced underutilization and was subsequently closed during the performance year.

The narrative for FY24 result
During the reporting period, LCRS services were operational only in three areas: Oahu, the Big Island, and Maui, with the latter experiencing underutilization and eventual closure. For Maui, two primary factors can be attributed to this low utilization. Firstly, following the Maui wildfire, individuals in need of support reportedly found alternative solutions due to increased available services. Secondly, the utilization-based contract model for service providers proved unsustainable when facilities were underused. Kauai service area previously sought to establish an LCRS from 2006 to 2007. Feedback from potential providers has indicated concerns about insufficient consumer demand to support a viable service on the island Alternative options, such as respite beds and Stabilization Intensive Case Management (SICM) services, were explored, but these efforts failed in attracting providers.

Performance target 2
Minimum average monthly percentage of stabilization beds available for placement of persons in crisis. The first-year target is a monthly 10 percent minimum average of stabilization beds. This target was achieved. The second-year target is to maintain a 10 percent minimum average.

The numbers and narrative for FY24 result
The average monthly percentage of stabilization beds available for placement of persons in crisis ranged from 13% to 31% (Pearl City facility) to 21% to 43% (Kona). Maui also had stabilization beds with rates of 23% to 95%. Other indicators of availability will also be considered in future planning cycles.

PRIORITY AREA 6. INTEGRATING BEHAVIORAL HEALTH AND PHYSICAL HEALTH CARE

Goal
Improve outcomes for adults and youth, especially those with more complex needs.

Performance target
Expand services provided to clients to address behavioral and physical health needs by adding a SAMHSA-certified Certified Community Behavioral Health Clinic (CCBHC). The Year 2 target is to maintain the CCBHC.

The numbers
Services were expanded with the opening of Maui's CCBHC but this is not certified yet.

The narrative for FY24 result
The pilot CCBHC is in Maui. The priority attention during the year was disaster response and recovery. The pilot CCBHC was started during the fiscal year amidst disaster response and recovery after the tragic Maui wildfire. The CCBHC increased the number of clients served. However, the CCBHC must include many services required to be certified, currently being addressed through contracts and agreements. The target must also be restated because SAMHSA does not directly provide CCBHC certification. SAMHSA's crucial role is in setting the standards and guidelines for the certification process, which the State ultimately carries out.

PRIORITY AREA 7. STRENGTHENING THE BEHAVIORAL HEALTH WORKFORCE

Goal
Improve mental health outcomes for priority populations. The goal aims to achieve three key performance targets.

Performance target 1
Decrease workforce vacancy rates within AMHD and CAMHD.

The numbers
The first-year target was to reduce the AMHD and CAMHD vacancy rates to 20 percent, which CAMHD achieved. The second-year target is to reduce the vacancy rates by an additional 20 percent.

The narrative for FY24 result
The vacancy rate is reported only for CAMHD, and teleworking has played a significant role in achieving this positive outcome. CAMHD aims to lower its vacancy rate or at least maintain the current level. Meanwhile, AMHD is undergoing a reorganization that will impact the positions that will be reinstated. The current AMHD measure of the vacancy rate, which includes positions that were not re-stablished, stands at 36%. The AMHD needs to re-establish the positions in order to fill these to reflect vacancy rate based on fillable positions.

Performance target 2
Increase the competency of staff and providers in person-centered care, trauma-informed care, and resiliency.

The numbers

The first-year target was to add 2 new SAMHSA-certified trainers in a trauma-informed care (TIC) approach or similar program, which was achieved. The second-year target is to gain 12 SAMHSA-certified trainers in a trauma-informed care approach or similar program.

The narrative for FY24 result

CAMHD has trainers in TIC. CAMHD additionally trained its clinical staff and service providers in *Practice Wise*. Practice Wise is a professional development program for mental health professionals. The training is in two parts: MAP (Managing and Adapting Practice) and MATCH ADTC (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems. MAP identifies elements common across evidence-supported treatments to address complex youth experiences. MATCH ADTC helps clinicians be more proficient in selecting, organizing, and delivering common practices used in evidence-based therapies to improve direct services to clients. CAMHD encourages clinicians to attend professional conferences (i.e., psychiatrists attending AACAP conferences). For FY25, CAMHD plans to continue its subscription to provide Practice Wise to new clinical staff refreshers for existing clinical staff, as well as clinician training at professional conferences if funding allows. For FY25, AMHD plans to use part of its funding allocation for TIC training, including trainer of trainers.

Performance target 3

Increase employment of recently certified peer specialists along with best practices.

The numbers

The first-year target was to increase the employment of graduates by 20 percent, which was achieved. The second-year target is to increase the employment of graduates by an additional 20 percent.

The narrative for FY24 result

This is based on seven employed out of the 13 graduates of the AMHD training. Additionally, CAMHD graduated an entire cohort of certified youth partners. CAMHD's OnTrack Hawai'i (OTH) FEP program hired a 0.5 FTE youth peer specialist who successfully completed the course to be certified as a peer specialist. The FEP Peer Support Specialist have been extremely helpful in helping clients pursue and attain education and/or employment goals. This peer support specialist was one of a group of youths who completed the peer support specialist certification training, which CAMHD provided from its budget. Peer support specialists may be called in to help youth receiving treatment from CAMHD, as appropriate, through a contractual arrangement with Epic Ohana, a non-profit. CAMHD also contracts with Child & Family Services (non-profit) to provide parent-peer support for parents of youth who are receiving CAMHD services.

Appendix 4. 2024 State Council Letter on Hawai'i's MHBG FY25 Mini-Proposal Application

JOSH B. GREEN, M.D.
GOVERNOR OF HAWAII
KE KIA'ĀINA O KA
MOKU'ĀINA 'O HAWAI'I

KATHERINE AUMER, PH.D.
COUNCIL CHAIRPERSON
LUNA HO'OMALU O KA PAPA

STATE OF HAWAI'I
DEPARTMENT OF HEALTH
KA 'OIHANA OLAKINO
STATE COUNCIL ON MENTAL HEALTH
P.O. Box 3378, Room 256
HONOLULU, HAWAII 96801-3378

September 10, 2024

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Christopher "CJ" McKinney, Ph.D.
Public Health Advisor/Government Project Officer
SAMHSA-CMHS
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. McKinney:

Aloha! On behalf of the State Council on Mental Health, I am writing to inform you that Council members had opportunities to learn more about the FY25 Mental Health Block Grant (MHBG) mini proposal. The mini proposal noted two meetings where the contents were discussed, and the relevant meeting minutes or excerpts were attached. The mini proposal also stated the public input that was received.

We appreciate the open discussion that sprung out during these meetings. Although they did not substantially change the content of the mini proposal, they offered a deeper dive into issues that we have been concerned about. We are recommending more prevention and the importance of identifying contributing social determinants. We also recognize that members of Hawaii's forensic population need a place to go, the "in-between" solution, when the Hawaii State Hospital, jail nor behavioral health crisis centers are not the right places for their treatment and recovery.

The Council, however, is currently a bystander in the MHBG planning process. We believe this needs to change in the next planning cycle. We recommend a clearer articulation of the planning workflow and a more defined role for the Council. We are particularly grateful for the transparency of the new administrators of the AMHD and CAMHD, Gavin Takenaka and Keli Acquaro,

Appendix 4. Continuation…

respectively. We are aligned with their desire to continue improving data and the increased use of quality data to inform decisions. We welcome their suggestion to help them identify what performance measures and data the State should be prioritizing and looking at.

Thank you. For more information or questions, please contact us via email at doh.scmhchairperson@doh.hawaii.gov.

Sincerely,

Katherine Aumer

VISION: A Hawaii where people of all ages with mental health challenges can enjoy recovery in the community of their choice.

MISSON: To advocate for a Hawaii where all persons affected by mental illness can access necessary treatment and support to live full lives in the community of their choice.

Appendix 5. 2024 Bills that the SCMH testified on and that were signed into law

Bill	Description	Final Status
SB3139 SD2 HD3 CD1	Establishes a Crisis Intervention and Diversion Services Program within the Department of Health to expand existing services to divert certain persons experiencing mental health disorders and co-occurring mental health and substance use disorders to appropriate health care systems and services. Defines "mental health emergency worker". Requires the Department of Health to establish standards and rules for the designation of mental health emergency workers. With regards to emergency examination and hospitalization of persons who are deemed imminently dangerous to self or others, clarifies when a law enforcement officer may gain control of the person and the procedures the officer shall take to call for assistance from a mental health emergency worker; allows the person to be transported to facilities designated by the Director of Health in addition to licensed psychiatric facilities; and allows a person to be transported to a behavioral health crisis center designated by the Director of Health if a Crisis Intervention Officer has probable cause to believe that the person is imminently dangerous to self or others, as determined by a mental health emergency worker	Act 086, Gov. Msg. No. 1187
HB1830 HD2 SD1 CD1	Beginning 7/1/2026, establishes provisional or associate-level licensure requirements for marriage and family therapists, mental health counselors, and psychologists and authorizes insurance reimbursements in certain circumstances; authorizes psychologist license applicants who possess a provisional license to sit for the licensing examination before completing certain supervised experience requirements; and authorizes insurance reimbursements for services provided by a supervised social work intern in certain circumstances. Appropriates funds out of the Compliance Resolution Fund. (CD1)	Act 093, Gov. Msg. No. 1194
SB3094 SD2 HD2 CD1	Establishes a Peer Support Specialist Working Group within the Office of Wellness and Resilience to develop and make recommendations for a framework for peer support specialists in the State. Requires the working group to submit a report to the Legislature before the Regular Session of 2025. Sunsets the working group on 6/30/2025. (CD1)	Act 088, Gov. Msg. No. 1189
HB2159 HD2 SD2	Part I: requires the Department of the Attorney General to assist with the preparation and filing of petitions for assisted community treatment and with the presentation of the case, unless declined by the petitioner. Part II: repeals language entitling the subject of a petition for assisted community treatment to legal representation by a public defender. Part III: provides a mechanism for the automatic screening of certain nonviolent defendants for involuntary hospitalization or assisted community treatment. Part IV: authorizes courts to require certain probation violators to undergo a mental health evaluation and treatment program as a condition of continued probation. Part V: allows a court to appoint an attorney for the subject of a petition for assisted community treatment if the interests of justice require one be appointed and makes permanent the orders to treat over objection law in sections 334-161 and 334-162, HRS. (SD2)	Act 087 Gov. Msg. No. 1188

Appendix 6. SCMH Strategic Planning Retreat Three Year Goals and One-Year Objectives
Prepared by AMHD Staff

The SCMH identified these goals at its May 2024 strategic planning retreat, elaborated on one year objectives and sought progress in the months that followed.

GOAL 1. INCREASE COUNCIL'S EFFECTIVENESS

1 year objectives

- Expand council voices and views
- Improve onboarding

Methods

- Volunteers from the Council will engage in targeted outreach, seeking more voices for corrections, youth, kupuna, Native Hawaiians, LGBTQ, and first responders.
- Create an SCMH introductory brochure, the first steps will include updating of the SCMH website and AMHD filling its communication specialist position.

Results to date

- Outreach by volunteer members increased the number of applicants for SCMH's vacant seats; Governor appointed two new members to fill the seats for youth and consumer advocacy.
- The State's Office of Electronic Technology Services (ETS) guided and supported the updating of the SCMH website, which had a soft launching in September 2024. AMHD recently filled its communication specialist position with an 89-day hire.

GOAL 2. IMPROVE EQUITY IN ACCESS TO CARE

1 year objective

- Develop an improved plan for delivery access to care in the rural areas.

Methods

- Create an action committee to figure out the next steps.

Results to date

- Volunteers recruited for this action committee. Meanwhile, informational presentations (e.g., on clubhouses, disaster response) and on MHBG mini-proposal and performance reports are providing insights on ongoing actions in rural areas.

GOAL 3. MORE COMPLETE MAPPING OF MENTAL HEALTH CHALLENGES AND RESOURCES

1 year objective

- Compose an updatable directory of services that can be accessed, and which displays the full cycle (of care).

Methods

- Work with Mental Health of America Hawai'i (MHAH) for an updatable resource directory of services from keiki to kupuna, working to include what will be helpful to each local area.
- Create an action committee to analyze next steps.
- Explore also possible private and public sources to fund sustainability of effort.

Results to date

- MHAH has been consulted and it reported that it just released its 2024 Directory which it has uploaded in its website.
- An action committee was created for this objective.

GOAL 4. ATTACK WORKFORCE DEVELOPMENT CHALLENGES

1 year objectives

- Determine ways to higher pay rates for services, analyzing career pathways and glidepaths, recruitment, rate studies, DOH salaries, barriers to reimbursement.
- Monitor implementation of HB1830 (provisional licensing)

Methods

- Create an action committee to determine next steps
- Invite subject matter experts to present at Council meetings

Results to date

- A committee on workforce and care continuum met and recommended further information gathering. This is a committee for several interrelated goals.
- An action committee was created for this objective, recommending more presentations like on CAMHD's rate study, Medicaid & Care Continuum Services, DCCA on HB1830, DHRD on recruitment and applicants, AMHD Supportive Housing.
- Presentation or scheduled presentations on Medicaid and Coordinated Care Services, AMHD Community-Based Housing Services.

GOAL 5. IMPROVE COMPREHENSIVE CARE COORDINATION

1 year objectives

- Identify new funding sources for group homes
- Meet with insurance providers to review different parts of the care coordination systems to discuss (care coordination) reimbursement policies.

Methods

- Create an action committee to determine next steps
- Set up Council meetings with invited insurers.

Results to date

Please refer to Goal 4 results to date

#end#
January 2025