Hawaii

UNIFORM APPLICATION
FY 2020/2021 Community Mental Health Services Block Grant Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/02/2019 12.02.57 AM)

Center for Mental Health Services
Division of State and Community Systems Development
State Information

Plan Year
Start Year 2020
End Year 2021

State DUNS Number
Number 809935679
Expiration Date 7/14/2020

I. State Agency to be the Grantee for the Block Grant
Agency Name Department of Health
Organizational Unit Behavioral Health Administration
Mailing Address P.O. Box 3378
City Honolulu
Zip Code 96801

II. Contact Person for the Grantee of the Block Grant
First Name Edward
Last Name Mersereau
Agency Name Department of Health, Behavioral Health Administrator
Mailing Address P.O. Box 3378
City Honolulu
Zip Code 96801-3378
Telephone 808-586-4416
Fax 808-586-4368
Email Address edward.mersereau@doh.hawaii.gov

III. Third Party Administrator of Mental Health Services
Do you have a third party administrator? ☐ Yes ☐ No
First Name
Last Name
Agency Name
Mailing Address
City
Zip Code
Telephone
Fax
Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)
From
To
V. Date Submitted
Submission Date 9/2/2019 12:02:05 AM
Revision Date

VI. Contact Person Responsible for Application Submission
First Name Judith
Last Name Clarke
Telephone 808-453-6946
Fax 808-453-6939
Email Address judith.clarke@doh.hawaii.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
State Information

Chief Executive Officer’s Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to...
State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,”
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the
Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section
1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying
undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING
$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing
or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or
an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant,
the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal,
revision, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to
influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a
Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall
complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed,
Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this
application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all
tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients
shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into.
Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any
person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000
for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and
accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims
may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply
with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any
indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early
childhood development services, education or library services to children under the age of 18, if the services are funded by Federal
programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also
applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal
funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or
alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC
coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each
violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and
will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain
provisions for children’s services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Bruce S. Anderson, Ph.D.

Signature of CEO or Designee 1: ________________________________

Title: Director, Department of Health Date Signed: ________________________________

1If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
June 14, 2018

TO: Bruce S. Anderson, Ph.D.
    Director of Health

SUBJECT: Designation of Signature Authority to the Director of Health
         for the Annual Substance Abuse and Mental Health Services
         Administration (SAMHSA), Center for Mental Health Services
         (CMHS) Community Mental Health Block Grant Application

As the Director of the Department of Health, I hereby designate you as
the State of Hawaii’s signature authority for the Community Mental
Health Block Grant Application that is submitted annually to the
Substance Abuse and Mental Health Services Administration, Center for
Mental Health Services. You are hereby authorized to sign all Funding
Agreements, Certifications and Assurances that must be signed and
submitted for the annual Community Mental Health Block Grant
Application and related documents. This designation will remain in
effect until such time as it may be rescinded.

DAVID Y. IGE
Governor, State of Hawaii
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Bruce S. Anderson, Ph.D.

Signature of CEO or Designee: [Signature]

Title: Director, Department of Health

Date Signed: AUG 27 2019

mm/dd/yyyy

If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

**Standard Form LLL (click here)**

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<tr>
<th>Signature:</th>
<th>Date:</th>
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**Footnotes:**
Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:
Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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Footnotes:
Step 1: ASSESS THE STRENGTHS AND ORGANIZATIONAL CAPACITY OF THE SERVICE SYSTEM TO ADDRESS SPECIFIC POPULATIONS.

ADULT MENTAL HEALTH SERVICE SYSTEM

The Hawaii Department of Health, Adult Mental Health Division (AMHD) is considered the State Mental Health Authority (SMHA) that oversees the Hawaii’s public system of adult mental health services. Individuals with serious mental illness are the primary target population for SMHA funded services, including those who are uninsured or underinsured, those who are court ordered, and individuals in crisis. Through licensing, regulations, and policies, the AMHD establishes standards to ensure effective and culturally competent care to promote recovery.

The AMHD is a division under the Hawaii State Department of Health (DOH), Behavioral Health Administration (BHA). BHA also includes the Alcohol and Drug Abuse Division (ADAD), the Child and Adolescent Mental Health Division (CAMHD), and the Developmental Disabilities Division (DDD). The AMHD provides services to adults through state operated Community Mental Health Centers (CMHCs), the Hawaii State Hospital, and Purchase of Service contracted providers. The AMHD uses state general and special funds to provide services to adults who meet the definition of having a serious mental illness (SMI). Individuals with SMI who are eligible for mental health services may also receive mental health services through the Hawaii State Department of Human Services (DHS), MedQUEST Division’s QUEST Integration program.

Cultural competency is integrated into the AMHD services through a set of congruent policies, procedures, and staff trainings that promotes effective service delivery to all consumers and especially those of diverse backgrounds. The guiding principles of the AMHD reflect the culture of the organization and state the way in which services are delivered. The AMHD guiding principles are:

- Mental health treatment works.
- People recover every day in Hawaii.
- AMHD supports recovery in all aspects of our work.
- Appropriate housing and employment are keys to recovery.
- We strive to treat our consumers in independent living settings.
- Behavioral Health is essential to health; we partner with other health care professionals to provide integrated treatments.
- We strive to use technology to work smarter.
- We strive to educate ourselves and provide training to others.
- AMHD supports the use of innovative strategies to reduce involvement of individuals with mental illness in the criminal justice system.
- We strive to identify and provide best practice mental health care to our consumers.
- We strive to develop and provide best practice forensic services to integrate with and collaborate with the courts, corrections system, and law enforcement agencies to reduce consumer’s justice involvement.

The AMHD includes clinical and administrative lines of authority and oversight responsibility under the leadership of the AMHD Administrator. Statewide Service Coordinators (SSCs) have statewide responsibility for the development of services, program standards, and policies and procedures that
align with evidence-based practices and professional standards. The SSCs coordinate with relevant agencies to their service specialty; determine contract scopes of services and identify training and technical needs for the AMHD system of care. In this organizational context, Utilization Management and Performance Improvement are also considered part of the clinical lines.

The AMHD eligibility criteria are organized into the following three categories: Category I: Continuing Services; Category II: Time Limited Services (including, but not limited to, Homeless and Crisis Services); and Category III: Disaster Services. The primary focus of AMHD’s current eligibility criteria includes individuals diagnosed with a serious mental illness (SMI), who may also have a co-occurring mental and substance use disorder, as well as those who are legally encumbered. AMHD consumers must continue to demonstrate significant functional impairment; one that seriously limits their ability to function.

Opportunities for the clinician to gain an understanding of the consumer and for the consumer to access the most appropriate mental health services; an assessment of the consumer’s physical, psychological, and social functioning status is conducted to determine whether the individual is eligible for AMHD services. For individuals ages 18 and older who are seeking mental health services, the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 is used in assessing disability. Individuals must also: 1) live in Hawaii and be a citizen of, or have permanent residency status in the U.S.A., 2) fall within similar assets/income requirement for Medicaid, and 3) meet a delineated insurance status or continue to be without insurance coverage.

Below is the number of consumers served by the AMHD in FY 2018:

<table>
<thead>
<tr>
<th>Age</th>
<th>Female</th>
<th>Male</th>
<th>Not Available</th>
<th>Total</th>
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ADULT MENTAL HEALTH DIVISION’S ARRAY OF SERVICES BY COUNTY

A continuum of services has been developed to meet the needs of individuals with mental illness and substance use disorders in Hawaii. They are:

CASE MANAGEMENT/SUPPORT SERVICES

1. **Bi-Lingual Interpreter Services**: Cultural and linguistic care coordination is arranged in conjunction with a case management team for consumers who speak little or no English to support them in their recovery and to provide better access to formal mental health services.
   - Islands served: Oahu

2. **Case Management**: There are three types of case management.

   - **Community-Based Case Management (CBCM)**: Standard case management coordinated by team members on behalf of the consumer, with the consumer’s input, and in recovery-oriented manner. CBCM activities include, but are not limited to, assessing the consumer’s needs, care planning and coordination, implementing care plan items, and regularly reviewing services to assist the consumer in their recovery. CBCM services may also include assisting the consumer with obtaining health insurance, coordinating medical health, and insurance coverage benefits, assisting with residential housing, maintaining contact with the consumer’s family, as appropriate, assisting the consumer with additional supports and collateral services, and advocating on behalf of the consumer.
   - Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

   - **Intensive Case Management Plus – High Utilizer (ICM – Plus High Utilizer)**: In addition to CBCM, ICM – Plus High Utilizer services include intensive and highly integrated services provided to consumers who have experienced recurring crises, are frequently hospitalized or incarcerated, and who require a higher level of service coordination to become or remain stable in their community housing placement.
   - Island served: Oahu

   - **Intensive Case Management Plus – Homeless (ICM – Plus Homeless)**: In addition to CBCM, ICM – Plus Homeless services include rapid linkage with continuing support services provided to consumers who are homeless, frequently arrested, are the subject of frequent calls for an MH-1, and have frequent emergency department visits.
   - Island served: Oahu

3. **Homeless Outreach**: This service identifies and engages with homeless individuals with mental illness and provides the support necessary to link them with formal mental health and social services. Homeless Outreach workers interact with homeless individuals, who are suspected of having a mental illness and assist them to obtain an Eligibility Determination and appropriate linkage into services.
   - Islands served: Kauai, Oahu, Maui, and Hawaii Island

4. **Peer Coach**: Peer coach services provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and development and maintenance of community living skills through the eyes of someone who received or is receiving mental health services. Peer coaching involves providing increased attention and support to consumers when they are under high stress, beginning to decompensate, or returning to the community after a hospitalization.
   - Islands served: Kauai, Oahu, Maui, and Hawaii Island
5. **Representative Payee**: Representative payee services are intended to provide money management for registered consumers who have the capability to learn how to manage their own finances within two (2) years of initial services authorization. It is an educational component of our community recovery services which teaches the consumer how to budget, save, and pay bills. The consumer learns to manage their financial resources and to be responsible for the debt they incur.
   - Islands served: Kauai, Oahu, Maui, and Hawaii Island

**COMMUNITY HOUSING**

6. **24 Hour Group Home**: The 24-hour Group Home housing service provides twenty-four (24) hours a day, seven (7) days a week housing in a supervised setting. Services are prioritized for consumers discharged from the Hawaii State Hospital (HSH) and Kahi Mohala. Consumers referred and admitted to this level of housing are those who, without twenty-four (24) hour supervised care from supportive on-site staff, are at risk for decompensation and hospitalization if placed at a lower level of care. This service is designed to be individualized by integrating the individual into the community, with staff support, in the least restrictive housing placement, and consistent with the individual’s needs.
   - Islands served: Kauai, Oahu, Maui, and Hawaii Island

7. **8-16 Hour Group Home**: The 8-16 Group Home housing service provides supervised housing between eight (8) and sixteen (16) hours a day, seven (7) days a week. Services are prioritized for consumers discharged from the Hawaii State Hospital (HSH) and Kahi Mohala. Consumers referred and admitted to this level of housing are those who do not require 24-hour housing staff support but do require at least minimal housing supports daily. The ideal 8-16-hour group home resident can complete several daily tasks, if not most, independently but requires assistance from on-site staff from time-to-time. This service is designed to be individualized by placement, and consistent with the individual’s needs.
   - Islands served: Kauai, Oahu, Maui, and Hawaii Island

8. **Semi-Independent**: The Semi-Independent housing service provides group living with property management staff on-site eight (8) hours a day, plus some weekend coverage. The ideal semi-independent group home resident is someone who demonstrates he/she is capable of independently handling non-crisis issues for a day or two until scheduled staff are on-site. This service is designed to be individualized by integrating the individual into the community, with staff support, in the least restrictive housing placement, and consistent with the individual’s needs. Additionally, this service focuses on home and community integration through the encouragement of independence, dignity, privacy, and personal choice.
   - Islands served: Kauai, Oahu, Maui, and Hawaii Island

9. **Shelter Plus Care (S+C) for the Homeless**: This is a United States Department of Housing and Urban Development (HUD) rental subsidy program in which a residential specialist locates housing for homeless individuals with serious mental illness. Housing is selected by consume. A 24-hour housing support team is available to assist landlords and consumers. The rental subsidy allows consumers to pay no more than 30 percent of their entitlements for rent.
   - Islands served: Kauai, Oahu, Maui, Molokai, and Hawaii Island

10. **Supported Housing/Bridge Subsidy**: Supported housing provides consumers the option to live in permanent housing of their choice. The ideal supportive housing resident is someone who demonstrates he/she can live either alone (single occupancy) or in a home or apartment with a relative or with friends (dual/multi occupancy) where there is no regular structured supervision
from housing and mental health staff. Mental health staff provide support separate from the consumer’s living arrangements, but in-home support is encouraged as needed to assist the consumer with successfully assuming the role of tenant and neighbor. This service is designed to be individualized by integrating the individual into the community, with staff support, in the least restrictive housing placement, and consistent with the individual’s needs.
- Islands served: Kauai, Oahu, Maui, Molokai, and Hawaii Island

11. **Therapeutic Living Program (TLP):** The TLP provides ongoing residential/treatment support for consumers that are not ready to manage their medication in a more independent housing setting. Nursing services are available on site during the week, including support for basic physical health and medication management. Some psychosocial rehabilitation programming is provided on-site, but residents are encouraged to engage in community-based support such as Clubhouse or Day Treatment.
- Island served: Oahu

12. **Transitional Housing/Safe Haven:** This HUD-funded transitional housing program, called Safe Haven, is primarily for homeless consumers. Twenty-four (24) hour supervision is provided along with primary care and case management services.
- Islands served: Oahu, Maui and Hawaii Island

**CRISIS SERVICES**

13. **Crisis Line of Hawaii:** This is a 24-7 crisis and suicide hotline with membership in the National Suicide Prevention Lifeline (NSPL). The Crisis Line of Hawaii staff provides supportive listening and crisis counseling, dispatches and authorizes crisis outreach services, and serves as the after-hour’s link for oral *Ex-Parte* orders.
- Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

14. **Crisis Mobile Outreach (CMO):** CMO provides assessment and intervention services for adults in an active state of crisis. This service is available twenty-four (24) hours a day, seven (7) days a week and can occur in a variety of settings including the consumer’s home, local emergency department, in the community, etc. This service provides an opportunity for immediate crisis intervention and de-escalation, including risk assessment, mental health status and medical stability, and exploration of service options in the community.
- Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

15. **Crisis Support Management (CSM):** CSM provides time-limited support and intervention services to individuals who are in crisis and who are not linked to AMHD services or who do not have an AMHD funded case manager. Services assist the individual in returning to a pre-crisis state and gaining access to necessary services.
- Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

16. **Licensed Crisis Residential Services (LCRS):** The LCRS offers short-term, acute interventions to individuals experiencing or recovering from a psychiatric or behavioral health crisis. This is a structured residential alternative or diversion from psychiatric inpatient hospitalization. LCRS services are for individuals who are actively experiencing a period of acute stress that significantly
impairs the capacity to cope with normal life circumstances. This program provides services which address the psychiatric, psychological, and behavioral health needs of the individual.

- Islands served: Oahu, Maui, Hawaii Island

**FORENSIC SERVICES**

17. **Clinical Assessment & Referral Services: Court Based Clinician**: Clinical assessment and referral services in the District Court are provided by a Court Based Clinician. The Court Based Clinician provides services in support of AMHD’s mission to coordinate and promote integrated mental health services to individuals with serious mental disorders, many of whom have criminal justice involvement. The primary purpose of this position is to provide consultation and liaison services to courts and criminal justice agencies; evaluate and monitor consumers with serious mental illness (SMI) and criminal justice involvement regarding their risk level, engagement with treatment planning determining eligibility based on psychological evaluation, and adherence to court ordered conditions; and provide recommendations regarding risk management and reduction strategies to support maintenance of community tenure. This position serves as a technical expert regarding admission procedures and eligibility criteria for mental health programs (i.e. post-booking jail diversion, and Oahu Mental Health Court).

- Island served: Oahu

18. **Community-Based Fitness Restoration**: This program provides fitness restoration in a community setting, after a defendant has been released on conditions to the community on a 704-406(1) legal status. This program is an alternative approach to restoration in a hospital setting. Outpatient competency restoration offers an effective alternative to lengthy hospital commitments for consumers who can safely be restored to fitness within a community setting. Like Hale Imua, the program is tailored to meet the unique needs of each individual, including linkages to community programs and resources, such as Clubhouses.

- Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

19. **Conditional Release Exit Support and Transition Program (CREST)**: This program provides an avenue for consumers on Conditional Release (CR) to prepare for potential discharge from CR. It involves a multi-session group format with a primary focus on identifying warning signs, triggers, crisis plan, and other issues related to life after CR. Additional support and resources are provided to consumers to understand the court system and other parties that are involved in the legal process.

- Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

20. **Consultation/Liaison with Law Enforcement and Department of Public Safety**: AMHD provides support for training law enforcement first responders with the skills needed to effectively interact with individuals who are mentally ill and those in crisis and delivering effective services in the crisis context. Specifically, this service takes the form of mental health consultation and liaison by Mental Health Emergency Workers (MHEW) who are trained to provide consultative services (varies by county). In Honolulu County, Honolulu Police Department employs police department contracted psychologists who are designated MHEWs. Financial support for this program provided by the AMHD. In Maui County, a formal Crisis Intervention Team (CIT) program was developed where requests for consultation from Crisis Mobile Outreach teams is received and addressed. In both
Hawaii and Kauai counties, informal arrangements for consultation between law enforcement personnel and the local mental health authority is addressed. The AMHD collaborates with the Public Safety Department Corrections Division in providing consultation on challenging clinical cases involving detainees and inmates with mental illness and through the MH-9 process, and the ability to transfer a detainee to Hawaii State Hospital from a correctional facility when hospital level of care is indicated.

- Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

21. Consultation to Specialty Courts—Mental Health Court (MHC): The Mental Health Court team is led by the Hawaii State Judiciary in collaboration with staff from the AMHD who provide clinical support. The Court Based Clinician serves as the liaison to criminal justice and other community agencies and is the primary staff assigned to interface between mental health and criminal justice issues including risk assessment, management and reduction. The Court Based Clinician provides initial clinical evaluations and re-evaluations specifically related to referrals and current MHC participants.

- Island served: Oahu

22. Court Ordered Forensic Evaluation Services: Court evaluation and liaison services are delivered through the AMHD Court Evaluation Branch which provides consultation services to the Judiciary in accordance with Hawaii Revised Statutes (HRS). The Branch maintains a list of certified examiners for the Judiciary. Examiners perform court ordered evaluations of adults for Circuit and District Courts statewide pursuant to HRS 704 including examination of mental disease, disorder or defect; fitness to proceed; penal responsibility; risk assessments to assist in the court’s disposition related to discharge, release on conditions, or commitment to the custody of the Director of Health; and examination of the mental condition of a defendant to assist in the court’s disposition of an application for discharge, conditional release, modification of conditions of release, or discharge from conditional release. Examiners also perform court ordered evaluations of juveniles for Family Court. Examiners prepare relevant reports and provide testimony in support of court ordered evaluations.

- Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

23. Forensic Coordination: Services are provided by AMHD Forensic Coordinators. Forensic coordinators are psychologists who provide coordination and consultation regarding court related elements of treatment and follow-up for consumers involved with the criminal justice system. Forensic Coordinators provides consultation and liaison services to treatment teams and criminal justice agencies; evaluate and monitor consumers with serious mental illness (SMI) and criminal justice involvement regarding their risk level, engagement with treatment planning and adherence to court ordered conditions. Forensic coordinators may provide recommendations regarding risk management and reduction strategies to support maintenance of community tenure. Forensic coordinators assist with overseeing the Jail Diversion Program, the Community Fitness Restoration Program and the Conditional Release Transition Program.

- Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

24. Hale Imua: This program serves criminal justice involved consumers on Conditional Release (CR) status and programming is based on a multidisciplinary approach to integrated treatment. Services are provided in a safe setting and focus on consumer’s strengths. The program is tailored to meet the
unique needs of each consumer including linkages to community programs and resources. The model is based on a continuity of care incorporating evidence-based practice techniques including classes that address recidivism. Each resident is provided with a comprehensive clinical team that includes psychiatrist, psychologist, nurse, and case management. Implemented as a state pilot project in 2005, services are primarily supported by the Windward Oahu Treatment Services Section staff. Hale Imua is implemented in a 24-hour group home setting.

- Island served: Oahu

25. **Honolulu Police Department Central Receiving Division Services**: This program provides two Advanced Practice Registered Nurses (APRNs) for up to 80 hours per week (2 FTE) at the HPD’s Central Receiving Division (CRD). The APRNs work in partnership with the Crisis Line of Hawaii, which provides the capability for cross-reference individuals and determine if they were currently receiving AMHD services. Information about arrests is relayed from the Crisis Line of Hawaii back to the case management team for follow-up. Major activities include reviewing medication and medication needs, making recommendations to the court on behalf of the detainees, and providing the court with community treatment alternatives to hospitalization. Data is also collected on the frequency of arrests and rates of detainees identified as homeless.

- Island served: Oahu

26. **Pre-Booking Jail Diversion**: This program operates as a joint effort between the AMHD and the Honolulu Police Department (HPD). When an individual is suspected of mental illness at a crime scene, the HPD officer can request consultation from an HPD contracted psychologist who is a designated Mental Health Emergency Worker (MHEW). A psychologist is available to HPD for consultation 24-hours a day. See Consultation/Liaison with Law Enforcement and Public Safety Department for additional information. Consultation services to law enforcement provide additional diversion opportunities.

- Island served: Oahu

27. **Post-Booking Jail Diversion**: Post-Booking Jail Diversion is a supportive case management service provided for potential consumers in post-booking and pre/post arraignment situations. The intent of this service is to reduce criminal recidivism by diverting eligible, non-dangerous mentally ill arrestees and detainees from incarceration. The service provides and/or coordinates outreach and therapeutic support to eligible consumers in accordance with evidence-based best practices to assure each consumer’s jail diversion plan addresses legal, public safety, and community tenure issues. The service coordinates activities that eligible consumers obtain basic needs including food, housing, clothing, transportation, and money; apply for and receive benefits and entitlements and have access to peer support and recovery opportunities.

- Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

**PSYCHOSOCIAL REHABILITATION SERVICES**

28. **Clubhouse**: The Clubhouse Model of Psychosocial Rehabilitation is a comprehensive and dynamic program of support and opportunities for consumer. In contrast to traditional day-treatment and other day program models, Clubhouse participants are called “members” (as opposed to “patients” or “clients”) and restorative activities focus on their strengths and abilities, not their illness. The Clubhouse is unique in that it is not a clinical program. There are no therapists or psychiatrists on staff. All clinical aspects of the program have been removed to focus on the strengths of the
Clubhouse member, rather than their illness. Additionally, Clubhouse members strictly participate on a voluntary basis. Clubhouse members and staff work side-by-side to manage all the operations of the Clubhouse, providing an opportunity for members to contribute in significant and meaningful ways; therefore, a Clubhouse is operated in a partnership model. Through this environment of support, acceptance, and commitment to the potential contribution and success of each member and staff, Clubhouses are places where members and staff can belong as contributing adults, rather than passing their time as patients who need treatment. The Clubhouse Model seeks to demonstrate that consumers with mental illness can successfully live productive lives and work in the community, regardless of the nature or severity of their mental illness. Clubhouse services include Transitional Employment (TE), Group Transitional Employment (GTE), Supported Employment (SE), Supported Education (SE), advocacy and case management.

- Islands served: Kauai, Oahu, Maui, Molokai, and Hawaii Island

29. **Hawaii Certified Peer Specialist Program**: The primary goal of the Hawaii Certified Peer Specialist (HCPS) program is to provide basic knowledge and skills for direct-care human service employment. The field placement/internship experience provides an environment for continued growth and the practical application of skills learned. A HCPS is an individual who has both lived experience with mental illness and has formal training in the peer specialist model (Georgia’s Model) of mental health supports. Interns must pass HCPS examinations, both oral and written, after earning approximately 80 hours of training and instruction. HCPS are prepared for employment as Certified Peer Specialists, peer educators, or Peer Coaches.

A subgroup of HCPS received specialized training and certification as Forensic Peer Specialists. Forensic Peer Specialists provide peer support that is offered to consumers with psychiatric and/or co-occurring challenges who are involved in the Criminal Justice System, from initial contact with law enforcement through re-entry into the community.

- Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

30. **Supported Education (SE)**: This Clubhouse service provides consumers with a full range of educational services from basic literacy through gaining of a General Equivalency Diploma (GED) to educational counseling for college, technical education or other courses. Necessary supports are provided such as study skills training and social skills training.

- Islands served: Kauai, Oahu, Maui, Molokai, and Hawaii Island

31. **Supported Employment (SE)**: Supported employment is based on models of 1) “Individual Placement and Support (IPS),” a “place-train” approach, or, 2) “choose get, keep and leave (jobs)” as opposed to engaging in pre-vocational training. These services are intended for consumers for whom competitive employment has not traditionally occurred, or has been interrupted, or intermittent as a result of their disability. Supported employment is paid, competitive work that offers ongoing support services in integrated settings for consumers and their employers. Elements include zero exclusion, consumer preference, rapid job search, integration with mental health services; and personalized benefits planning.

- Islands served: Kauai, Oahu, Maui, and Hawaii Island

32. **Transitional Employment (TE)**: This Clubhouse service offers members the opportunity for paid employment various hours a day and lengths of time depending on individual needs. Clubhouse staff assumes the paid TE job in the member’s (temporary) absence.
TREATMENT SERVICES

33. **Day Treatment**: This service is a structured day program for individuals diagnosed with co-occurring, mental illness, and substance abuse use disorders (MISA). The programming consists of three (3) or six (6) hours of treatment per day depending on the assessed clinical needs of the consumer. Day treatment is designed to assist the consumer with developing illness management skills to prevent relapse to substances, increase strategies to cope and/or manage severe symptoms of mental illness and improve overall life skills deficits.
   - Islands served: Oahu, Maui

34. **Hospitals (Inpatient, General, Non-Forensic)**: The provision of inpatient care within a unit designed to service seriously mentally ill patients who have just been admitted or are experiencing an acute phase of their illness in the course of an extended hospitalization. Services are primarily oriented toward developing a differential diagnosis, developing treatment plans to fully respond to the acute needs and stabilization of the patient’s psychiatric condition, and intensive intervention.
   - Islands served: Kauai, Oahu, Maui, and Hawaii Island

35. **Hospitals (Inpatient, Specialty/State, Forensic)**: The provision of secure care within a hospital setting that is designed to: 1) serve patients with a serious mental illness who require secure care beyond the acute phase of their illness with psychiatric rehabilitation services with the goal of achieving the highest level of functioning possible before returning to community living; 2) serve patients who are committed by a court to evaluate competency to stand trial, assess criminal responsibility, or provide recommendations to the referring judge or county department regarding court disposition or department resolution; 3) provide psychiatric treatment and fitness restoration to enable patients competent participation in court proceedings; 4) provide recommendation to the referring judge or county department to facilitate court disposition.
   - Island served: Oahu (Hawaii State Hospital)

36. **Intensive Outpatient (IOP) Hospital**: IOP outpatient hospital services provide consumers with stabilization of psychiatric impairments as well as enabling consumers to reside in the community or to return to the community from a more restrictive setting. The goals of the service are clearly articulated in each consumer’s individualized plan of care. Treatment is time-limited, ambulatory, active, and offers intensive, coordinated clinical service provided by a multi-disciplinary team.
   - Island served: Oahu

37. **Outpatient Treatment**: Outpatient clinic services include an array of services that are provided to the consumer in an outpatient clinic setting in combination with CBCM. Interventions include medication management, prescribing, monitoring, and administration along with evidence-based integrated substance use treatment and trauma-informed care to persons with serious mental illness. Services include case management, individual, group and family therapy, and psycho-education interventions designed to promote self-efficacy and build independent living skills.
   - Islands served: Kauai, Oahu, Maui, Molokai, Lanai, and Hawaii Island

38. **Specialized Residential Treatment - Mental Health**: This service is a residential program which focuses on increasing the consumer’s independent functioning in the community setting. The
continuum of care includes observation, monitoring, and treatment 24-hour a day, seven (7) days a week staffing. This service is designed for consumers who have co-morbid medical conditions, including physical disabilities and who may require unique and highly specialized services that do not typically exist in the community.

- Islands served: Oahu, Maui

OTHER SERVICES

39. **Expanded Adult Residential Care Home (E-ARCH):** This is a care home placement service supported by RN and psychiatric case managers. It primarily serves to successfully discharge consumers who are currently residing in the hospital who meet the intermediate care facility (ICF) level of care and are appropriate for admission to an E-ARCH.

- Island served: Oahu

40. **Primary & Behavioral Health Integrated Care:** The integrated primary and behavioral health care “Living Well Hawaii” project serves Hawaii residents with serious mental illness who receive healthcare services from the state-operated West Honolulu Treatment Service Section (Kalihi-Palama Community Mental Health Center), and the Leeward-Central Oahu Treatment Service Section (Central Oahu CMHC) in collaboration with the Kalihi-Palama CMHC. The project integrates primary healthcare into the behavioral health service setting to increase access to comprehensive healthcare and improve the health status and outcomes of individuals with a serious mental illness, co-occurring substance use disorders and medical co-morbidities. Kalihi-Palama CMHC primary healthcare providers and AMHD Community Mental Health Center behavioral healthcare providers collaborate in providing integrated “whole person: health services to enrollees. The project is jointly funded by the Hawaii State Department of Health (DOH) and a four (4) year federal SAMHSA grant awarded to the AMHD.

- Island served: Oahu

41. **Substance Abuse and Mental Health Services Administration (SAMHSA) Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery (SOAR):** This program is designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or who are at risk for homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.

- Islands served: Kauai, Oahu, Maui, Molokai, and Hawaii Island

OTHER STATE AGENCIES WITH RESPECT TO THE DELIVERY OF MENTAL HEALTH SERVICES

Hawaii features a health care delivery system that reflects the diversity and history of the State’s 1.42 million residents (2018) and seven populated islands in four major counties: Kauai, Oahu, Maui and Hawaii. As a result, approximately 70 percent of the state’s population residing in the City and County of Honolulu on the island of Oahu, most health care facilities, specialty, and subspecialty services are located on Oahu. Neighbor Island and rural Oahu residents often must travel to Honolulu for these services. Overall, the State’s hospitals, providers, and payers are moving towards a health care delivery system that pays for quality outcomes rather than units of services.
Within the Department of Health (DOH), two other divisions provide behavioral health services: The Child and Adolescent Mental Health Division (CAMHD) and the Alcohol and Drug Abuse Division (ADAD). Generally, individuals must be diagnosed with a serious mental illness, serious emotional/behavioral disturbance or alcohol or drug abuse problem or be in a state of crisis in order to receive CAMHD or ADAD services. The services offered by these divisions may supplement those that are covered by MedQUEST, although individuals do not need to be covered by Medicaid to qualify for many services.

Behavioral health has been identified as Hawaii’s most pressing health care priority, and one of the state’s goals for the “Healthy Families and Healthy Communities” initiative is to strengthen the health care delivery system to support behavioral health integration by reducing preventable hospitalizations, readmissions, and emergency room visits by 2021.

**Federally Qualified Health Centers (FQHCs):** Hawaii has sixteen Federally Qualified Health Centers on six islands that provided care for 155,436 patients in 2017. The FQHCs serve the medically underserved population and low-income residents on all six islands who would otherwise lack access to primary care services. The FQHCs are the largest provider network for Medicaid and second-largest provider source of direct primary medical services in the state. Therefore, the FQHCs emphasize a multi-disciplinary approach to delivering care provide behavioral health care, dental services, language assistance, health education and nutrition counseling, and assistance with program applications such as housing and cash assistance.

**Community Mental Health Center (CMHCs):** The Hawaii Department of Health (DOH), Adult Mental Health Division (AMHD) operates four state staffed CMHCs, several with smaller satellite clinic sites, which served approximately 7,633 adults with SMI on all seven main islands in FY 2018. Many of these individuals are covered by Medicaid are uninsured, or are court involved, including individuals on Conditional Release, Release on Conditions, participating in Mental Health Court or are in Jail Diversion.

**Family Guidance Centers:** The DOH Child and Adolescent Mental Health Division (CAMHD) operates nine Family Guidance Centers (FGCs) with at least one on each island. FGCs provide services to youth identified as in need of intensive mental health services. In addition to the intensive mental health services provided through a FGC, youth are assigned a FGC Mental Health Care Coordinator and may continue to receive School-Based Behavioral Health (SBBH) services and supports from the Hawaii State Department of Education.

**Medicaid Program:** The State Medicaid program is administered by the Hawaii State Department of Human Services, MedQUEST Division. Hawaii uses managed care through its Medicaid program, contracting with five health plans. These health plans include AlohaCare, Hawaii Medical Service Association (HMSA Blue Cross/Blue Shield), Kaiser Foundation Health Plan, ‘Ohana Health Plan, and United Healthcare Community Plan. HMSA serves the largest portion of the Medicaid population and all health plans serve other populations in Hawaii’s health care market.

In 2015, DHS established the QUEST Integration program to expand medical coverage to include populations previously ineligible for Medicaid, and to contain costs by shifting fee-for-service to a managed care delivery system. The most significant change for health plans is that they now all serve

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1 2017 Hawaii Health Center Data.
the aged, blind, and disabled (ABD) population. As of September 2018, the Medicaid Program provided coverage to 352,037 individuals².

The State Judicial System
Hawaii’s criminal justice system is comprised of two major components: The State Judiciary which is responsible for the population of individuals under court supervision (i.e. probation, conditional release, and drug courts) and the Department of Public Safety, which is responsible for the population of incarcerated individuals. The Judiciary’s First Circuit Mental Health Court (MHC) was established in response to the overrepresentation of people with mental illness in the criminal justice system, and the difficulties associated with managing this population. Defendants with mental illness released to the community on supervision have difficulty adhering to the terms and conditions of probation. This population has extensive treatment and service needs that require supervision strategies that traditional courts are not designed to provide. The First Circuit MHC redirects offenders from jail to community-based treatment with intensive supervision to ensure public safety and to support the recovery of defendants diagnosed with serious mental illness.

In this collaborative program, community treatment providers offer specialized care for participants requiring psycho-social rehabilitation, psychiatric treatment, substance abuse recovery, and other individualized treatment. Upon admission to the MHC program, participants redirected from incarceration to treatment receive multiple benefits that may include treatment and supervision support, reduced jail sentences, and possible early termination of probation or dismissal of charges.

The Community Outreach Court administered and operated by the Judiciary in the City and County of Honolulu was established in 2017 and has received funding from the legislature for a pilot project. Its goal is to help nonviolent offenders who face problems such as drug abuse and mental health challenges to obtain basic services and necessities, like food, shelter, and treatment, thereby reducing crime and recidivism. Many of those arrested for offenses such as drinking liquor in public, being in public parks after hours of closure, and camping on sidewalks, beaches, and other restricted public places do not appear for their court hearing which leads to the issuance of bench warrants for their arrest.

Once these individuals are brought into court, the sentences imposed are often monetary fines, as the offenses are not usually serious enough to warrant incarceration. However, most have little or no income and are unable to pay the fines. This noncompliance leads to another bench warrant, which repeats the cycle and keeps them in the system without offering any rehabilitative measures. In addition, the prosecution of these cases burdens and congests the court system without producing a meaningful resolution that will prevent recurrence of the offenses.

The Community Outreach Court is intended to function as a mobile justice system by traveling to neighborhoods and resolving cases against individuals who may be experiencing psychological conditions that make it difficult for them to attend a traditional court setting or pay imposed fines. The community court is also intended to impose alternative sentences such as community service and mandatory participation in programs deemed appropriate for individual offenders based on their need for specific mental health services, substance abuse treatment, sustenance, and shelter.

STRENGTHS OF THE SERVICE SYSTEM

After several years of stability with its recently retired administrator, the Adult Mental Health Division (AMHD) is currently undergoing a major transitional period as it undergoes a change in leadership, staff changes, and re-organization of its programs. There, however, remain a few programs that can be categorized as strengths of the service system:

TELEHEALTH
The AMHD has been utilizing telehealth across the public mental health system to meet the needs of individuals who are unable to meet in person with a psychiatrist. There are plans to expand this program during FY2020-2021. While telehealth opportunities are still in the formative stages, during the 2019 Legislative Session lawmakers approved a bill to give the state direction in promoting telehealth adoption and reducing barriers that have kept healthcare providers from embracing connected care. It is now a policy of the State of Hawaii to promote telehealth to deliver healthcare from a distance as an effective way of overcoming barriers to accessing care, and particularly for communities located in rural and remote areas of the state.

E-ARCH PROGRAM
The AMHD Expanded Adult Residential Care Home (E-ARCH) Program was initiated as a continuity of care project to address the rising census at the HSH. The program focused on discharge of patients residing at Hawaii State Hospital (HSH) who did not meet acute psychiatric criteria yet had no appropriate AMHD funded level of care for discharge. On a case-by-case basis, usually because of forensic encumbrance, other facility referrals have been approved for the AMHD E-ARCH Program consumers admitted to Kahi Mohala, Licensed Crisis Residential Services (LCRS), Specialized Residential Services Program (SRSP), and other hospitals including Castle Medical Center, the Queen’s Medical Center, and PaliMomi Medical Center.

Currently there are 40 consumers participating in the AMHD E-ARCH Program. There are approximately 27 licensed E-ARCH care givers and five private pay RN case managers contracted with AMHD for this service. Education and training continue to be provided to the care giver, their staff and the private pay RN case managers. Course topics on therapeutic relationships, boundary setting, psychiatric diagnoses, co-morbidity, community risk assessment, and self-defense are taught by seasoned professionals including psychiatrists, psychologists, nurses, and community leaders.

COORDINATED ENTRY SYSTEM
A strategy that houses people by priority and allows communities to prioritize scarce housing resources for those with the greatest and most immediate needs is the coordinated entry system. The coordinated entry system is a cohesive system that enhances the quality of client screening and assessment, which is achieved via a user-friendly Homeless Management Information System (HMIS) system that allows for customized and automated client assessment referral and secure data sharing. This program has been recognized for reducing system-wide fragmentation in ending and preventing homelessness. Its commitment to streamlining the process for all HUD-designated subpopulations and accessing resources to end homelessness.
HOW THE AMHD SYSTEM ADDRESSES THE NEEDS OF DIVERSE POPULATIONS IN HAWAII

The AMHD offers a wide range of behavioral health services, and the continuum of care spans from services that are more restrictive to those that are less restrictive. Services are provided to all eligible individuals including racial and ethnic minorities, the Lesbian, Gay, Bisexual, Transgender, and Questioning, plus (LGBTQ+) community, Native Hawaiian, and other historically underserved populations.

RACIAL AND ETHNIC MINORITIES
The AMHD served 7,633 consumers in FY2018, of which 10 percent\(^3\) were identified as Native Hawaiian and Other Pacific Islander. With limited resources and staffing, the AMHD focused on opportunities to integrate the needs of these minorities into existing programs.

According to the 2016 U.S. Census, approximately 26.7 percent of Hawaii’s population belong to a racial or ethnic minority group, Hawaiian or Other Pacific Islanders, Black or African American, Hispanic or Latino, and migrants covered under the Compact of Free Association (COFA). The race/ethnic group most commonly reported as experiencing more health problems than average was Native Hawaiian, followed by Other Pacific Islander.

According to the Healthcare Association of Hawaii’s Needs Assessment Report, two mental health indicators exhibit race disparities. In 2017, the largest disparity is for suicide death rate, where the Native Hawaiian/Other Pacific Islander group (31.2 deaths/100,000 population) had a rate three times higher than the overall population in the state (10.9 deaths/100,000 population).

In Hawaii, COFA migrants are primarily from the Federated States of Micronesia, Republic of Marshall Islands, and Republic of Palau. Under the compact, COFA migrants are allowed to receive Medicaid or low-income health care benefits; however, ten years ago, Congress withdrew the healthcare benefits. That has now placed an enormous burden on the approximately 15,000 Micronesians on the state healthcare system. As a result, uninsured Micronesians often use hospital emergency rooms for their health care needs.\(^4\) There have been reports of high rates of morbidity due to chronic diseases, such as diabetes, obesity, and tobacco in this population.

LGBTQ+ Community
The State of Hawaii has made tremendous progress in passing policies to protect LGBTQ+ people. Many recent policies, including marriage rights, parity in health insurance coverage, and protections from discrimination, are critical successes to be preserved, and current trends in policymaking are in alignment with the needs of the LGBTQ+ communities. For example, the Hawaii State Department of Health’s Tobacco Prevention and Education Program identified LGBTQ+ adults as a priority population to target for tobacco prevention and cessation resources in its recently released 5-year strategic plan. An effort to understand, address, and consistently monitor disparities in health risk factors and is being undertaken to achieve and maintain positive health outcomes for the LGBTQ+ population.

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3 2018 SAMHSA, Hawaii Uniform Reporting System (URS) Output Tables.

CHILDREN’S MENTAL HEALTH SYSTEM

Hawaii’s child serving system is generally centralized at the state level. For most operational areas, services are provided and funded by the state. Hawaii’s education, health and human services, labor, business and commerce, agriculture, public safety and regulatory functions are largely provided by state government. The four county governments, divided among the islands, provide services such as local law enforcement, criminal justice, emergency response, and infrastructure provision, such as roads and sewers. The counties provide limited health and human service programs.

Child & Adolescent Mental Health Division (CAMHD)

The Child and Adolescent Mental Health Division is charged to provide: 1) preventative health services for children and youth; 2) diagnostic and treatment services for emotionally disturbed children and youth; and 3) provide treatment and rehabilitative services for mentally ill children and youth. Such services are to be delivered at the earliest possible moment after the need for such services is established. All eligible children and youth between the ages of birth and seventeen (0 - 17) receive the necessary mental health services to ensure their proper and full development. (Hawaii Revised Statutes §321-171). The Child and Adolescent Mental Health Division is required to coordinate the effective and efficient delivery of mental health services to children and youth, including services provided by private nonprofit agencies under contract to the Department of Health, and be responsible for the development and implementation of centralized and highly specialized community-based programs for children and youth. Children’s mental health services are provided through a combination of public and private services. Direct services such as clinical oversight and intensive case management are provided by the state, while additional services are provided by a network of private providers under state contract.

The CAMHD through its seven Family Guidance Centers and a Family Court Liaison Branch, herein after referred to as “Branches”, provide case management services to youth and families statewide through the assigned Care Coordinator. In addition to the case management services, CAMHD employs licensed clinical staff who provide treatment and clinical oversight for their respective Branch. CAMHD also has the ability to procure needed services from its contracted provider agencies to meet the treatment needs of youth. CAMHD provides services to youth who a) have been certified as qualifying under the Individuals with Disabilities Educational Act (IDEA) for special education services and who are in need of related mental health services to benefit from their free and appropriate public education; and b) youth who meet the eligibility requirements for CAMHD’s Support for Emotional and Behavioral Development (SEBD) program.

CAMHD is committed to assuring appropriate and effective services for eligible youth and their families. Services are designed to support youth in their educational program, promote healthy functioning, increase independence, and to build upon the natural strengths of the youth, family/guardian and community. Families/guardians are expected to be active participants in the behavioral support process, given the overwhelming evidence that constructive family participation enhances their youth’s progress. Interventions are evidence-based and tailored to address the identified needs of the youth/family. Interventions/plans and progress/outcomes are regularly reviewed and modified, as needed, to effectively achieve goals.
ELIGIBILITY CRITERIA FOR CHILDREN'S MENTAL HEALTH SERVICES

CAMHD serves Hawaii youth with “high need” for mental health treatment services, sometimes referred to as youth who have Severe Emotional and Behavioral Disturbances (SEBD). To be eligible, youth must:

a. Meet criteria for a mental health diagnosis as determined by a Qualified Mental Health Professional (QMHP).
   i. The diagnosis must be listed in the Diagnostic and Statistical Manual of Mental Health Disorder, 5th Edition (DSM-5).
   1. Substance Use Disorders on their own do not qualify youth for CAMHD services, but they can co-occur with a psychiatric disorder.
   2. Youth who have moderate to severe Developmental Disabilities are not eligible for CAMHD services, but those with mild Developmental Disorders that co-occur with a psychiatric disorder may qualify.

b. Demonstrate significant functional impairment. This means the youth is showing significant difficulties functioning in several life domains.
   i. CAMHD uses the Child and Adolescent Functional Assessment Scale (CAFAS) to determine whether youth meet this criterion.

c. Be funded by one of the following:
   i. Their QUEST-Integration insurance or
   ii. Office of Youth Services (OYS) through a referral from their probation officer or and Director of OYS staff or
   iii. Special Education/General Funds through a referral by their DOE Individual Educational Program (IEP) Team or
   iv. By qualifying for a special CAMHD grant project. Current projects offering free services for qualified youth include:
      1. Kealahou Services for girls on Oahu who have experienced significant trauma or
      2. On Track Hawaii program for youth and young adults who have a psychotic disorder

More information about these grant funded programs and their admission criteria can be obtained by calling the CAMHD Clinical Services Office (808-733-9856).

ELIGIBILITY AND CO-OCCURRING DISORDERS

Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, mild intellectual impairments, secondary diagnoses of developmental disorders, or medical impairments (e.g. blindness, deafness, diabetes, etc.) The presence of co-occurring disorders is assessed with all youth at the point of initial assessment, as well as routinely during the course of ongoing treatment. CAMHD does not provide services that are appropriate for youth with moderate or severe intellectual disabilities or severe autism spectrum disorders. Youth with mild intellectual disabilities and pervasive developmental disorders that are co-occur with a diagnosed mental health disorder may be eligible for CAMHD in-home supports and treatment services.
It is required that all contractors will provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments.

MENTAL HEALTH SERVICES FOR CHILDREN

EMERGENCY MENTAL HEALTH SERVICES

24-Hour Crisis Telephone Stabilization: This service serves all youth whose immediate health and safety may be in jeopardy due to a mental health issue. Stabilization provides consultation, referral and the necessary support to dissipate the crisis situation.

Crisis Mobile Outreach: This service provides mobile outreach assessment and stabilization services face-to-face for youth in an active state of psychiatric crisis. Services are provided twenty-four hours per day, seven days per week. Immediate response is provided to conduct a thorough assessment of risk, mental status, immediate crisis resolution/stabilization and de-escalation if necessary.

Therapeutic Crisis Home: Therapeutic Crisis Home provides short-term crisis stabilization interventions in a safe, structured setting for youth with urgent/emergent mental health needs. This service includes observation and supervision for youth who do not require intensive clinical treatment in a psychiatric setting and can benefit from a short-term, structured stabilizing setting. The primary objective of this service is to provide crisis intervention services necessary to stabilize and restore the youth’s functioning and return them to their natural setting.

EDUCATIONALLY SUPPORTIVE INTENSIVE MENTAL HEALTH SERVICES

Ancillary Services: Ancillary Services are supportive services that facilitate mental health treatment delivery as outlined in the CSP for time-limited interventions that are not available through existing contracted services. Examples include: transportation services, interpretive services, specific clinical services that are not available through contracted providers and special community programs or classes.

Respite Supports: Respite is the provision of care, arranged by the parent(s) of an identified youth(s) to provide relief to the parent(s)/primary caregiver(s) to help maintain the youth(s) in the home. Respite is integrated with other mental health services, as needed to promote coordinated, effective service delivery to the youth(s) and family.

Psychosexual Assessments: These assessments are specialized diagnostic and evaluation services involving a strengths-based approach to identify youths’ needs in the specific context of sexually abusive behaviors that have led to the youth being arrested, charged, or adjudicated for a sexual offense.

Functional Family Therapy: This service is an evidenced-based family treatment system provided in a home or clinic setting for youth experiencing one of a wide range of externalizing behavior disorders (e.g., conduct, violence, drug abuse) along with family problems (e.g., family conflict, communication) and often with additional co-morbid internalizing behavioral or emotional problems (e.g., anxiety, depression).
**MultiSystemic Therapy:** Multisystemic Therapy (MST) is an evidence-based time-limited intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior (including crimes against others and property, aggression and other disruptive behaviors, substance use, and status offenses such as truancy, and curfew violations). Treatment averages 60 hours, over the course of 3-to-5 months. MST treats the youth’s entire ecology (home and family, school, peers community) and aims to improve the following targets: 1) Keep youth in their homes, reducing out-of-home placements; 2) Keep youth in school; 3) Keep youth out of trouble, reducing re-arrest rates; 4) Improve family relations and functioning; 5) Decrease adolescent psychiatric symptoms; and 6) Decrease adolescent drug and alcohol use.

**Intensive In-Home Therapy:** This service is used to stabilize and preserve the family’s capacity to improve the youth’s functioning in the current living environment and to prevent the need for placement outside the home or a Department of Human Services (DHS) resource family home. It also may be used to re-unify the family after the youth has been placed outside the home, or to support the transition to a new DHS resource family for youth with behavioral challenges. This service is a time-limited focused approach that incorporates family-and youth-centered evidence-based interventions and adheres to CASSP principles. This service may be delivered in the family’s home or community. This service also assists families in incorporating their own strengths and their informal support systems to help improve and maintain the youth’s functioning.

**Intensive In-Home Paraprofessional Support:** This service augments Intensive In-Home (IIH) Therapy services by supplying trained paraprofessional personnel who provide intensive support to youth and caregivers for the purpose of averting treatment in a more restrictive environment such as a residential or inpatient treatment setting. This service is offered on a short-term basis, and it must include intervention services such as one-to-one skills training, supportive counseling, positive behavioral support, coaching, modeling, and data collection, along with enhanced supervision. These services must be provided in close accordance with specific goals and objectives as delineated in the youth’s Mental Health Treatment Plan. The Intensive In-Home Paraprofessional Support Worker (PSW) will work under the close guidance of the youth’s assigned IIH therapist. This is not a standalone service, and it may not be used in a school setting.

**Intensive Independent Living Skills:** A comprehensive treatment service provided to youth and young adults who need to work intensively on developing a range of skills to prepare for independent living. The youth or young adults live in his/her home setting while participating in the service. This service focuses on developing skills and resources related to life in the community and to increasing the participant’s ability to live as independently as possible. Service outcomes focus on maximizing the youth or young adults’ ability to manage their illness and their lives with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational, and vocational opportunities. The amount of time any individual spends in these services will vary, depending on the individual needs.

**Independent Living Skills Paraprofessional Support:** This service augments Intensive Independent Living Skills therapy by supplying trained paraprofessional personnel who provide intensive support for youth and young adults transitioning to independence. This service is offered on a short-term basis, and it must include intervention services such as one-to-one skills training, supportive counseling, positive behavioral support, coaching, modeling, and data collection. These services must be provided in close
accordance with specific goals and objectives as delineated in the youth’s Mental Health Treatment Plan. The Paraprofessional Support Worker (PSW) will work under the close guidance of the youth’s assigned IILS therapist. This is not a stand-alone service, and it may not be used in a school setting.

**Therapeutic Respite Home:** This service provides short-term care and supervision for youth with emotional and/or behavioral challenges in a supportive environment as a planned part of their treatment. These homes provide structured relief to the youth to prevent disruptions in the regular living arrangement. The goal of Therapeutic Respite Home services is to provide rest and relief to the youth and to help the youth achieve their highest level of functioning. Therapeutic Respite Home is not provided as a stand-alone service, and there is close coordination of this service with other on-going mental health treatment services.

**Multidimensional Treatment Foster Care:** An intensive evidence-based, family-based services provided in a foster family setting to youth with a history of delinquent and/or disruptive behaviors and emotional challenges. The two (2) major aims of MTFC are to: 1) create opportunities so that youth are successfully able to live in foster families rather than in group or institutional settings; and 2) simultaneously prepare parents, relatives, or other aftercare resources to provide these same youth with effective parenting so that positive changes made in the MTFC setting can be sustained over the long run. MTFC is an evidence-based treatment intervention which utilizes trained and supervised foster parents to: 1) provide youth in care with close supervision; 2) provide youth with fair and consistent limits and consequences; 3) provide a supportive relationship with the youth; and 4) minimize association with peers who may be a bad influence.

**Transitional Family Home:** An intensive, short-term community-based treatment service provided in a family home setting for youth with emotional and behavioral challenges. These homes provide a normative, community-based environment with therapeutic parental supervision, home structure, and support for youth capable of demonstrating growth in such a setting. This setting provides a supportive platform for family therapy and treatment to occur with the goal of reuniting youth with their family or other longer term family home. These youth are generally capable of attending their home school or an alternative community educational or vocational program. Such homes may also be beneficial for youth in transition from a more restrictive placement as these homes offer a family-like orientation. This level of care is appropriate for youth in need of treatment placements of six (6) to eight (8) months and/or shorter-term crisis stabilization of one (1) to three (3) months.

**Community-Based Residential, Level III:** Community-Based Residential programs provide twenty-four hour, seven days a week treatment and supervision in a safe and therapeutic environment. This service provides youth with integrated service planning to address the behavioral, emotional and/or family problems, which prevent the youth from taking part in family and/or community life. Services are provided in the context of a comprehensive, multidisciplinary and individualized treatment plan based on the youth’s clinical status and response to treatment. These programs are designed for those youth in need of a structured program that includes onsite education, diagnostic, and treatment services to enhance social skills and activities of daily living that cannot be provided in the community. The treatment primarily provides social, psychosocial, educational, and rehabilitative training and focuses on family/guardian reintegration. Active family/guardian involvement through family therapy is a key element of reintegration into home, school, and community life. Community-Based Residential programs may be specialized but all programs must treat mental health and substance abuse symptoms.
Community-Based Residential Level II (CBR II): This service provides twenty-four hour care and integrated evidence-based and best practice treatment that address the behavioral and emotional problems related to sexual offending, aggression or deviance, both adjudicated and non-adjudicated offenses, that prevent the youth from taking part in family and/or community life. These programs are designed for those youth who pose a moderate risk to the community and whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services.

CBR II provides support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth accept full responsibility and be accountable for sexually abusive or antisocial behavior; 5) identify and change cognitive distortions or thinking errors that support or trigger offending; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger re-offending and; 8) provide management of other behavioral or emotional problems including trauma resulting from prior physical, sexual, and/or emotional abuse.

Community-Based Residential Level I: This level provides twenty-four hour locked care and integrated evidence-based treatment that addresses the behavioral and emotional problems related to sexually aggressive or deviant offending behavior, which prevents the youth from taking part in family and/or community life. This program is designed for those youth who pose a high risk to the community and whose needs can best be met in a structured program of small group living that includes educational, recreational, and occupational services.

High Risk Community-Based Residential program Level I provides support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth display responsible and accountable behavior for sexually abusive or antisocial behavior with minimizing risk of reoffending and externalizing blame; 5) identify and change cognitive distortions or thinking errors that support or trigger offending ; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger reoffending and; 8) provide management of other behavioral or emotional problems.

Hospital-Based Residential: Hospital-Based Residential programs offer the highest level of intensive psychiatric and nursing intervention twenty-four hours per day, seven days a week. Hospital-Based Residential service consists of a full range of diagnostic and therapeutic services offered with capability for emergency implementation of medical and psychiatric interventions. This in-patient treatment is designed to treat youth with severe behavioral health conditions that requires rapid stabilization of psychiatric symptoms. This service is required to provide intensive evaluation, medication titration, symptom stabilization and intensive brief treatment of up to sixty (60) days. The highly structured program also provides educational services, family therapy, and integrated service planning through a multidisciplinary assessment of the youth and skilled milieu of services by trained staff. Services are provided in a locked unit of a licensed inpatient facility.

Mental Health Evaluation: This evaluation is a diagnostic assessment which provides needed information concerning a youth’s psychosocial functioning. This strengths-based assessment seeks to
identify the needs of the youth in the context of his/her family, community, school and/or current treatment program. This service includes interviews, use of assessment instruments, written reports, and feedback to the youth and the caregiver(s).

**Psychological Testing:** Psychological testing is performed as one component of a Mental Health Evaluation, and it is not authorized as a stand-alone service. Psychological testing is the use of one or more standardized measurements, instruments or procedures to observe or record human behavior, and requires the application of appropriate normative data for interpretation or classification. Psychological testing may be used to guide differential diagnosis in the treatment of mental health disorders and disabilities. Testing may also be used to provide an assessment of cognitive and intellectual abilities, personality and emotional characteristics, and Neuropsychological functioning.

**Summary Annual Evaluation:** This assessment is performed in order to describe the current status of the youth and his or her circumstances. It is performed yearly, when the Branch Clinical Lead determines that there are no clinical concerns that would call for a more in-depth Mental Health Evaluation. The service includes a brief assessment and report, with feedback to the youth and his/her parent(s) or guardian(s).

**Psychiatric Evaluation:** Psychiatric diagnostic examination, specifically completed by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist, includes history, mental status exam, physical evaluation or exchange of information with the primary physician, and disposition. This service is limited to an initial or follow-up evaluation for medically complex or diagnostically complex youth. This evaluation does not involve psychiatric treatment or medication management.

**Medication Management:** Medication Management is the ongoing assessment of the youth’s response to medication, symptom management, side effects, adjustment and/or change in medication and in medication dosage. Routine medication management is provided by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist or a Licensed Advanced Practical Registered Nurse with prescription privileges.

**Individual Therapy:** Individual Therapy is regularly scheduled face-to-face therapeutic services with a youth focused on improving his/her individual functioning. Individual therapy includes evidence-based interventions such as cognitive-behavioral strategies, motivational interviewing, psycho-education of the youth, skills training, safety and crisis planning, and facilitating access to other community services and supports. Data are gathered regularly through self-monitoring, parent monitoring, or frequent administration of brief standardized measures in order to track progress toward meeting treatment goals. These therapy services are designed to promote healthy independent functioning and are intended to be focused and time-limited, with interventions reduced and discontinued as the youth and family are able to function more effectively.

**Group Therapy:** Group Therapy is regularly scheduled, face-to-face therapeutic services for groups of three or more youth for the purpose of addressing symptoms/problems that prevent the development of healthy functioning in the home, school or community. These therapy services are designed to teach specific skills for addressing the symptoms associated with defined disorders or challenges, to provide support for the use of these skills and to provide psychoeducation about mental health issues. Group Therapy services are focused and time-limited. This service can include groups that address youths’
needs utilizing a “multi-family group” format, in which the parents or guardian attend the group along with the youth.

**Family Therapy:** Family Therapy is regularly scheduled face-to-face interventions with a youth and his/her family, designed to improve family functioning and treat the youth’s emotional challenges. The family therapist helps the youth and family increase their use of effective coping strategies, healthy communication, and constructive problem-solving skills. Data are gathered regularly through self-monitoring, parent monitoring, client/parent ratings or frequent administration of brief standardized measures in order to track progress toward meeting treatment goals. Family Therapy sessions may be held in the course of ongoing Individual Therapy with the youth in order to provide opportunities for the therapist to consult with the parent(s) or guardian(s) and review progress toward goals either conjointly with the youth present or separately without the youth present. Family Therapy services are designed to be time-limited with interventions reduced and then discontinued as the youth and family are able to function more effectively.

**Partial Hospitalization:** Partial Hospitalization is a non-residential day treatment program of a licensed Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certified hospital or behavioral health facility. The environment provides a highly structured, intensive milieu treatment with a focus on medical/psychiatric resources. This level of care provides stabilization of youth with serious emotional disturbances, therapeutically supported diversion from inpatient care, and restoration to a level of functioning that enables a youth’s return to the community. Partial hospitalization also provides supportive transitional services to youth who are no longer acutely ill and require minimal supervision to avoid risk. The primary goal of the partial hospitalization programs is to keep youth connected with his/her family/community while providing short-term intensive treatment.

**CAMHD’S CONTRACTUAL RELATIONSHIPS**
CAMHD provides an array of mental health services through its branches and contracted providers. Referrals are made to contracted provider agencies by the CAMHD Care Coordinator (CC) after a full review of the youth’s current strengths and needs as indicated by the admission criteria in the service specific standard as described in the Child and Adolescent Mental Health Performance Standards (CAMHPS). The CC ensures that services are initiated by the contractor in a timely manner as routine services must be initiated within thirty days. All contracted services require prior authorization from CAMHD before service can be provided. With the exception of Emergency Services that must be provided immediately. Without service authorizations Contractors cannot bill for services rendered. The CC is responsible to initiate prompt authorization of services.

It is expected that all youth will have access to needed services. The role of the CC is to make referrals to agencies based on a full review of the youth’s current strengths and needs and to ensure that services are initiated in a timely manner. If CAMHD youth from one island is referred to and accepted by an out of home provider on another island, CAMHD will pay for the travel costs for admission, discharge and for CAMHD Branch approved therapeutic passes.

**CONTINUITY OF CARE**
The DOH’s subcontractors are expected, and contractually required, to provide all youth accepted for contracted services with continuity of care until the youth meets the criteria for appropriate discharge or transition to another level of care indicated in team decisions.
STRENGTHS OF THE CHILDREN’S SYSTEM OF CARE

Commitment to the Hawaii CASSP Principles
Based on the input from youth, families and stakeholders, CAMHD adopted the Hawaii Child and Adolescent Service System Program (CASSP) Principles. Nationally, the CASSP principles (Stroul, B.A. and Friedman, R.M., 1986) were developed based on the original work of Jane Knitzer (Unclaimed Children, 1982) to provide a framework for systems of care. Early in the 1990’s Hawaii communities and stakeholders reviewed and adapted the CASSP principles to ensure the principles are culturally and linguistically relevant to our community:

Respect for Individual Rights: The rights of children and youth will be protected, and effective advocacy efforts for children and youth will be promoted.

Individualization: Services are children and youth and family centered and culturally sensitive, with the unique needs of the youth and family dictating the types and mix of services provided.

Early Intervention: Early identification of social, emotional, physical, and educational needs will be promoted to enhance the likelihood of successful early intervention and lessen the need for more intensive and restrictive services.

Partnership with Youth and Families: Families or surrogate families will be full participants in all aspects of the planning and delivery of services. As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.

Family Strengthening: Family preservation and strengthening, along with the promotion of physical and emotional well-being, is a primary focus of the system of care. Services that require removal of children and youth from their home will be considered only when all other options have been exhausted, and services aimed at returning the children and youth to their family or other permanent placement are an integral consideration at the time of removal.

Access to Comprehensive Array of Services: There will be access to a comprehensive array of services that addresses each child’s unique needs.

Community-based Service Delivery: Service availability, management and decision-making rest at the community levels.

Least Restrictive Interventions: Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs.

Coordination of Services: The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that children and youth can move throughout the system in accordance with their changing needs, regardless of point of entry.

Culturally Competent Services
CAMHD remains committed to ensuring that all services are provided in a culturally and linguistically competent manner. As a result of the unique and diverse nature of Hawai’i’s population, including over ten common non-English language-speaking subgroups, CAMHD staff and administration understand the importance of addressing cultural beliefs and differences and remain fully aware of the ways in which
the quality and effectiveness of mental health services are inherently tied to those beliefs and differences. Cultural competency is addressed with all of the providers within the CAMHD network and with all Division staff and administrators through training opportunities in this area as well as the provisions for cultural competence included in relevant policy and procedures, contract management standards, and parental rights brochures. In CAMHD’s Consumer Report, 96.1% of respondents reported the belief that services were culturally sensitive (the highest agreement ratings of all areas measured). CAMHD’s registered population is diverse and reflects the characteristics of the general population.

### CAMHD Youth National Origin and Race Fiscal Year 2018

<table>
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<th>National Origin (%) of Available</th>
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<td></td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>Black or African-American</td>
<td></td>
<td></td>
<td>2%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td></td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Other Race</td>
<td></td>
<td></td>
<td>0%</td>
</tr>
</tbody>
</table>

**CAMHD Clinical Model**

To ensure appropriate, effective and efficient treatment, CAMHD maintains clinical oversight of each youth served. Each youth is assigned a Mental Health Care Coordinator who will facilitate the planning, coordination of services and monitoring of treatment through consultation with the Branch Clinical Lead.

**Clinical Lead.** Within each Branch, a Clinical Psychologist and a Child Psychiatrist provide clinical direction to the treatment provided to youth through their collaboration and consultation with the youth’s assigned Care Coordinator. Clinical review by a psychologist or psychiatrist helps to assure that the services authorized are appropriate to address the youth’s difficulties and that they meet “medical necessity” criteria. Each youth will be assigned a “Clinical Lead” who will oversee their care and authorize services. The Clinical Lead’s involvement may also include consulting with the service provider to help with planning treatment and designing interventions for the youth in order to assure efficient, effective care.

**Intensive Case Management**

Within 48 hours of registration, youth at CAMHD are assigned a Mental Health Care Coordinator (MHCC) from their regional Family Guidance Center to provide intensive case management. The MHCC serves as the central point of contact for the delivery and coordination of mental health services to youth and the
family and ensures that needed services, interventions, and strategies are identified and delivered in a coordinated manner and in partnership with the families.

The MHCC is also responsible for engaging the youth and family, referring the youth for appropriate services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality services, and continuously monitoring the effectiveness of interventions. The youth’s MHCC is responsible for convening an initial Coordinated Service Plan meeting within 30 days of eligibility determination, or immediately, if the youth has immediate needs and assuring service delivery within 30 days of identification for routine services. When appropriate, responsibilities also include coordination of care with Family Court, the Department of Human Services (child welfare and Medicaid) and other state and community agencies. The MHCC is responsible for facilitating the integration, coordination, and monitoring of behavioral health services across programs and domains and to initiate necessary adjustments to services when needed through the team based process. Parent Partners from the Family Support Organization are also available to provide peer support to parents. Contracts are responsible for coordination of services that are provided within their agency and regular communication about their services to the MHCC.

In order to assure youth-centered, culturally competent and effective services, MHCCs undergo internal training on engagement skills, intensive case management, coordinated service planning process, mental health assessments, Child and Adolescent Functional Assessment Scale (CAFAS), Ohio Scales, and Achenbach tools, evidence-based services and practice elements, and interagency performance standards and practice guidelines.

<table>
<thead>
<tr>
<th>Youth's Most Recent Primary Diagnosis (DSM-5) FY 2018</th>
<th>N</th>
<th>% of Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>75</td>
<td>4.8%</td>
</tr>
<tr>
<td>Bipolar and Related Disorders</td>
<td>16</td>
<td>1.0%</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>241</td>
<td>15.3%</td>
</tr>
<tr>
<td>Disruptive, Impulse-Control, and Conduct Disorders</td>
<td>378</td>
<td>24.0%</td>
</tr>
<tr>
<td>Neurodevelopmental Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder</td>
<td>326</td>
<td>20.7%</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>12</td>
<td>0.8%</td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td>3</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other Neurodevelopmental Disorders</td>
<td>3</td>
<td>0.2%</td>
</tr>
<tr>
<td>Obsessive-Compulsive and Related Disorders</td>
<td>6</td>
<td>0.4%</td>
</tr>
<tr>
<td>Schizophrenia Spectrum and Other Psychotic Disorders</td>
<td>22</td>
<td>1.4%</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>16</td>
<td>1.0%</td>
</tr>
<tr>
<td>Trauma- and Stressor-Related Disorders</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Adjustment Disorder

218 13.8%

### Posttraumatic Stress Disorder

143 9.1%

### Other Trauma- and Stressor-Related Disorders

18 1.1%

### Other Infrequent CAMHD Diagnoses

4 0.3%

### General Medical Conditions or Codes No Longer Used

95 6.0%

**Not Available (% of Total)**

796 (33.6%)

*Includes, but is not limited to, Dissociative Disorders, Elimination Disorders, Feeding & Eating Disorders, Gender Dysphoria, Neurocognitive Disorders, Paraphilic Disorders, Personality Disorders, "Other Mental Disorders," and "Other Conditions That May Be a Focus of Clinical Attention."

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**Data-Driven**

CAMHD’s emphasis on data-driven decision making is another strength. Service data is constantly analyzed to both ensure quality and identify needed areas of improvement. This is evident through an extensive library of relevant technical reports ranging from Quality Assurance programs, quarterly Interagency Performance Monitoring and Utilization Management Reports, Annual Fact books, Provider Reports, and Consumer Survey Reports. Data analyzed and presented in these reports have been published in peer-reviewed publications, presented at national conferences and posted online for public consumption. Also, results from these reports are not only presented to CAMHD’s various committees via hard copy and/or online, but are often presented to local stakeholders. Stakeholder interpretation of data often results in a different focus and priority, depending on the needs brought to light by the reports.

**Health Information Technology**

Over the past few years, CAMHD has made considerable progress in the area of Health Information Technology, especially with its implementation of the MAX Electronic Medical Records (EMR) system and Telehealth services.

CAMHD is developing, with the assistance of an outside contracted agency, a secure electronic medical records system that will provide real-time data-driven clinical decision making, quality assurance and improvement, data analytics, and billing capabilities. CAMHD has invested considerable time and expertise to design the new system to meet the needs of end users toward the goal of improving day-to-day practice and outcomes for the children and youth we serve. During the past year, while CAMHD was in the process of designing the system, staff and a few contracted providers served as beta testers to improve the workflow and utility of the EMR. Once the major kinks were resolved, incremental training of all of CAMHD’s direct service staff and providers began. Enhancements and streamlining of the MAX EMR system continues to evolve.

By providing Telehealth capability at each of the CAMHD’s Family Guidance Centers and major providers across the state, CAMHD will be able to increase access to care in remote/shortage areas and increase family contact and family therapy for youth and their families who are physically separated. This will benefit youth in residential placement on one island that have family members living on another.
Telehealth will allow the family to have some contact with the youth and will also provide an opportunity for the family to continue family therapy. The secure Telehealth system adheres to HIPAA privacy requirements. Another goal is to integrate Telehealth functions with Electronic Health Record operations. Not only will operations be more efficient but cost savings will arise from reducing travel costs as well as increase access to professional services from anywhere across the Telehealth network. Training sessions can also be hosted throughout the state using the videoconference system.

**Quality Assurance in Clinical Care**
CAMHD measures and tracks multiple critical clinical indicators for all clients with regard to client progress. CAMHD administers and monitors the Ohio Scales and CAFAS to measure improvements in client functioning, and tracks and evaluates reasons for discharges. To assure quality in provider services, CAMHD evaluates performance measures such as Client Satisfaction surveys, proportion of PDE utilization (as measured by the MTPS) and service utilization for evidence-based programs such as Multi-Systemic Therapy and Functional Family Therapy. To ensure person-centered care, CAMHD monitors grievances, sentinel events, seclusions and restraints, and number of families served by the Family Support Organization.

At the broader system of care level, as a result of the 1994 Felix Consent Decree, the Department of Education and Department of Health-CAMHD developed an interagency accountability system to monitor, evaluate, and improve the system of care. Around 2002, the Departments of Health and Education began meeting regularly to share information on the performance of their own systems as well as the interface between them. In 2004 the effort was expanded to include additional child-serving agencies into the Interagency Quality Assurance and Accountability System. More recently the group was renamed the Hawaii Interagency State Youth Network of Care (HI-SYNC) and its monthly meetings include representatives from Child Welfare Services, Family Court, Developmental Disabilities Division, Alcohol and Drug Abuse Division, Early Intervention Services, the Children’s Coordinating Councils Office, and Hawai’i’s statewide family organization. At the local level, district quality assurance teams meet monthly to review data and track improvement activities, while each “shared” child is reviewed at least quarterly. Annual case-based reviews are used to measure child status and system performance. A joint report, Hawaii Youth Interagency Performance Report (HYIPR) has already been issued. Currently, work is in process to formalize the working relationships into a new Memorandum of Understanding among HI-SYNC members.

**SERVICES TO ADDRESS THE NEEDS OF DIVERSE POPULATIONS**

**Services for Lesbian Gay Bisexual Transgender (LGBT)**
As a youth-serving organization, the children’s mental health division acknowledges that LGBT youth are in various stages of awareness and comfort with their sexual orientation and gender identity. Children’s mental health has non-discrimination policies in place regarding Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, 2 Spirit, *Mahu* and gender non-conforming youth. The policy and practice guidelines establish operational practices that reinforce commitment to respect and dignity to ensure that all people have equal access to all available services, placements, care, treatment and benefits without bias and in a professional and confidential manner. The highest quality of services will be provided regardless of their actual or perceived race, ethnicity, sex, immigration status, disability, national origin, sexual orientation, or gender identity or expression. All reasonable steps within our
control will be made to meet the diverse needs of all youth, employees, and contractors and provide an environment in which all individuals are treated with respect and dignity. Employees, volunteers and contractors use respectful language and terminology that does not further stereotype about LGBT people. Youth are allowed to dress and present themselves in a manner consistent with their gender identity. Grooming rules and restrictions, including rules regarding hair, make-up, shaving, etc. are the same for male and female units. Transgender girls cannot be required to have a male haircut or to wear masculine clothing. Transgender boys shall not be required to maintain a female hairstyle, to wear make-up, or to wear feminine clothing.

CAMHD also established a Safe Spaces Committee – a cohort of staff and community members whose mission is to create and maintain an LGBT-affirming system of care that promotes the use of inclusive language, encourages accepting attitudes, embraces diversity, and provides education to the greater community. The Committee spearheaded several initiatives in an effort to improve CAMHD services and the broader system of care for Lesbian, Gay, Bisexual, and Transgender, Questioning or Queer (LGBTQ) individuals. Accomplishments of the Committee include: 1) draft and champion the passage of Act 181, which changed the age of consent for mental health services from 18 to 14, aligning mental health age of consent with reproductive health services and substance abuse treatment; 2) established a non-discrimination policy for CAMHD; 3) created and distributed affirming, safe spaces posters to all CAMHD Family Guidance Centers; 4) maintains and disseminates an LGBT Youth Resource Brochure – currently assembling a neighbor island version; 5) sponsored CAMHD staff’s attendance at the 2015 and 2017 Building Competency in Serving LGBT Youth Conference; 6) presented to the Committee on LGBT Youth in the Juvenile Justice System; and 7) edited CAMHD forms, policies, and procedures to ensure they are LGBT inclusive.

Services for Co-occurring Disorders
Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, intellectual or developmental disabilities, or medical impairments. The presence of co-occurring disorders is assessed with all youth at the point of initial evaluation, as well as routinely during the course of on-going treatment. CAMHD does not provide services that are appropriate for youth with moderate or severe intellectual disabilities or severe autism spectrum disorders. Youth with mild intellectual disabilities and pervasive developmental disorders that are secondary to a diagnosed mental health disorder may be eligible for CAMHD in-home supports and treatment services. CAMHD requires all its providers to provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments. Youth with a primary diagnosis of substance abuse can access services from our sister agency, the Alcohol and Drug Abuse Division (ADAD). When necessary, ADAD has capacity available for residential treatment.

Services for Special Populations
Through agreement with the Adult Mental Health Division, CAMHD operates Hawaii’s Evidence-Based Program for Early Intervention to Address Early Serious Mental Illness. Through a contract with the University of Hawaii, Department of Psychology, CAMHD secured the expertise of a Clinical Psychologist experienced in the Recovery After Initial Schizophrenia Episode (RAISE) program. Dr. David Cicero of UH established a Coordinated Specialty Care clinic for adolescents and youth ages 15-24 for the prevention and early treatment of First Episode Psychosis. The clinic follows the empirically supported RAISE model. A multidisciplinary team provides a variety of services, including assessment, team facilitation,
psychiatric services, case management, individual cognitive behavioral therapy, individual resiliency training, psychosocial groups, family education and supported employment and educational services. Recently, assessment services were expanded to two neighbor islands, Kauai and Hawaii. At the end of June 2019, however, the Clinical Director, David Cicero, moved out of state and CAMHD is in the process of transitioning the program into an in-house, all-CAMHD staff model. The active cases continue to be served, but new enrollments have been put on hold. As the staff positions are filled, training on the evidence-based model and practices will be implemented. The transition may require revised policies and procedures, as well as a review of the legal issues. While CAMHD cannot project a timeframe for when the clinic will be fully operational again, we are committed to supporting this vulnerable population and re-establishing a First Episode Psychosis program for Hawaii.

CAMHD has 3 SAMHSA system of care grants to address the needs of specific populations.

**Kealahou Services (Hawaiian: Navigating Pathways to Healing)**
Kealahou Services focuses on improving the lives of girls who have experienced significant trauma. The program collaborates with Hawaii’s child-serving agencies, communities and families to help girls build and nurture healthy relationships that will allow them to reconnect with their families, communities and themselves. Kealahou Services provides one-on-one support to girls, assists girls in setting and accomplishing personal goals, and offers opportunities for girls to participate in social and cultural group activities that promote connection to family, community and self.

**Project Laulima (Hawaiian: Many hands working together)**
The purpose of Project Laulima is to develop more integrated and comprehensive services to children and youth with co-occurring mental health needs and developmental disabilities. The Developmental Disabilities Division and Child and Adolescent Mental Health Division of the DOH, the Department of Education, the Department of Human Services, and several family and youth organizations are brought together to work on improving collaboration and coordination to meet the multi-agency needs of children and youth with both mental health needs and developmental disabilities. Project Laulima focused on the development of new policies and programming, and providing service accountability. To support the work, activities such as community outreach activities, workforce development and comprehensive training initiatives were undertaken. Work from the grant has initiated a new service, Comprehensive Behavioral Intervention. Comprehensive Behavioral Intervention (CBI) is based on basic, well-documented approaches. Since then, over 45 youth have been enrolled.

**Kaeru (Japanese: Returning to a point of origin)**
Kaeru Services is specifically focused on returning youth from out-of-state residential treatment programs back to their home communities and preventing the future displacement of youth to out-of-state programs when possible. The program will utilize a combination of an intensive care planning process and a clinical intervention model. Implementing Kaeru Services will involve strengthening the infrastructure of the Hawaii’s child-serving system so that it better exemplifies system of care principles. This will include a better integration of family and youth voice and choice at all levels of the system, increased cultural and linguistic competence, and improved interagency collaboration.

The projected outcomes of this program include the successful return of youth placed in out-of-state placements; the reduction of future placements of youth in out-of-state care; a reduction in the cost
resulting from fewer out of state placements; improvement in the delivery of clinical services and improvement in quality of life outcomes.

CAMHD New Services
An exciting development is that a community-based residential level 3 (CBR 3) program was recently opened on the Big Island in East Hawaii. The residential program will provide 24 hour/7 days a week treatment and supervision of eligible boys on the Big Island in a safe and therapeutic environment with limited transitional support services to assure successful discharge. The program uses a family-focused, trauma-informed, non-coercive approach in the milieu with evidence-based individual, group and family therapy. The CBR 3 program provides youth and family with integrated treatment services to address the behavioral, emotional and/or family problems, which prevent the youth from taking part in everyday family and/or community life. The CBR 3 program is licensed for eight beds for boys between the ages of 12 to 18.

Another exciting development is a collaborative project to open a Residential Crisis Stabilization Program (RCSP). Hawaii’s children’s mental health, substance abuse, child welfare and youth service agencies came together around the issue of providing adequate services to youth experiencing a crisis. Several recent situations arose in which one or more of the state agencies had experienced major difficulty finding a safe way to care for and stabilize youth. The agencies, DOH-CAMHD, DOH-Alcohol and Drug Abuse Division, Department of Human Services Child Welfare Services and Office of Youth Services formed a Consortium to issue a Request for Proposal for services which would jointly fund the Residential Crisis Stabilization Program.

RCSP provides short-term crisis stabilization interventions in a safe, structured setting for youth with urgent/emergent mental health needs. This service includes observation and supervision for youth who do not require intensive clinical treatment in a psychiatric setting and can benefit from a short-term, structured stabilizing setting. The primary objective of this service is to provide crisis intervention services necessary to stabilize and restore the youth’s functioning and return them to their natural setting. The facility has 8 beds for youth who may pose a danger to self or others, is expressing some suicidal ideation or is engaging in some self-destructive or self-injurious behaviors or youth who evidence lack of judgement, impulse control, or cognitive/perceptual abilities.
Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:
This step should identify the unmet service needs and critical gaps in the state’s current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state’s M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state’s priorities and goals. This could include data and information that are available through the state’s unique data system (including community-level data), as well as SAMHSA’s data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative, HHS has identified a broad set of indicators and goals to track and improve the nation’s health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

Step 2. ANALYSIS OF UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM

Hawaii faces significant shortages and distribution challenges in its healthcare workforce which impacts access to care, the delivery of care, and ultimately health outcomes. Currently, the top challenges to healthcare in Hawaii is the challenge in recruiting and retaining professionals, such as physicians and nurses. In 2018, Hawaii was short more than 750 physicians across the medical fields according to University of Hawaii professor, Kelley Withy, who conducts an annual survey. This calculation accounts for a critical workforce shortage of physicians on the neighbor islands and the unique demands for medical specialties like psychiatry.

The shortage of psychiatrists across the state is especially seen on the island of Molokai where there is no psychiatrists, and Hawaii Island is so short on mental health resources that several Honolulu psychiatrists routinely fly there in an attempt to close the gap in access to treatment. In Honolulu, where most of the state’s psychiatry offices are concentrated, patient need at times outpaces practitioner availability.

Further, the local housing shortage is well documented as the availability of transitional housing and other community-based support services for those with behavioral health challenges is an ongoing challenge, and which translates into a large homeless population. Building the infrastructure and making available transitional housing and other community-based support services for those with behavioral health challenges will be an ongoing challenge for Hawaii in the years to come.

The Adult Mental Health Division (AMHD) utilizes prevalence data, behavioral health indicators, population estimates and outcome data to monitor unmet service needs and critical gaps in service. Some of the tools used are: the Uniform Reporting System (URS), the SAMHSA Mental Health Statistics Improvement Program (MHSIP), the Quality of Life (Interview) results, and the Behavior Health Barometer.

Unmet needs and critical service gaps across the AMHD System of Care identified were:

- Access to quality care in rural and geographically remote areas
- Lack of psychiatrists across the State
- Lack of hospital psychiatric bed availability for non-forensic consumers
- Transportation to access appointments and employment on the neighbor islands
- Consumers with private insurance don’t have access to Clubhouses
- Inconsistent quality of skills and vacancies among workers
- Develop, train, and sustain peer specialists in the workforce
- Need more group homes statewide
- Need integrated mental health services
- Lack of psychosocial rehabilitation services in the community to support consumers
- Lack of local detox facilities
- Need to create funding stream for gaps in care
- The need for Adult Residential Care Homes (ARCH) for the SMI population
- The need for a Skilled Nursing Facility

The AMHD will address most service gaps based on prioritization and availability of funds. Based on the unmet needs and critical service gaps, the AMHD made the following goals as the priorities to address the unmet needs at the local, county, and state levels. The main goals therefore are to:
- Address areas within the AMHD to improve operational efficiencies;
- Establish population-based services to promote recovery, resiliency and positive outcomes for individuals with SMI;
- Attract, recruit, and retain a competent, credentialed workforce; and
- Increase the engagement of consumers and access to services across systems for individuals with SMI.

Other areas under review are:

**Shortage of psychiatrists**
- The State is considering a collaboration with the University of Hawaii for Psychiatric Residency Training at the Hawaii State Hospital.
- The AMHD has been looking at using social media in its recruitment of psychiatrists by placing job announcements in professional publications on the mainland.
- The AMHD is seeking State and Federal financial incentives for the return of service in underserved areas.
- The AMHD is piloting the use of tele-psychiatry in several of its clinics.
- The AMHD is using Advance Practice Registered Nurses (APRN-Rx) to address the shortage of psychiatrists.

**Crisis Services**
- The State is looking into Urgent care for immediate follow-up, where there are up to three therapy sessions, full psychiatric work-up, medications/prescriptions and referrals for additional follow-up. This service will be located within a Crisis Triage Center or Crisis Stabilization Unit.
- Mental Health Emergency workers will be replicated for Hawaii, Kauai, and Maui counties. The basic framework for these emergency workers will be built into a Crisis Services contract.
- Since there are no crisis beds on Kauai, the development of a “Crisis Respite” model for individuals who need crisis services and who might be eligible for a Licensed Crisis Residential Services is being entertained.

**Case Management and Community Support Services**
- The Community Based Case Management service (CBCM) contracts are proposed to be changed to a maximum 1:24 staff to consumer ratio, versus the current maximum 1:30 ratio.
- The need for increased units of service (case management hours) is being addressed by requiring providers to track and report consumer acuity levels in order to justify increased case management units/hours.
- The AMHD plans to offer additional Representative Payee Services.
- A pool of qualified professionals has been expanded to include Advanced Practice Registered Nurse with prescriptive authority (APRN-Rx) to work in rural areas.
- The AMHD plans to allocate more CBCM slots on Kauai County.

**Community Housing Services**
- Implementation of new housing admission and continuing stay criteria will create movement of consumers through the service array toward more independent long term community housing.
- Re-visit long term strategy to ensure adequate movement of consumers through AMHD’s housing continuum.
• Decrease lengths of stay in 24-hour group homes statewide, and encourage greater movement to least restrictive and non-AMHD funded housing.
• Improve AMHD’s management of housing resources and promote increased presence in 24-hour group homes via on-site chart reviews and discharge planning.
• Develop tools/processes necessary to more accurately track current vacancies in 24-hour group homes as well as to assist providers with maintaining candidate waitlists which are reflective of AMHD priorities.

Psychosocial Rehabilitation Services
• Psychosocial rehabilitation programming will continue to be included in all case management contracts to increase rehabilitative capacity statewide.
• The Department of Health has placed hiring Clubhouse staff as a major priority for continuous recruitment and emergency hire.
• Efforts are underway to improve workforce development for current staff.
• Hire stable staffing that can develop jobs and provide job coaching skills to Clubhouse members, as well as, staff who are willing to work flexible hours to accommodate holidays and weekend hours.
• Look into refurbishing or purchase an apartment building for Clubhouse members on Hawaii Island.

Long Term Care
• The State is actively working towards building a 50-bed Skilled Nursing Facility.
• In response to Hawaii’s growing older adult population and co-morbidity of serious/chronic medical needs of the population, AMHD is working to offer Adult Residential Care Homes, who are specifically trained and mentored to address the needs of the fragile and/or elderly individuals with SMI.

CHILDREN’S MENTAL HEALTH UNMET SERVICE NEEDS AND GAPS

For the upcoming block grant period, the Child and Adolescent Mental Health Division (CAMHD) proposes the following priorities. At the time of this writing, however, CAMHD was in the process of recruiting a new Administrator. Once the new Administrator is formally appointed, CAMHD’s priorities may need to be adjusted.

• Increase access to mental health services for homeless youth
• Support recovery through family peer-to-peer support
• Sustain and expand evidence-based, trauma-informed mental health care
• Develop culturally-appropriate initiatives to meet the needs of LGBTQ populations
• Provide Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness
• Expand the use of interactive communication technologies to engage individuals and their families, and enhance communication among scarce resources
• Continue to expand the capacity of the electronic medical records system to improve clinical care and communication
• Incorporate resilience planning to promote self-direction in youth and young adults
• Expand on interagency partnerships and collaborations within the system of care
Houseless Youth
Despite the picturesque setting, and perhaps because of it, Hawaii is home to many people without a permanent residence. The cost of living and the cost of housing are among the highest in the nation. As wealthy people from across the ocean purchase luxury second and vacation homes, the locals are priced out of the housing market. One of the hardest hit ethnic groups is Native Hawaiians. Many Native Hawaiians have resorted to living in cars and beaches, taking their families with them.

According to The O’ahu 2019 Point In Time Count\(^1\), of the 4,453 homeless individuals on the island of Oahu on January 22, 2019, 24% (1,060) identified as experiencing a mental health issue that severely interferes with the quality of their daily life.

In addition to individuals, families experience homelessness. The total number of family individuals who experienced homelessness was 1,357. Fifty eight percent (58%) of homeless family members are Native Hawaiian/Pacific Islander, suggesting that family homelessness disproportionately affects the local indigenous population. An overwhelming majority of Oahu’s unsheltered homeless families (60%) are living on the Waianae Coast.

Among the homeless, 144 were unaccompanied youth between the ages of 18-24 and 37 were unaccompanied minors age 17 and under. The majority of unaccompanied youth identified as multiracial (51%) and Native Hawaiian/Pacific Islander (24%). The unsheltered population of unaccompanied youth are most likely to be staying on the Waianae Coast.

According to SAMHSA\(^2\), children experiencing homelessness also frequently experience the following:

- Hunger
- Poor physical and behavioral health outcomes
- Missed educational opportunities
- Instability at home and in school
- Family separation
- Violence

The Children’s Defense Fund (Children in the States 2019 – Hawaii) states that:

- Almost 3,000 Hawaii public school students were homeless in the 2016-2017 school year.
- In 2018, more than 3 full-time minimum-wage jobs were necessary for a family to afford a two-bedroom rental unit at fair market rent.
- In 2016, 18 percent of children lived in food-insecure households.
- 18 percent of Hawaii children relied on the Supplemental Nutrition Assistance Program (SNAP) to meet their nutritional needs in FY2017.
- 90 percent of Hawaii children receiving a free and reduced-price lunch during the 2016-2017 school year did not participate in Summer Nutrition Programs in 2017.

Since March 2009, CAMHD has supported the provision of mental health services to homeless children and youth on the Waianae Coast, including those who live on the beach. CAMHD has contracted with Catholic Charities to provide individual, group and family therapy and crisis management. All services

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are provided in a trauma-informed, culturally competent manner. In addition to providing access to basic needs such as food, clothing, hygiene and school supplies, staff empower the youth and their families in order to strengthen their support systems and their capacity to act on their own behalf.

CAMHD will continue to support this program with mental health block grant funds.

Family Peer-to-Peer Support
Families of children with behavioral, emotional and mental health challenges benefit from receiving peer support. Peer supports provide an enhancement to formal services to promote the health and wellbeing of children and families. Peer “Parent Partners” are seen as essential natural supports to caregivers and the entire family. Parent Partners are selected based on having similar “lived experience” of parenting a child with behavioral, emotional and/or mental health challenges. Hawaii’s Parent Partners help parents navigate the complicated child-serving system. Since youth may be involved with Child Welfare Services, the juvenile justice system, the DOE School-Based Behavioral Support or Special Education programs, as well as CAMHD services, it is helpful to have a navigator who understands and can interpret the disparate goals, timelines and terminology of the various agencies. Peer support programs connect families with other families experiencing similar challenges, who often become allies for each other. Parent Partners may provide family psychoeducational workshops and support groups which provide informational and emotional support.

The National Federation of Families for Children’s Mental Health asserts that the research finds that family peer-to-peer support improves outcomes for family members such as reduced parental stress, insecurity, and helplessness; improved motivational levels, patience, and tolerance; and an increased sense of empowerment.

Since the 1994 Felix Consent Decree (a class action lawsuit concerning inadequacies in the state’s education system and the related mental health services provided to children with disabilities) to the present, CAMHD has continuously partnered with a Family Peer-to-Peer Support program. CAMHD began its relationship with a family-run organization as a strategic component of Hawaii’s mental health “system of care”. Hawaii Families as Allies (HFAA) was one of the five original nonprofit family run organizations in the country. HFAA began in 1986 as a true grassroots organization started by families who knew that networking and sharing knowledge with other parents would help them help themselves and other families find success in parenting children with emotional, behavioral or mental health challenges. CAMHD contracted with HFAA from 1994-2016 and Child and Family Services from 2016-present to provide family support services. Those contracts have included both state and federal Mental Health Block Grant funds. CAMHD proposes to continue provision of this recovery-focused program.

Trauma-informed Services
Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse, and other types of trauma-inducing experiences. These experiences can initiate strong emotions and physical reactions that can persist long after the event and affect their daily lives. The National Child Traumatic Stress Network reports that traumatic reactions can include a variety of responses such as intense and ongoing

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emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, attention and academic difficulties, nightmares, difficulty sleeping and eating, and physical symptoms such as aches and pains. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as involvement with the criminal justice system.

CAMHD was granted a six-year SAMHSA grant to improve services and outcomes for CAMHD’s female youth with histories of trauma. These girls were at risk for running away, truancy, abuse, suicide, arrest and incarceration. Project Kealohou was a cross-agency effort among the state’s mental health, juvenile justice, education and child welfare systems to promote system of care principles of community-based, individualized, culturally and linguistically competent, family driven, youth-guided and evidence-based services. Project Kealohou developed trauma-informed and gender-responsive care for females ages 11-18 who had experienced psychological trauma. These services were Hawaii’s first set of services and strategies specifically designed to address the internalizing behaviors typical of females. Evaluation of the program showed significant improvements across multiple clinical and functional domains of service recipients. A financial analysis indicated that the outcomes were obtained with minimal overall increase compared to standard care alone.

CAMHD proposes to sustain the trauma-informed initiative by maintaining the trauma-specific treatments and strategies for girls with histories of trauma.

Culturally-appropriate LGBTQ services
Health disparities among sexual minority, transgender and gender non-conforming communities have become an area of increasing concern and focus at the national, state, and local levels. Improving the health, safety, and well-being of sexual minority, transgender and gender non-conforming individuals is a Healthy People 2020 goal. In 2011, the Institute of Medicine (IOM) released its first comprehensive Lesbian, Gay, Bisexual, and Transgender (LGBT) health report which recognized that sexual minority, transgender and gender non-conforming people “face barriers to healthcare that profoundly affect their overall well-being.”

According to the Department of Health’s Hawaii’s Sexual and Gender Minority Health Report (2017), sexual and gender minority youth often have to cope with the challenges of social stigma and discrimination. These youth may face neglect or abuse from their families and bullying from peers due to their sexual orientation. Not surprisingly, rates of depression and suicidality are higher among sexual minority, transgender and gender non-conforming youth. Sexual and gender minority youth who have been highly victimized are more than twice as likely to report being clinically depressed than other Lesbian, Gay, Bisexual (LGB) youth.

Hawaii’s LGB and questioning youth report a significantly higher prevalence of mental distress and suicidal ideation compared to heterosexual youth. The proportion of LGB youth who report feeling sad or hopeless for two or more weeks in the past year is almost twice that of heterosexual youth. Additionally, LGB and questioning youth are significantly more likely to have engaged in self-injurious acts such as cutting or burning, considered suicide, made a suicide plan, and attempted suicide in the past year than heterosexual youth. The prevalence of LGB youth who report that they have considered and attempted suicide is also significantly higher than questioning youth.
In September 2018, the Hawaii Department of Health released a first-of-its-kind study to assess the health of transgender youth of Hawaii. According to *The Hawaii Sexual and Gender Minority Health Report 2018*,

- Just over 3% (1,260) of public high school students in Hawai‘i identify as transgender.
- Transgender youth are nearly three times more likely to report binge drinking in the past month, compared to cisgender youth (those whose gender identities conform to their biological sex).
- One-quarter of all transgender youth said they have ever injected an illegal drug, versus only one percent of cisgender youth.
- Forty percent of transgender youth said they have been bullied on school property or online in the last year, compared to 23 percent of cisgender youth.
- One-quarter of transgender youth skipped school because they felt unsafe, compared to only seven percent of cisgender youth.
- Nearly 50 percent of transgender youth said they purposely hurt themselves in the past year, compared to 17 percent of cisgender youth.
- Half of transgender youth attempted suicide in the past year, compared to only eight percent of cisgender youth.
- Nearly half of TG youth live in unstable housing situations compared to only 6% of cisgender youth.

CAMHD proposes to engage the LGBTQ community to identify culturally competent strategies to promote access to mental health care for this underserved population.

**Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness**

CAMHD proposes to continue using block grant dollars to sustain a Coordinated Specialty Care program for First Episode Psychosis. CAMHD will be transitioning the program initiated by the University of Hawaii Departments of Psychology to an in-house model. CAMHD staff, including qualified mental health professionals and a child psychiatrist will continue to provide evidence-based therapeutic and assessment services to youth within the first two years of experiencing symptoms of psychosis. These services will be tailored to the needs of each individual, involve support from a multidisciplinary team and consist of individual and group therapy, medication management using the Shared Decision-Making Model, assistance and support to find a job or return to school and assistance and support for families.

**Interactive Communication Technologies**

Almost 40 percent of uninsured individuals are under the age of 30 and use technology as a substantial, if not primary, mode of communication. CAMHD proposes to expand its use of interactive communication technologies so that our communication with our target population will be more accessible and available. Currently CAMHD has active Facebook, Instagram and vimeo accounts. Last September 2018 during Suicide Prevention Month, CAMHD partnered with AMHD and the national Crisis Text Line to help spread the word about the Crisis Text Line, as well as help recruit more volunteer crisis counselors. Crisis Text Line is free, 24/7 support for those in crisis. People who text to the line are connected to live, trained crisis counselors who move texters from a “hot” moment to a cool calm, guiding them to create a plan to stay safe and healthy. The Crisis Text Line for Hawaii uses a unique, Hawaii-based keyword for Hawaii texters to use (and for us to track) which is “ALOHA”, texted to 741741. CAMHD utilizes telepsychiatry and ZOOM to conduct therapeutic and administrative meetings across the islands.
Technology is being developed daily. A recent news article at CNBC reported that State Farm insurance is working with Amazon on a new Alexa tool that helps people stay in contact with their aging family members:

“The skill, as Amazon calls Alexa apps, will allow owners of Amazon Echo Show devices to share alerts and check-ins so adult children and caregivers can know that their relatives are safe and in the right place. Along with a State Farm-developed mobile app, the skill creates “a virtual circle of support, coordination and communication at any time of the day while delivering a personalized experience to the senior.”

Innovations such as these could also benefit individuals suffering from depression, anxiety and social isolation.

Data and Information Systems
Timely, high-quality, ongoing and specific data help public health officials, policy makers and clinicians to understand mental health trends and how they are evolving; to inform the development of targeted interventions, focus resources where they are needed most; and to evaluate the success of response efforts.

CAMHD continues to work on increasing the capacity of its electronic medical records system to manage and analyze demographic data, treatment goals and targets, workflow processes and targets, clinical outcomes, and other data of the children and youth with serious emotional and behavioral health challenges. Having access to timely data is critical to improving clinical outcomes and reducing costly delays. Limited resources can be utilized in a more efficient manner, and youth will no longer get “lost” or “fall through the gaps” of the system.

CAMHD contracts with the University of Hawaii, Department of Psychology to help with the continual evolution of the electronic medical record system, as well as develop and disseminate effective data-driven products, resources, and tools to assist clinicians and policymakers to improve client, process and systems outcomes.

Sustaining System of Care Partnerships
CAMHD has been facilitating the Hawaii Interagency State Youth Network of Care (HI-SYNC) a collaborative group of Hawaii’s child-serving state agencies, including (but not limited to) the CAMHD, Family Health Services Division, Early Intervention Section (EI) & Developmental Disabilities Division (DDD), the Department of Education’s School Based Behavioral Health (SBBH) and Special Education (SpEd) Services, the Department of Human Services’ (DHS) Child Welfare Services (CWS) and Office of Youth Services (OYS), and the Hawai’i State Judiciary’s Family Court. The group is convened monthly to discuss barriers and improvements to the state system of care. The Hawaii Interagency State Youth Network of Care (HI-SYNC) collaborative partnership of child-serving agencies is an active and effective body. For example, in the 2018 legislative session, the CAMHD supported House Bill 2364, a measure introduced and passed by the Office of Youth Services, aimed at (1) establishing the Kawailoa Youth and Family Wellness Center and (2) transforming the approach of juvenile justice to a therapeutic model. In initial discussions with OYS, CAMHD identified several potential opportunities for CAMHD involvement at the Kawailoa facility, including possible collaboration with OYS to develop a request for proposals process and contract with outside agencies for behavioral and emotional health services and possible provision of certain types of intensive evidence-based treatments to youth clients (21 years and under) at Kawailoa, presenting with high-risk behaviors (e.g., suicidality, substance use, aggression).
The collaborative supported by all members. During the 2018 legislative session, a concurrent resolution was introduced to permanently establish the HI-SYNC, develop regionally-based multi-agency committees across the state and legitimize the need for an interagency network to address complex needs of families within the state. The measure was supported by all the members and successfully passed.

Within HISYNC, the issue of providing adequate services to youth experiencing a crisis had been a focus of the group. There had been situations in which one or more of the HISYNC members experienced major difficulty finding a safe way to care for and stabilize a youth. This led to an agreement between CAMHD, the Alcohol and Drug Abuse Division, Child Welfare Services and the Office of Youth Services formed a Consortium to jointly fund a new program, the Residential Crisis Stabilization Program.

**Transition Age Youth**

According to Youth.gov, when youth age out of the child-serving system, they are at increased risk of the following challenges:

- Unstable housing or homelessness
- Lack of adequate education
- Lack of employment and job training
- Problems with physical health, behavioral health and general well-being
- Lack of access to health care
- Justice system involvement
- Lack of social connections

As youth mature and begin to age out of the children’s mental health system, the assigned CAMHD Care Coordinator works with the youth to develop an individualized transition plan for the youth’s future. These planning sessions are person-centered, self-directed and participant directed. CAMHD proposes to develop more robust supports for transition age youth.

Possible strategies may include:

- **Supportive Adults and Mentors.** Transitions are more successful when youth have strong connections with a trusted adult supporter. Connections to non-parental adults through informal mentoring is reported to enhance the outcomes of foster care youth in education/employment, psychological well-being, and physical health. Mentored youth demonstrate decreased participation in unhealthy behaviors such as unprotected sexual activity, alcohol and substance abuse, and delinquent activities.

- **Young Adult Support Group.** Provides connection to peer role models, mentors and peer networks with similar mental health needs. Provides opportunity to build positive relationships and support networks.

- **Youth Advocacy Group.** Opportunities to serve in leadership roles help youth develop the skills, experience and confidence for increased self-sufficiency and self-advocacy later in life.

- **Transition Supports.** Support recovery goals through the provision of goods and services identified in the recovery or resilience planning process.

**Strengthening Health Practitioner Training and Education**

Goal 5 of SAMHSA’S FY2019-2023 Strategic Plan is to improve the supply of trained and culturally competent professionals and paraprofessionals to address children’s mental health needs.
Hawaii, like the rest of the nation is in short supply of qualified mental health professionals. CAMHD proposes to invest in its current workforce by providing training and education in evidence-based clinical practice. With the continuing evolution of CAMHD’s electronic medical record, training will walk end-users through the newest improvements and enhancements.
### Planning Tables

#### Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area</td>
<td>Community-Based Services</td>
</tr>
<tr>
<td>Priority Type</td>
<td>MHS</td>
</tr>
<tr>
<td>Population(s)</td>
<td>SMI</td>
</tr>
</tbody>
</table>

**Goal of the priority area:**

Increase access to mental health services.

**Objective:**

To provide mental health services that individuals find accessible.

**Strategies to attain the objective:**

Monitor the number of consumers served in the Adult Mental Health system of care, compared to the prevalence of adults with serious mental illness.

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#### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Number/percent of adult receiving AMHD services.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>Unduplicated number/percent of consumers served by AMHD by age, gender, race/ethnicity, and by county. The baseline measure for SFY 2017-2018 is 7,510.</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>7,633 (SFY 2018 - 2019), AMHD failed to meet the targeted 5% increase.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>SFY 2019 - 2020 (To be determined)</td>
</tr>
<tr>
<td>Data Source</td>
<td>Census data for Hawaii. SAMHSA Uniform Reporting Service Tables.</td>
</tr>
<tr>
<td>Description of Data</td>
<td>Baseline SFY 2017 -2018 = 7,510 Year 1 SFY 2018- 2019 = 7,633 Year 2 SFY 2019-2020 = To be determined</td>
</tr>
</tbody>
</table>

#### Data issues/caveats that affect outcome measures:

---

<table>
<thead>
<tr>
<th>Priority #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area</td>
<td>Homeless Intensive Case Management Program</td>
</tr>
<tr>
<td>Priority Type</td>
<td>MHS</td>
</tr>
<tr>
<td>Population(s)</td>
<td>SMI</td>
</tr>
</tbody>
</table>

**Goal of the priority area:**

To decrease the incidence of arrests and hospitalizations for homeless individuals with a serious mental health condition, and to provide linkages to continuing supports.

**Objective:**

The Intensive Care Management team will provide supportive services 24 hours/days, 7 days/week through rapid response to emergent needs, assisting...
consumers in resolving crisis in the least restrictive setting and preventing the need for more intensive interventions.

**Strategies to attain the objective:**
- Decrease the rate of admissions to the system.
- Decrease the rate of hospitalization and arrests.
- Increase the number of permanent housing placements.

### Annual Performance Indicators to measure goal success

| Indicator # | 1 |
| Indicator: | Number of homeless individuals with arrests and hospitalizations. |
| Baseline Measurement: | Ensure homeless individuals have no arrests, emergency room visits and are placed in shelters or temporary to permanent housing. |
| First-year target/outcome measurement: | Decrease the number of arrests and hospitalizations by 50%. |
| Second-year target/outcome measurement: | Decrease the number of arrests and hospitalizations by 75%. |

**Data Source:**
- Electronic Health Records
- Homeless Management Information System

**Description of Data:**
- Baseline SFY 2017 - 2018 = 38 arrested, 20 hospitalizations out of 111 consumers (unduplicated).
- Year 1 SFY 2018 - 2019 = 12 arrested, 5 hospitalized out of 79 consumers as of May, 2019 (unduplicated).
- Year 2 SFY 2019 - 2020 = To be determined

**Data issues/caveats that affect outcome measures:**
Contracts to providers did not occur in a timely manner during SFY 2018-2019, which resulted in data for up to May 2019. New contracts occurred August 1, 2019.

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**Priority #:** 3

**Priority Area:** Hawaii Certified Peer Specialist

**Priority Type:** MHS

**Population(s):** SMI

**Goal of the priority area:**
To train individuals with lived experiences of mental illness to model recovery skills for their peers.

**Objective:**
Increase the number of Hawaii Certified Peer Specialists (HCPS) in Hawaii, and to increase the number of employed HCPS.

**Strategies to attain the objective:**
To offer an annual training with no out-of-pocket expenses; identify service providers who will employ the HCPS, and to work towards filling HCPS in their service structure.

### Annual Performance Indicators to measure goal success

| Indicator # | 1 |
| Indicator: | Increase the number of Hawaii Certified Peer Specialists (HCPS). |
| Baseline Measurement: | As of July 2017, there are 35 HCPS individuals who are currently working. The goals is to increase the number |
| First-year target/outcome measurement: | Increase the number of HCPS by 10%. |
| Second-year target/outcome measurement: | Increase the number of HCPS by 10%. |
Data Source:
Certified Peer Specialists examination data sheets.

Description of Data:
Baseline SFY 2018 - 2019
Year 1 SFY 2019 - 2020
Year 2 SFY 2020 - 2021

Data issues/caveats that affect outcome measures:
This performance indicator will need to be redone due to internal logistical errors. The HCPS trainings were not completed due to the approval by the State Comptroller were not completed in a timely manner during the original Baseline and first years.

Priority #: 4
Priority Area: Social Security Benefits
Priority Type: MHS
Population(s): SMI

Goal of the priority area:
Increase access to SSI/SSDI Outreach, Access, and Recovery (SOAR) income benefits.

Objective:
To increase the number of homeless individuals enrolled in the SOAR program.

Strategies to attain the objective:
- Mandatory for all homeless outreach workers to be certified in SOAR.
- Once staff is certified, they must submit at least two SSI/SSDI applications per month for processing.

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Increase the number of homeless individuals to obtain SSI/SSDI benefits.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>Each application submitted by case managers will be approved by the Social Security Administration.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>10 percent</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>10 percent</td>
</tr>
</tbody>
</table>

Data Source:
Baseline SFY 2017 - 2018 = 8
Year 1 SFY 2018 - 2019 = 5
Year 2 SFY 2019 - 2020 = To be determined

Description of Data:
Number of homeless individuals registered for SSI/SSDI benefits.

Data issues/caveats that affect outcome measures:
In SFY 2018 - 2019, the AMHD did not meet the targeted outcome measurement. Therefore, the AMHD Housing Service Coordinator will need to find new ways of encouraging providers to be more proactive in enrolling homeless individuals.

Priority #: 5
Priority Area: To fund those priority treatment and support services not covered by CHIP, Medicaid, Medicare or private insurance for low
income individuals and that demonstrate success in improving outcomes and/or supporting recovery.

Priority Type: MHS
Population(s): SED

Goal of the priority area:
Increase access to mental health treatment and support to houseless children and their families.

Objective:
Provide mental health treatment and support services to houseless children and youth.

Strategies to attain the objective:
Provide outreach, engagement and mental health services to houseless children and their families.

Annual Performance Indicators to measure goal success

| Indicator #: | 1 |
| Indicator:   | Number of houseless children and youth who are provided mental health services |
| Baseline Measurement: | 100 houseless children and their families |
| First-year target/outcome measurement: | 100 houseless children and their families will be identified and provided mental health services |
| Second-year target/outcome measurement: | 100 houseless children and their families will be identified and provided mental health services |

Data Source:
Catholic Charities Homeless Mental Health Supports annual program report.

Description of Data:
Number of houseless children who were provided individual therapy

Data issues/caveats that affect outcome measures:

Priority #: 6
Priority Area: To promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment.
Priority Type: MHS
Population(s): ESMI

Goal of the priority area:
To prevent or reduce progression toward serious mental illness

Objective:
Provide empirically supported comprehensive individualized treatment at an early age to reduce progression toward serious and persistent mental illness

Strategies to attain the objective:
Develop and offer empirically supported coordinated specialty care to adolescents and young adults soon after their first episode of psychosis

Annual Performance Indicators to measure goal success

<p>| Indicator #: | 1 |
| Indicator:   | Number of youth and young adults who received First Episode Psychosis services |
| Baseline Measurement: | 16 youth and young adults who received First Episode Psychosis services |</p>
<table>
<thead>
<tr>
<th>First-year target/outcome measurement:</th>
<th>16 youth and young adults who received First Episode Psychosis services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>16 youth and young adults who received First Episode Psychosis services</td>
</tr>
</tbody>
</table>

**Data Source:**
Child and Adolescent Mental Health Division’s electronic medical record

**Description of Data:**
- Number of youth assessed for the First Episode Psychosis program
- Number of youth enrolled in the First Episode Psychosis program

**Data issues/caveats that affect outcome measures:**
FF2020-21 data will be affected by the transition from a University contracted program to an in-house program at the Child and Adolescent Mental Health Division. The data will reflect a drop as new enrollments have been put on hold until the in-house CAMHD program is fully operational sometime after the Spring of 2020.
### Planning Tables

#### Table 2: State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

**Planning Period Start Date:** 7/1/2019  
**Planning Period End Date:** 6/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention*</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**</td>
<td>$383,306</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$64,397,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td>$600,000</td>
<td>$3,500,000</td>
<td>$0</td>
<td>$50,265,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td>$611,757</td>
<td>$1,000,000</td>
<td>$500,000</td>
<td>$58,839,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)***</td>
<td>$130,000</td>
<td>$1,500,000</td>
<td>$4,535,656</td>
<td>$21,185,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$0</td>
<td>$1,725,063</td>
<td>$6,000,000</td>
<td>$5,035,656</td>
<td>$194,686,000</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

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### Table 6 Non-Direct-Services/System Development [MH]

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$500,000</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$378,000</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$705,000</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$40,000</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$50,000</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$40,000</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$95,000</td>
</tr>
<tr>
<td>8. Total</td>
<td>$1,808,000</td>
</tr>
</tbody>
</table>

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

**Footnotes:**
Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “health system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care. Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with...
partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.


26 http://www.samhsa.gov/health-disparities/strategic-initiatives


Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

The Department of Health (DOH) has made it a priority to integrate behavioral health services into primary care settings where timely access to behavioral health services is needed. According to the Director of Health in 2018, the DOH planned to work with community partners to provide training and ongoing learning opportunities to improve the capacity of primary providers to screen for, identify, and address the behavioral health needs of patients they serve; implement systems change to facilitate seamless referrals between primary care providers (PCP) and behavioral health specialists for patients with serious mental health conditions; expand access to health information technology for PCPs and behavioral health providers to ensure timely sharing of patient information and care coordination; and strengthen the healthcare delivery system to support behavioral health integration.

The Adult Mental Health Division (AMHD) continues to implement the Living Well Hawaii Project to individuals with serious mental illness who receive services from the West Honolulu Treatment Services Section and the Central/Leeward Oahu Treatment Services Section of the Oahu Community Mental Health Center Branch in collaboration with the Kalihi-Palama Health Center. The project is the first primary and behavioral health care collaboration in Hawaii that utilizes an Integrated Care Management Team comprised of primary care staff employed by Kalihi-Palama Health Center (a private, non-profit, federally qualified health center) and the Department of Health’s behavioral health staff to embed primary care services into the Community Mental Health Center. Thus, the goal of the project is to improve the physical health status of people with mental illness and chronic, comorbid medical conditions by fully integrating physical and mental health services.

The Integrated Care Management Team is comprised of the consumer, the primary care provider, and the behavioral health providers who work with consumers who live with co-occurring mental health and substance use disorders. The nurse is responsible for supporting the work of the primary care provider by performing routine tasks and procedures such as measuring the consumer’s vital signs, administering medications and injections, recording information in medical record keeping systems, preparing and handling medical instruments and supplies, collecting and preparing specimens of bodily fluids and tissues for laboratory testing, and triaging the consumer’s primary healthcare needs in the absence of a primary care provider. A plan of care is then established to achieve physical and behavioral health outcomes.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The Hawaii Adult Mental Health (AMHD) provides services and supports through an integrated public-private partnership.
consisting of Purchase of Service (POS) contracted community-based agencies and state staffed Community Mental Health Centers. The AMHD’s delivery system is a coordinated system of care with capacity for crisis services, community-based services, and outpatient and inpatient services to address the needs of individuals and their families with mental illness and substance use disorders. Recently, the emphasis has been on establishing more uniform payment methodologies and contracts for publicly funded mental health and co-occurring substance use disorders.

To reduce fragmentation of services for individuals with serious mental illness and substance use disorders, the DOH and the Department of Human Services (DHS) have consolidated their behavioral health service provisions with the Comprehensive Community Services (CCS) program. The CCS program is a recovery focused, integrated behavioral health program that provides community based integrated services for individuals of all ages who need ongoing services for a mental illness and substances use disorder. CCS also provides a coordinated and comprehensive array of recovery services, treatment, and psychosocial rehabilitation services, such as, representative payee, supported employment and supported housing. The DHS has also shifted in the integrated system of care from pay-for-performance (volume), to pay-for-quality (outcomes).

Many youth receiving services from the Child and Adolescent Mental Health Division (CAMHD) have mental health disorders that co-occur with substance abuse, mild intellectual impairments, secondary diagnoses of developmental disorders, or medical impairments (e.g. blindness, deafness, diabetes, etc.) The presence of co-occurring disorders is assessed with all youth at the point of initial assessment, as well as routinely during the course of ongoing treatment. Youth with mild intellectual disabilities and pervasive developmental disorders that are secondary to a diagnosed mental health disorder may be eligible for CAMHD in-home supports and treatment services. All contractors are required to provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments. These services are funded through State dollars.

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? Yes ☐ No ☐
   b) and Medicaid? Yes ☐ No ☐

4. Who is responsible for monitoring access to M/SUD services by the QHP? The State Medicaid agency, Department of Human Services, MedQUEST Division, monitors access to M/SUD services for the Medicaid Managed Care Organizations.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? Yes ☐ No ☐

6. Do the M/SUD providers screen and refer for:
   a) Prevention and wellness education Yes ☐ No ☐
   b) Health risks such as
      i) heart disease Yes ☐ No ☐
      ii) hypertension Yes ☐ No ☐
      iii) high cholesterol Yes ☐ No ☐
      iv) diabetes Yes ☐ No ☐
   c) Recovery supports Yes ☐ No ☐

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? Yes ☐ No ☐

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? Yes ☐ No ☐

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions? During the 2019 Legislative Session, a Senate Concurrent Resolution was enacted for the Department of Health to convene a mental health and substance abuse parity work group to determine how the state can comply with and exceed federal mental health and substance abuse parity laws and regulations. The working group was requested to examine the following elements:
   • Coverage options, including mandatory coverage of mental illness and substance abuse;
   • Definitions of covered conditions and other terms necessary to implement the State’s parity laws;
   • Individual and small group plans;
   • Financial and durational limits on treatment;
   • Managed care;
   • Out-of-network coverage;
   • Adequacy of network provider panels;
   • Prescription medications;
   • Specific services for serious mental illness;
   • Oversight of implementation; and
   • Independent external review of claims.
10. Does the state have any activities related to this section that you would like to highlight?
   None at this time.

   Please indicate areas of technical assistance needed related to this section
   Technical assistance is not needed at this time.

   OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

   Footnotes:
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities\(^\text{42}\), Healthy People, 2020\(^\text{43}\), National Stakeholder Strategy for Achieving Health Equity\(^\text{44}\), and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)\(^\text{45}\).

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary’s top priority in the Action Plan is to “assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.”\(^\text{46}\)

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status\(^\text{47}\). This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations\(^\text{48}\). In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.


\(^{44}\) [https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf](https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf)

\(^{45}\) [http://www.ThinkCulturalHealth.hhs.gov](http://www.ThinkCulturalHealth.hhs.gov)
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

   a) Race
   • Yes ☐ No

   b) Ethnicity
   • Yes ☐ No

   c) Gender
   • Yes ☐ No

   d) Sexual orientation
   • Yes ☐ No

   e) Gender identity
   • Yes ☐ No

   f) Age
   • Yes ☐ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?
   • Yes ☐ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?
   • Yes ☐ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?
   • Yes ☐ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?
   • Yes ☐ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?
   • Yes ☐ No

7. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, \( V = \frac{Q}{C} \)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states’ use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA’s Evidence Based Practices Resource Center assesses the research evaluating an intervention’s impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA’s Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General, \(^{49}\) The New Freedom Commission on Mental Health, \(^{50}\) the IOM, \(^{51}\) NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). \(^{52}\) The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in “Psychiatry Online.” \(^{53}\) SAMHSA and other federal partners, the HHS’ Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA’s Treatment Improvement Protocol Series (TIPS) \(^{54}\) are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA’s Evidence-Based Practice Knowledge Informing Transformation (KIT) \(^{56}\) was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.
SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  
   - Yes  
   - No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   a) ☐ Leadership support, including investment of human and financial resources.
   b) ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☑ Use of financial and non-financial incentives for providers or consumers.
   d) ☐ Provider involvement in planning value-based purchasing.
   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
   f) ☑ Quality measures focus on consumer outcomes rather than care processes.
   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h) ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:


50 The President’s New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.


53 [Link to Psychiatryonline.org]

54 [Link to Store.samhsa.gov]

55 [Link to Store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf]
Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?
   - Yes ( )
   - No ( )

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
   - Yes ( )
   - No ( )

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   Hawaii has a coordinated specialty care clinic serving adolescents and young adults ages 15-24 for the prevention and early treatment of First Episode Psychosis. The clinic follows the empirically supported model provided by the Recovery After Initial Schizophrenia Episode (RAISE) program. A multidisciplinary team provides a variety of services. The specialty team provides the following components: assessment, team facilitation, psychiatric services, case management, individual cognitive behavioral therapy, psychosocial groups, family education and supported employment and educational services.

   According to the RAISE study funded by the National Institute of Mental Health, schizophrenia, which is characterized by psychosis, usually begins between the ages of 16 and 30. It develops in stages, and RAISE research has found that care provided at the earliest stage produces the best results.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?
In agreement with the Adult Mental Health Division, the Child and Adolescent Mental Health Division (CAMHD) is responsible for carrying out the Mental Health Block Grant mandate for an evidence-based practice for early intervention to address serious mental illness. It was felt that CAMHD, as the child-serving division, had the highest probability of identifying individuals earlier at a younger age and shortly after their first episode of psychosis. Based on the agreement, CAMHD expends not less than 10 percent of the total Mental Health Block Grant to Hawaii.

The Child and Adolescent Mental Health Division has contracts with the University of Hawaii Department of Psychology and John A. Burns School of Medicine, Department of Psychiatry for the provision of evidence-based services for youth and young adults who have experienced a first episode of psychosis. The University of Hawaii Department of Psychology developed the OnTrack Hawaii clinic for First Episode Psychosis in collaboration with the Department of Psychiatry, which provides the psychiatric services. The clinic is focused on the early assessment and treatment of youth and young adults experiencing their first episode of psychosis. The clinic follows the evidence-based RAISE (Recovery After Initial Schizophrenia Episode) model, which is a coordinated specialty care treatment program and provides comprehensive individualized treatment in the form of case management, supported employment and education, psychotherapy, family education and support, and primary care coordination. The John A. Burns School of Medicine Department of Psychiatry provides pharmacotherapy and other psychiatric services.

All services are tailored to support each client’s unique needs for recovery. Treatment plans are developed by employing the concepts of shared decision making and person-centered care. This allows the client to be a part of developing their comprehensive treatment plan.

Presentations and discussions about this new specialty service were held with CAMHD staff, including case managers, mental health supervisors and the clinical leads at each of the community-based CAMHD Family Guidance Centers around the state. CAMHD developed new procedures to refer eligible CAMHD youth to the OnTrack Hawaii program. Dialog was opened with other referral sources, such as the Adult Mental Health Division, hospital emergency departments, acute inpatient settings and community-based residential programs. Schools and community programs were also provided information about the program and referral processes. Several young adults in the program were referred by the counseling office of the University of Hawaii, and are continuing with their studies with the support of the First Episode Psychosis program.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ☑ Yes ☐ No

5. Does the state collect data specifically related to ESMI? ☑ Yes ☐ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☑ Yes ☐ No

7. Please provide an updated description of the state’s chosen EBPs for the 10 percent set-aside for ESMI.

The University of Hawaii, Department of Psychology, together with the Department of Psychiatry has implemented all of the RAISE model components, including individual resiliency training, supported education and employment, family psychoeducation and support, and medication management. The FEP clinic, which is the first of its kind in Hawaii, aims to help clients improve their quality of life by helping youth get back on track at work, school, and relationships with friends and family. Recently, the clinic expanded assessment services to two neighbor islands, Kauai and Hawaii.

A recent development is the departure of Dr. David Cicero, the Clinical Psychologist in charge of the OnTrack Hawaii program. Through his appointment at the University of Hawaii, Dr. Cicero recruited graduate students to work in the clinic to provide case management, supported education, and psychoeducation to the youth and family members. With the loss of the principal clinician over the project, CAMHD has decided to transition the program into an in-house model while adhering to RAISE fidelity.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state’s ESMI programs including psychosis?

Hawaii’s First Episode Program will undergo significant changes in the upcoming period. After spending several years in Hawaii, Dr. David Cicero, the young clinical psychologist in charge of the OnTrack Hawaii program decided to re-locate his young family back to the mainland.

For FFY2020-2021, Hawaii’s Coordinated Specialty Clinic will be transitioning from the University of Hawaii Departments of Psychology and Psychiatry to a team of Child and Adolescent Mental Health Division staff. With the departure of the University of Hawaii Psychology professor and his graduate students, CAMHD made the decision to transition the evidence-based Coordinated Specialty Care program to an in-house model. Qualified CAMHD staff, including clinical social workers and a psychiatrist were recruited to provide all the RAISE model components, including individual resiliency training, supported education and employment, family psychoeducation and support, and medication management. By utilizing internal staff, the FEP program will have a more stable staff core and increased cultural relevance and rapport with the service population. Our CAMHD staff tend to be homegrown and more firmly rooted in the islands and our unique culture. Previously the program relied on graduate students who rotated in and out every semester, so the revamped program will see less staff turnover, fewer interruptions in service and increased continuity of care. By internalizing the program, CAMHD will have better oversight at both the micro and macro levels. Additional staff positions may need to be established to increase 24/7 coverage for this high needs population and as we expand the program to serve our Neighbor Island youth.

New enrollments into the FEP program was put on hold and for now the active FEP cases have been transition to the youth’s own private providers. Many youth came into the program with their own psychiatrists and the FEP program coordinated care with
those providers.

The priorities for CAMHD are to get our staff trained in the RAISE model and to review the existing policies, procedures, forms, etc. and modify them to meet CAMHD’s standards as well as any regulatory standards and codes.

Another priority is to transition the record keeping system to CAMHD’s electronic health record system. At this time, the record system is in paper form and not linked with CAMHD’s electronic medical record. The CAMHD system will facilitate more efficient data capturing and client outcome monitoring to ensure program fidelity. It will also improve information sharing among the OnTrack program, CAMHD, and our other contracted mental health providers, especially when the youth transition between different levels of service.

9. Please explain the state’s provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

OnTrack Hawaii collected data on in suicidality, global functioning, identification, intake enrollment, improved symptoms, psychiatric hospitalizations, prescription adherence and side effects and school participation. OnTrack clients completed standardized assessments at several different time points throughout their treatment to track performance measures. Some of the tools and rating scales used are the Columbia Suicide Severity Rating Scale, Global Functioning Scale: Social and Role, PTSD Screening Questionnaire I & II and the Positive Negative Syndrome Scale.

During the transition of the FEP program to CAMHD, management will review and assess whether use of any or all of the tools and instruments will continue or if there will be modifications to better integrate with CAMHD’s protocols. CAMHD staff will also transition the University of Hawaii program from paper files to CAMHD’s electronic medical record system, MAX, similar to all other CAMHD programs.

10. Please list the diagnostic categories identified for your state’s ESMI programs.

Inclusion criteria for care from the OnTrack Hawaii clinic is a diagnosis of Schizophrenia, Schizoaffective Disorder, or Schizophreniform Disorder. Clients may be admitted to the program with other specified schizophrenia spectrum disorder and other psychotic disorder or unspecified schizophrenia spectrum disorder if deemed appropriate by the OnTrack director.

However, clients with other specific schizophrenia spectrum disorder, attenuated psychosis syndrome, are not eligible for the program as mandated by the Substance Abuse and Mental Health Services Administration.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:
5. Person Centered Planning (PCP) - Required MHBG

Narrative Question
States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person’s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person’s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person’s needs and desires.

1. Does your state have policies related to person centered planning?  
   - Yes  
   - No  

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.  
   n/a

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.  
   A person-centered approach is used when developing and updating the Individual Service Plan (ISP) of consumers. As much as possible, the plan builds on the consumer’s strengths and their capacity to engage in community activities while addressing their needs, preferences, choices, and abilities. Consumers are encouraged to actively participate in the planning, prioritization, implementation, and evaluation of services offered through Community Mental Health Center (CMHC) and Purchase of Service (POS) providers. They are also encouraged to articulate their wishes, hopes, and preferences.

   With their treatment team, consumers attend and participate in all ISP meetings including attendance by their psychiatrist and case manager. With their consent, supplementary support members (i.e. forensic coordinator, family and friends), are also invited to ISP meetings. The person-centered plan includes the following components:
   - Goals: expressed in first person statements and address problems, challenges, and needs;
   - Clinical goals: unique and understandable to the person served; and
   - Actions: identifies who will be responsible for assisting the consumer with each goal.

   For youth, the process is an individualized and ongoing process that is youth-guided and family/guardian centered. Mental health service planning supports the use of medically necessary evidence-based interventions in the least restrictive environment. As the youth transition toward adulthood, the goals of the planning revolve primarily around increasing independence.

   Strategies are included to address the following domains.
   - Living arrangement/personal engagement
   - Vocation/education
   - Mental health and medical care
   - Community/social experience
   - Financial support, and
   - Employment

   For youth, a personal Safety Plan is developed in collaboration with the youth and details his/her preferences for handling potential crises. The Crisis Plan documents the youth’s problematic behaviors, setting events, triggers, the youth’s preferred methods of calming and regaining control, and the steps his/her caregivers will take in the event that behaviors begin to escalate out of control. The Crisis Plan builds on available information about the youth and the youth’s personal Safety Plan.

4. Describe the person-centered planning process in your state.  
   Within seventy-two hours of admission to an Adult Mental Health Division funded program, an initial assessment that identifies and addresses the consumer’s immediate health and safety needs is developed. The initial assessment informs the consumer’s ISP and views the relationship with the consumer and family members as a partnership that supports the consumer’s hopes, dreams and goals. At a minimum, the ISP is reviewed by the case manager on a quarterly basis to determine if the goals and objectives meet the needs of the consumer based on the most recent clinical review of the service documentation and assessment of functioning. Based on the frequency of service provision, an ISP review is expected to be done when progress is determined, new opportunities for improvement emerge, and growth is observed through building upon existing strengths.
The discharge plan of the ISP incorporates a plan that describes transition from current services to other appropriate intensive services. It is summarized with an estimated timetable for achieving the goals and objectives in the service plan. Further, ongoing consultation with the consumer and person-centered planning team is assessed to assure that the consumer’s changing strengths, preferences, functional levels, and social and cognitive capabilities is addressed at the time of discharge.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not needed at this time.

Footnotes:
Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question
SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☐ Yes ☐ No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ☐ Yes ☐ No

3. Does the state have any activities related to this section that you would like to highlight?

   The Adult Mental Health Division’s (AMHD) core functions include setting service delivery standards; promoting practices that support recovery; person-centered planning; providing contractual and service delivery oversight; and ensuring that delivery of quality services is consistent for everyone who needs them. To achieve these functions, AMHD continues to strengthen its statewide structure for performance and contract management. This system utilizes an integrated, systematic and consistent approach to the management for individual contracts in order to evaluate statewide effectiveness of services, inform ongoing program methods to review service utilization, budgets, compliance with standards, and consumer outcome data.

   The AMHD adheres to all applicable purchasing and contracting laws of the State of Hawaii’s purchase of service system in the management of contracts. All providers of the Mental Health Block Grant funding are informed that they are receiving federal dollars. Providers, based on funding threshold, are also instructed of the A-133 audit requirements. Further, the AMHD conducts periodic contract management meetings with providers in which fiscal and programmatic information is integrated and reviewed to ensure compliance, opportunities for improvement are identified, and high performance is recognized. The AMHD conducts an annual review of the quality of the financial management systems of purchase of service providers. The majority of AMHD’s contracts are currently paid through various payment methodologies, including cost reimbursement and unit rate pricing. These payment methodologies are not based on an individual-based encounter or claims-based approach to payment, but rather on
costs that make up the program being purchased.

Fiscal monitoring of providers requires AMHD to conduct on-site reviews to: (1) ensure actual allowable expenses are being submitted for reimbursement, not budgeted expenses; and (2) the sub-recipients’ (that are nonprofit organizations) compliance with the Sarbanes-Oxley Act – with regards to the charging of auditors (partner or firm); 45 CFR Part 92.35 – with regards to debarred and suspended parties, and 45 CFR Part 92.36 (b) – with regards to conflict of interest situations.

Resolution of provider audit findings requires AMHD to: (1) maintain a tracking system of the MHBG sub-recipients’ Office of Management Budget (OMB) Circular A-133 audit reports; (2) follow-up on the audit reports with significant deficiencies that may impact AMHD’s programs; (3) issue a management letter within six months after receipt of the sub-recipients’ audit report; (4) ensure the sub-recipients take appropriate and timely corrective actions to resolve the deficiencies; and (5) consider whether the sub-recipients’ audit necessitate actions to be taken by AMHD.

CAMHD has a set of core components in our current system of care. These core components underlie the values CAMHD strives to operationalize in its practices. The CAMHD expects the same commitment from contractors to support these components in their respective practices. The core components are articulated in CAMHD’s Performance Standards (aka “Teal Book”), which every CAMHD staff person and contract must uphold.

Commitment to Evidence-based Practices
Mental health services provided within the CAMHD system are expected to be evidence-based. Interventions with youth are meant to incorporate elements of those treatments identified as most promising based on credible scientific data. The proposed array of services provides a medium through which evidence-based interventions can be applied at high levels of intensity and in a variety of settings, depending on the needs of the youth. The CAMHD regularly reviews, summarizes, and disseminates relevant research data to support agencies in their selection and implementation of services. All treatment planning for psychosocial and pharmacological interventions should stem from careful consideration of the most current research.

Commitment to Ethical Service Delivery
The CAMHD is committed to providing services in an ethically upstanding manner, consistent with the ethics codes of the American Psychological Association, National Association of Social Workers, American Psychiatric Association, and those of other national organizations relating to the provision of mental health services. The CAMHD employees and contractors are expected to provide services in a non-discriminatory manner, consistently maintain appropriate professional boundaries, regularly seek informed consent, and respect the youths’ and families’ rights, prioritizing the benefits to the client of any therapeutic intervention over personal or professional gain.

The CAMHD maintains commitment to serving all eligible youth, regardless of race, ethnicity, national origin, religion, culture, sex, sexual orientation, gender identity and expression, and disability. The CAMHD and its contractors continually strive to provide eligible youth and families with services sensitive to and nurturing of each individual and youth’s and family’s identity, language and culture. Services are to be provided in a youth and family centered culturally appropriate manner, and inclusive of the youth’s preferred name and pronoun.

Commitment to Quality
The CAMHD is committed to ongoing evaluation of performance, compliant billing practices, and the use of data to improve provider and CAMHD system development. Its quality improvement practices involve an extensive system for examining performance and using findings to make informed decisions about services and needed adjustments to program implementation. The CAMHD tracks and analyzes performance data across all aspects of service delivery and care. CAMHD uses this information to determine how well the system is performing for youth, how well contracted providers are serving the youth and how well youth are progressing. Services are monitored through tracking of trends and patterns found in utilization, outcome and satisfaction data, and examinations of practice and quality of services.

Commitment to Information System Performance
CAMHD is committed to the development of health information systems as tools to improve youth services. These systems are developed in alignment with healthcare policies at the national level. CAMHD system developments are aimed at the long-range goal of a paperless care system, a centralized electronic health record, efficient and immediate secure information sharing, availability of real time data for a variety of state array indicators (i.e. census, utilization, sentinel events, demographics, credentialing etc.), and efficient billing of services in compliance with national requirements and standards. These systems changes are to reach the goal of near-real time availability of information for decision-making by those providing services to specific youth, and managing the CAMHD systems of care as a whole.

Commitment to Providing Medically Necessary Services
CAMHD as a Medicaid Provider may only authorize treatment that is Medically Necessary and will use this definition of Medical Necessity to guide its service delivery:

a. The medical goods or services provided or ordered must:
   i. Be necessary to protect life, to prevent significant illness or significant disability;
   ii. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the enrollee’s needs;
iii. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational; Be reflective of level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide, and
iv. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee’s caretaker, or the provider.
b. "Medically necessary" or “medical necessity” for hospital services require that those services furnished on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished on an outpatient basis.
c. The fact that a provider has prescribed, recommended, or approved medical or allied goods, or services does not, in and of itself, make such care, goods or services medically necessary or a medical necessity.

Please indicate areas of technical assistance needed related to this section
Technical assistance is not needed at this time.

Footnotes:
Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
   Hawaii does not have any federally recognized tribes.

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?
   Please indicate areas of technical assistance needed related to this section.

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Footnotes:
Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question
Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Adult Mental Health Division (AMHD) state-operated Community Mental Health Center (CMHC) system provides mental health treatment, group and family treatment, medication monitoring, and case management services for adults, eighteen (18) years or older who have a serious mental illness (SMI) diagnosis and meet AMHD eligibility criteria. Many adults with SMI also have a co-occurring alcohol or substance use diagnosis. The CMHC system implemented an Integrated Dual Diagnosis (IDDT) treatment approach and maintains a close working relationship with chemical addiction service providers in the community where these individuals are referred for treatment. Other services that enable individuals with SMI to function outside of inpatient or residential institutions include outreach treatment services, housing recovery support services, and supported employment.

Examples of outreach treatment services include:
• Eligibility determination screening (information, referral, and linkage services);
• Crisis services;
• Psychiatric evaluation;
• Medication assessment and management;
• Case management assessment;
• Nursing health screening and medication administration, and monitoring;
• Other assessments as appropriate (substance abuse, forensic risk, trauma);
• Recovery (treatment) planning meetings;
• Individual/family/group psychotherapy;
• Wellness education and psycho-education support groups;
• Hawaii Certified Peer Specialist support and mentoring;
• Referrals for psych-social, skill building and transitional employment services;
• Ongoing communication/collaboration between the CMHC and other providers: e.g. Courts and Corrections, the Judiciary, hospitals, specialized treatment providers, housing providers, Social Security Administration (SSA), and third party payors; and
• Referral for transfer, discharge and follow-up.

Further, the CMHC system incorporated the International Clubhouse model into its provision of rehabilitation services. A primary focus of psychosocial rehabilitation services is to maintain clinical stability, support community integration and tenure and to improve the quality of life for adults with SMI to live in the community. Consumers who chose to be supported in their recovery through psychosocial rehabilitation and vocational training within the CMHC Clubhouse Programs (CMHC Rehabilitation Service Sections) are referred for membership while in the community and at any level of care within the AMHD system. Additional enrichment of the Recovery model is achieved through the support of Hawaii Certified Peer Specialists (HCPS). HCPS’ embody recovery principles and provide opportunities for role modeling, mentoring, relationship and community re-integration skill building through the sharing of their life experiences.

In Hawaii, it is always a goal and value to place children and youth in the least restrictive environment. Thus, the Child and Adolescent Mental Health Division (CAMHD) has a wide array of outpatient services.

Outpatient Treatment Services for Youth include:
• Ancillary Services
• Respite Supports
• Psychosexual Assessment
• Mental health Evaluation
• Psychological Testing
• Summary Annual Evaluation
Psychiatric Evaluation  
Medication management  
Individual Therapy  
Group Therapy  
Family Therapy  
Functional Family Therapy  
MultiSystemic Therapy  
Intensive In-Home Therapy  
Intensive In-Home Paraprofessional Support  
Intensive Independent Living Skills  
Independent Living Skills Paraprofessional Support

Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, intellectual or developmental disabilities, or medical impairments. The presence of co-occurring disorders is assessed with all youth at the point of initial evaluation, as well as routinely during the course of on-going treatment. CAMHD requires all its providers to provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments. Youth with a primary diagnosis of substance abuse can access services from our sister agency, the Alcohol and Drug Abuse Division (ADAD). When necessary, ADAD has some bed capacity available for residential treatment. Hawaii youth are not committed to the state mental health hospital.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

   a) Physical Health
   b) Mental Health
   c) Rehabilitation services
   d) Employment services
   e) Housing services
   f) Educational Services
   g) Substance misuse prevention and SUD treatment services
   h) Medical and dental services
   i) Support services
   j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
   k) Services for persons with co-occurring M/SUDs

   Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state’s case management services

The Adult Mental Health state operated Community Mental Health Center (CMHC) system is mandated to provide case management services. Case management services provide individualized, goal focused, recovery based outpatient clinical services which include care coordination activities that enable consumer to lead meaningful lives in the community. In the CMHC system, the case manager is the single point of accountability for facilitating and coordinating case management services, which enables the consumers to maintain their independence within the community.

The goal of case management services is to provide goal-oriented and individualized supports, which focuses on improved self-sufficiency for consumers served through assessment, planning, linkages, advocacy, coordination and monitoring activities. To achieve this, case management services are:

   • Consumer-centered, i.e., services are based on, and responsive to the needs of consumers rather than the needs of the system or the needs of providers.
   • Incorporated into consumers’ self-help approaches and are provided in a manner that allows the consumers to retain the greatest possible control over their own lives. As much as possible, consumers are to set their own goals and decide what services they will receive.
   • Culturally and linguistically sensitive. For example, services are available and accessible to all eligible-individuals regardless of race, age, gender, religion, sexual orientation and language.
   • Built upon the assets and strengths of the consumers in order to help them maintain a sense of identity, dignity and self-esteem.
   • The consumers’ Recovery Plan include, but not limited to, goals in the consumer’s own voice that are reflective of their needs, strengths, and short and long-term objectives.
4. Describe activities intended to reduce hospitalizations and hospital stays.

The state operated Community Mental Health Center (CMHC) system provides Jail Diversion program interventions to divert consumers with a SMI diagnosis who are charged with a misdemeanor and/or non-violent charges from incarceration and/or inpatient hospitalization. Consumers meeting Jail Diversion criteria are referred for approval by the court for community placement, treatment, and case management services. As a result of court involvement, a close working relationship exists between the CMHC case managers, CMHC Forensic Coordinators, the AMHD Courts and Corrections Branch, and the State of Hawaii Judiciary.

Another program intended to reduce hospitalization among individuals with SMI or co-occurring substance use disorder, is the Crisis Line of Hawaii. Services provided by the Crisis Line of Hawaii are intended to keep individuals out of the hospital by referring them to the most appropriate resources and services in the community including telephone support, assessment, diagnosis, crisis outreach and referrals to treatment. Other services provided include triage with county police officers and linkage to existing services such as case management. The Crisis Line of Hawaii staff are available statewide, 24-hours a day, seven days a week. A trained crisis intervention specialist provides telephone support and, when appropriate, will dispatch a crisis mobile outreach worker to the individual’s location. The AMHD contracts with private organizations in the community to provide an array of services to assist individuals in need.
of crisis intervention services including: Crisis Mobile Outreach, Crisis Support Management, andLicensed Crisis Residential Services. The services within the crisis services program are listed below:

Crisis Mobile Outreach (CMO): CMO provides assessment and intervention services for adults in an active state of crisis. This service is available statewide, twenty-four (24) hours a day, seven (7) days a week and can occur in a variety of settings including the consumer’s home, in the community, and in the emergency department. This service provides an opportunity for immediate crisis intervention and de-escalation thorough assessment of risk, mental status and medical stability, and exploration of service options in the community.

Crisis Support Management (CSM): CSM provides time-limited support and intervention services to individuals who are in crisis and not linked with services or who do not have a Division-assigned case manager. Services assist the individual in returning to a pre-crisis state and gaining access to necessary services.

Licensed Crisis Residential Services (LCRS): The LCRS offers short-term, acute interventions to individuals experiencing or recovering from a psychiatric or behavioral health crisis. This is a structured residential alternative or diversion from psychiatric inpatient hospitalization. LCRS services are for individuals who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances. This program provides services that address the psychiatric, psychological, and behavioral health needs of the individual.

Crisis Management Fund: This fund is used to provide short-term supplies of psychiatric medications, or crisis shelter when the LCRS is full or not appropriate for the case.

CAMHD and its contractors have procedures to ensure the safety and well-being of youth at all times. These procedures are designed to manage, control or alter potentially harmful conditions, situations, or operations including those leading to abuse, neglect and sexual exploitation, or induced by the youth’s high risk behaviors to prevent or reduce the probability of physical or psychological injuries to youth.

The Child and Adolescent Mental Health Division (CAMHD) makes every effort to place children in the least restrictive environment and limits lengths of stays to time frames that have been shown to maximize youth outcomes. CAMHD has analyzed its own local data to determine the appropriate and effective length of stay guidelines for each service in its array. By using local aggregate outcome data, CAMHD was able to determine the most appropriate time frame for each level of care, and incorporated them into the service reauthorization standards. The Child and Adolescent Functional Assessment Scale (CAFAS) and Monthly Treatment and Progress Summary (MTPS) data to analyzed to determine the time frame in which the majority of youth showed maximum improvement. This time frame serves as the threshold for which a second level of review is needed in order to continue the service, since only a minority of youth showed continued improvement beyond this point in time. The thresholds are used to guide treatment time frames. Treatment beyond any given threshold must have a Utilization Review Team review to ensure the youth will continue to benefit from further treatment. CAMHD Care Coordinators and contractors together plan the transition to the greater or lesser level of support and services.
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state’s M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>76,770</td>
<td>n/a</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>12,300</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Please see the Attachment Section for the Adult Mental Health Division’s response to Criterion 2.

For children, based on the literature, a conservative estimate of 5% of youth with SED yields an estimate of about 12,300 youth in Hawaii with SED (5% of the 246,002 youth in Hawaii between the ages of 5 and 19). Prevalence estimates provided to us by NRI (2017) estimates about 13,131 youth with SED in Hawaii.

For planning purposes, CAMHD’s Program Improvement and Communications Office (PICO) evaluates CAMHD’s population, services and outcomes. The evaluations focus on trends over time and whether the Division is making progress in improving key performance measures. CAMHD also partners with the University of Hawaii on multiple Health Information Technology and clinical improvements. In the past, the partnership has worked on translating systems data into actionable information and identifying predictors of client success or identifying early risk profiles for the purposes of improving clinical outcomes.
Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- a) Social Services
- b) Educational services, including services provided under IDE
- c) Juvenile justice services
- d) Substance misuse prevention and SUD treatment services
- e) Health and mental health services
- f) Establishes defined geographic area for the provision of services of such system
**Narrative Question**

**Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults**

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

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**Criterion 4**

a. Describe your state’s targeted services to rural population.

The Department of Health (DOH), Office of Primary Care and Rural Health coordinates federal, state, and local efforts aimed at improving the health of Hawaii’s rural and medically underserved populations. The office works with rural health partners to collaborate on recruitment and retention of health professionals for rural populations. Initiatives that are currently being addressed include promoting health networks, providing grassroots input into statewide health planning, and promoting the development of new services for rural areas.

The DOH definition of rural populations include the islands of Kauai and Hawaii Island (Big Island), as well as Maui County. Services are provided in rural areas through contracted purchase of service providers, the Adult Community Mental Health Centers (CMHC), the children's community-based Family Guidance Centers, mobile teams, and satellite clinics. Services are generally more decentralized, and outreach is more evident since transportation and distance are obstacles. These counties consistently experience health care staffing shortages including dentists, psychiatrists, psychologists, and social workers. Due to this staff shortage of both primary care physicians and psychiatrists to serve remote, medically underserved areas, a collaborative team process was developed with the Federally Qualified Health Centers (FQHCs) to allow individuals to get their medical issues addressed and, at the same time, get their mental health needs addressed.

To help with this staff shortage, Hawaii has turned to telehealth services. The DOH is now providing psychological services remotely via telephone, email, or videoconferencing. According to the Hawaii Business Magazine article (April 2, 2019), email usage has tripled and videoconferencing usage has increased 10 percent over the previous year. Clinicians found that by using telehealth, consumers have benefited from timely access to care, improved care delivery, higher levels of patient acceptance, expanded staff capacity, and cost savings.

b. Describe your state's targeted services to the homeless population.

Homeless individuals with serious mental illness (SMI) are one of the most vulnerable populations in our society. In and out of jails, prisons, hospitals, and emergency rooms, this group of individuals are often at risk for suicide, homicide, and abuse. Anecdotally, they often utilize the emergency room for mental health issues that could be treated through regular, preventive mental health care. Hawaii has also focused specific attention on the homeless population by developing specialized outreach and supportive housing services using state and federal funds.

For the State of Hawaii, there was a one percent overall decrease in the number of homeless individuals, which resulted in a five percent increase of unsheltered homeless individuals over sheltered individuals. In the 2019 Point-In-Time (PIT) homeless study, conducted on January 22, 2019, the total number of homeless individuals statewide was 6,448 compared to 6,530 individuals in 2018. The statewide decrease on Oahu and Maui County was one percent respectfully, and 21 percent on Hawaii Island). Kauai experienced an overall increase of 51 percent.

The AMHD supports several programs that provide outreach to homeless individuals with SMI, as well as individuals with co-occurring substance use disorders. The AMHD receives federal funding from the Substance Abuse and Mental Health Services Administrations (SAMHSA) through the Projects for Assistance in Transition from Homelessness (PATH) formula grant. This grant provides outreach to individuals with serious mental illness (SMI) experiencing homelessness or at risk of becoming homeless to assist in accessing housing, behavioral health services and other services to facilitate recovery and stabilization. Other AMHD’s programs have also helped to address eligibility for chronically homeless individuals into AMHD services by using a “Presumptive Eligibility” approach. The AMHD’s array of services support the best practice, “Housing First” model, and provides services including, but not limited to, dedicated “homeless preference” housing and representative payee services. The AMHD is dependent on PATH providers to be advocates of change by linking individuals who are experiencing homelessness.

According to the Oahu 2019 Point in Time Count taken on January 22, 2019, there are 4,453 homeless individuals on the island of Oahu. An overwhelming majority of Oahu’s unsheltered homeless families (60%) are living on the Waianae Coast. Twenty-four percent (1,060) identified as experiencing a mental health issue that severely interferes with the quality of their daily life. Among the homeless, 144 were unaccompanied youth between the ages of 18-24 and 37 were unaccompanied minors age 17 and under. The majority of unaccompanied youth identified as multiracial (51%) and Native Hawaiian/Pacific Islander (24%). The unsheltered population of unaccompanied youth are most likely to be staying on the rural Waianae Coast.

The children’s division will use block grant funding to provide targeted services to a rural, homeless population on the Waianae Coast. The AMHD supports the provision of mental health services to homeless children and youth on the Waianae Coast, including those who live on the beach. CAMHD has contracted with Catholic Charities to provide individual, group and family therapy and crisis management. All services are provided in a trauma-informed, culturally competent manner. In addition to providing access to...
basic needs such as food, clothing, hygiene and school supplies, staff empower the youth and their families in order to strengthen their support systems and their capacity to act on their own behalf.

A trauma-trained Social Worker provides individual, group and family therapy to the homeless children and their families. Eligible children have symptoms of mental illness that meet diagnostic criteria and affect their functioning in school and community. Typically, the children exhibit problems in emotion and behavior, and those issues are often related to attachment disorders, trauma and maternal depression. Parents and teachers report difficulties in dealing with these challenging behaviors. In 2018, 35 individuals were provided mental health crisis management services, 107 children attended group counseling sessions, 63 primarily Native Hawaiian individuals were provided case management services, and over 79 children were linked to mental health services, 50 children were linked to educational services and 106 families were provided referrals/linkages to other resources.

c. Describe your state's targeted services to the older adult population.

Hawaii's population, aged 65 years and older represent the fastest growing age group in the United States. By 2020, one in four residents of Hawaii will be 60 years or older (Hawaii State Plan on Aging). According to the Hawaii Department of Business, Economic Development, and Tourism (DBEDT), the state's elderly population, those 65 years and older, grew 33.7 percent between April 1, 2010, and July 1, 2018, with an average growth rate of 3.6 percent annually. Despite this increase, older adults represented 10 percent of those who received mental health services.

The Substance Abuse and Mental Health Services Administration (SAMHSA) Uniform Reporting System Report for 2018 shows that nationally 3.6 percent of individuals aged 65 and older received mental health services, while 1.5 percent who were 75 and over. In the same report, eight percent of Hawaii's residents aged 65 and older received mental health services, while 1.6 percent of the 75 or older group received mental health services. The results also show that 30-80 percent of individuals with substance use, who were admitted to substance use treatment, had a mental health diagnosis.

In summary, older adults in Hawaii receiving mental health services have shown increased likelihood of receiving case management services, decreased reporting of mental health symptoms, and decreased incidents and lengths of psychiatric hospitalization. Hawaii has found that community-based, multidisciplinary mental health treatment teams are effective with older adults. According to the 2018 Healthcare Association of Hawaii Community Health Needs Assessment, seniors are less likely to seek treatment from behavioral health professionals for many reasons. Some of these reasons are: 1) lack of knowledge about the effects of behavioral health treatment, 2) inadequate insurance, 3) shame, 4) trust and denial of problems, and 5) the stigmatizing impact of acknowledging a behavioral problem. Further, seniors living in poverty have greater likelihood of negative health outcomes, plus they may not have the means to afford care, thus, skipping appointments or foregoing mental health treatment.
Criterion 5

Describe your state’s management systems.

Please see the Attachment Section for the Adult Mental Health Division’s response to Criterion 5.

The Child and Adolescent Mental Health Division (CAMHD) is led by a CAMHD Administrator and consists of both line and staff offices. The staff offices are maintained at the state level with 82 positions. The line offices are organized into three (3) CAMHD branches consisting of an Oahu Services Branch, a Neighbor Island Services Branch and a Family Court Liaison Branch. The Oahu Branch and Neighbor Island Branch are further divided into seven (7) community-based Family Guidance Centers (FGCs). A network of approximately 16 contracted provider agencies located throughout the State provides an array of home and community-based and residential treatment services.

The CAMHD state office includes the Central Administrative Services Office, Clinical Services Office, Healthcare System Management Office and the Program Improvement and Communications Office.

The Central Administrative Services Office is responsible for budgeting, accounting, personnel resource management, and contracting. This section is also responsible for maximizing alternative funding sources, such as Title XIX, Title IV-E, and grants.

The Clinical Services Office has overall responsibility for providing clinical services, clinical leadership, oversight, technical assistance, and training to the CAMHD branches and contract providers to ensure evidence based practices are used and clinical services meet or exceed national standards; quality management responsibilities, such as monitoring the branches implementation of policies and procedures and assessing service capabilities; developing and evaluating the adequacy of and maintaining an array of behavioral health services with sufficient capacity and resources to provide clinically appropriate services to CAMHD consumers; assuring accountability for all professional services provided; and ensuring compliance to clinical standards for Medicaid behavioral health providers.

The Healthcare System Management Office is responsible for: providing understanding and knowledge of Medicaid and healthcare reform to the CAMHD staff; ensuring operations and business practices are developed, coordinated, structured, and maintained to comply with federal and state health records, billing and credentialing standards and requirements, to include maximizing on-going and alternative sources of funding to support an array of comprehensive mental health services to children, adolescents, and their families. This Office is also responsible for protecting system integrity, to include, reviewing and auditing coding practices and maximizing revenue generation; overseeing the CAMHD compliance with HIPAA federal and state requirements; developing and maintaining credentialing and privileging criteria for mental health professionals within CAMHD and external providers, to include ensuring system compliance with HIPAA and provider credentialing; and developing, implementing, maintaining, and monitoring the CAMHD quality assurance procedures. Under the Healthcare System Management Office, CAMHD’s Management Information System (CAMHMIS) provides the organizational foundation for CAMHD’s outcome tracking, utilization management, accountability systems, billing and general registration, as well as information technology initiatives, including the electronic health records system, and telehealth. The electronic health record is designed to support:

- Use of information to engage families in care;
- Improve quality, safety, and efficiency, leading to improved health outcomes;
- Support standardization of community-based operations,
- Increase revenue from Federal sources through increased accurate billing for existing services; and
- Support private insurance contracting for unique services.

The Program Improvement and Communication Office is responsible for: overseeing internal communications and communications that connect CAMHD to providers, the public, and government and private agency sectors; planning, developing, implementing, and reviewing written operational policies and procedures; developing, implementing, and maintaining a statewide reporting system; and conducting planning, grant writing, special studies, and research activities. The children’s mental health planner is housed in this Office and provides the planning, program development, contract management and budgetary oversight of the SAMHSA children’s mental health block grant; strategic planning, monitoring and reporting; and legislative policy analysis. The children’s mental health planner recently completed the development policies and procedures around the management of the Block Grant. The policies and procedures specify how the grant may and may not be used, the process to manage the contractual and fiscal obligations, the calculation of the maintenance of effort and the children’s set-aside.

Community-based Family Guidance Centers

The community-based Family Guidance Centers (FGCs) are responsible for providing high quality, culturally competent, evidence-based treatment services to eligible children and adolescents. The FGCs are strategically located in geographic areas that correspond with the Department of Education school districts. Three FGCs are located on Oahu, where close to 72% of the state’s...
population reside. Also, there is one FGC each on the rural neighbor island counties--Kauai, Maui, and the Big Island, with partial coverage for the islands of Molokai and Lanai. Most of the FGCs also have satellite offices. The geographic placement of FGCs and their satellite offices help to address the needs of Hawai’i’s ethnic and racial diversity, which differs by geographic location.

Each FGC is led by a Center Chief, and is staffed with a psychiatrist, one or more psychologists, a quality assurance specialist, a fiscal officer, and social workers and mental health care coordinators to provide intensive case management. Services provided by the centers include clinical team management, intensive case management, direct service provision, authorization for contracted services, and utilization and quality monitoring. The FGCs work in partnership with youth and their families to design and implement individualized service plans.

The Family Court Liaison Branch (FCLB) provides screening, assessment, evaluative, diagnostic, treatment, and consultative services to youth with mental health challenges in the state juvenile justice system. FCLB provides mental health treatment linkages between the Family Court, Hawai’i Youth Correctional Facility, and the State’s Detention Home. The FCLB works in partnership with families and the court system to design and implement individualized service and treatment plans suitable to the specialized needs of children and youth involved with the Hawai’i juvenile justice system. FCLB differs from CAMHD’s other branches because it does not have a geographical limitation, and provides direct services in collaboration with other state agencies and Family Court. FCLB staff spends considerable time and effort in conducting mental health assessments of youths at the direction of Family Court judges and in advocating for treatment of such youth in less restrictive settings, where appropriate.

Supervision
CAMHD is committed to quality service through regular, ongoing, strength-based, skill building supervision of all staff that provide direct services to youth. CAMHD and each Contractor shall have clear lines of accountability and a clearly described supervision structure for all employees and independent contractors.

Contractors must have policies and procedures and the mechanism to ensure supervision of all direct services and professionals by a Qualified Mental Health Professional (QMP) and paraprofessional staff by a QMP or a Mental Health Professional (MHP) who is supervised by a QMP. The Contractor is responsible for maintaining and tracking supervision records.

All personnel (employees or subcontractors) must have an individualized supervision plan based on a needs assessment completed annually by their respective supervisor. Documentation of individual supervision session must include dates and duration, name and credentials of supervisor, goals and interventions, and summary of the sessions. Documentation must be included in the individual’s supervision file and must include documentation of follow-up and consistency from previous supervision sessions.

Evaluation of Staff Performance
All CAMHD employees and Contractor shall have a process for evaluation of staff performance that includes a review of qualifications (i.e., an assessment of the employee’s capabilities, experience, and satisfactory performance), reports of complaints received including resolutions, corrective actions taken, and supports provided to improve practice and to continue to monitor the staff evaluation process.

Credentialing Requirements
CAMHD is committed to ensuring that staff is competent and qualified to provide the intervention/services to students/youth as evidenced by the following departmental credentialing requirements.

Credentialing requirements apply to all individuals providing direct services including subcontractors of a Contractor. All Contractors shall have written policies and procedures that reflect their responsibility to credential and re-credential their direct care staff, sub-contracted individuals, and clinical supervisory staff prior to provision of services. Contractors shall be guided by CAMHD’s credentialing policies and procedures in developing their policies and procedures. Primary sources of information shall be verified by Contractors as a function delegated by CAMHD.

CAMHD Care Coordination
All CAMHD youth have their services coordinated by a care coordinator to ensure timely, appropriate and coordinated service delivery.

The Care Coordinator (CC) is the case manager who is responsible for engaging the youth and family and assisting parents with coordinating the youth’s education, health care and mental health services. Parent Partners are also available to provide peer support to parents in this regard. CCs are responsible for referring the youth for appropriate CAMHD services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality services, and continuous monitoring of the effectiveness of interventions to assure that youth receive medically necessary care.

The CAMHD provides services and supports through an integrated public-private partnership consisting of contracted community-based agencies and state managed, community-based Family Guidance Centers, and a centralized state office to provide administrative and performance oversight functions. Most of the youth served by CAMHD attend public schools, and may be involved with the child welfare system, juvenile justice system, or other Dept of Health divisions, including the Alcohol & Drug Abuse Division, Developmental Disabilities Division, and Early Intervention Services. A large percentage of the CAMHD population...
in QUEST Healthplan (Medicaid) services, which requires linkages to primary care providers. The CAMHD system is committed to working with all other child-serving agencies to integrate services and programs across agencies in the best interest of the youth and their families.

Mental health services provided within the CAMHD system are expected to be evidence-based. Interventions with youth are meant to incorporate elements of those treatments identified as most promising based on credible scientific data. CAMHD's array of services provides a medium through which evidence-based interventions can be applied at high levels of intensity and in a variety of settings, depending on the needs of the youth. CAMHD regularly reviews, summarizes, and disseminates relevant research data to support agencies in their selection and implementation of services.
Criterion 2: MENTAL HEALTH DATA SYSTEM EPIDEMIOLOGY

Estimate of the Incidence and Prevalence in the State of Serious Mental Illness among Adults

Criterion 2 of the MHBG application is directed to discussion of the estimated prevalence of serious mental illness (SMI) in Hawaii and the quantitative targets to be achieved in the system care in Criterion 1. This is covered in the National Outcome Measure No. 1: Adults Receiving AMHD Services (Treated Prevalence). This discussion also includes statewide and county specific information.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommended estimated prevalence rate of SMI is 5.4 percent of the adult population nationally (June 24, 1999 Federal Register, Vol 64 No. 121 pages 33890-33897). Application of 5.4 Prevalence Percentage Rate of Hawaii’s SMI Adult Population is shown in Table 1.

Table 1
Estimate of Statewide Prevalence for Adults with SMI
FY 2017

<table>
<thead>
<tr>
<th>County</th>
<th>Adult Population¹</th>
<th>Estimated Adult SMI Prevalence (5.4%)</th>
<th>Number Served FY 2018²</th>
<th>Percent SMI Prevalence Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Total</td>
<td>1,421,658</td>
<td>76,770</td>
<td>7,633</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

Application of the 5.4 Percent Prevalence Rate of Hawaii’s SMI adult population by County, utilizing the latest available population figures by County and Age (2017) is shown in Table 2. According to the U.S. Census Bureau, the estimated 2017 state population has increased slightly, but the distribution of residents has remained the same from the 2010 Census. Oahu continues to be the home of nearly three-fourths (70%) of the state’s population (1,421,658 residents), while 13.8 percent live on the Hawaii Island (Big Island) (196,411 residents), 11.5 percent in Maui County (164,094 residents including Molokai, and Lanai), and 5.0 percent or 71,093 residents reside on Kauai. The prevalence rate shows that Hawaii Island had the highest percent of consumers served at 16.5 percent, followed by Kauai (15.8%), Maui County (11.8%), with Oahu having the lowest percent of consumers served (7.0%).

The AMHD system of care is only one part of the overall mental health system for adults with SMI. Significant numbers of individuals are also served through the private sector, Hawaii’s Pre-paid Health Insurance Act, and government insurance programs including Medicaid, Medicare, and MedQUEST. The preponderance of residency on Oahu necessitates a larger proportion of services to be delivered within the City and County of Honolulu, which must be balanced against provision of a comprehensive integrated system of care in all counties.

http://www.hawaii.gov/dbedt/info/economic/databook/db2017/section01.xls

² Statewide total is unduplicated; County data is unduplicated but is not additive to state total since some consumers move to a different county periodically.
Treated Prevalence

The number of individuals who received AMHD services in FY 2018 is reported in Table 3 by County and by Race/Ethnicity. The two largest populations served in the state by race/ethnicity are White (26.5%), and Asian (17.1%). Asians are more often served on Oahu (22.2%) and Kauai (16.0%) than in Maui County (12.4%) and Hawaii Island (7.7%). Whites are more often served on the neighbor islands (Hawaii Island (36.0%), Kauai (32.9%), and in Maui County (32.8%) than on Oahu (20.1%), which may reflect in-migration of this group during recent population increases to rural areas. The percent of Native Hawaiian/Other Pacific Islanders served commensurate on all the islands, although Oahu served 11.4% of individuals above the state average of 10.8%. For approximately one third (28.8%) of those served, information regarding race/ethnicity was not available.

Table 2
Estimated Adult SMI Prevalence by County, FY 2017, and Number Served FY 2018

<table>
<thead>
<tr>
<th>County</th>
<th>Adult Population 2017</th>
<th>Estimated Adults SMI Prevalence (5.4%)</th>
<th>Number SMI Served FY 2018</th>
<th>Percent SMI Served (5.4%) Prevalence of Each County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Oahu</td>
<td>990,060</td>
<td>69.6</td>
<td>53,463</td>
<td>10,606</td>
</tr>
<tr>
<td>Hawaii</td>
<td>196,411</td>
<td>13.8</td>
<td>10,606</td>
<td>1,746</td>
</tr>
<tr>
<td>Maui</td>
<td>164,094</td>
<td>11.5</td>
<td>8,861</td>
<td>1,044</td>
</tr>
<tr>
<td>Kauai</td>
<td>71,093</td>
<td>5.0</td>
<td>3,839</td>
<td>607</td>
</tr>
<tr>
<td>Statewide Total</td>
<td>1,421,658</td>
<td>100.0</td>
<td>76,770</td>
<td>7,633</td>
</tr>
</tbody>
</table>

Table 3
Adults Served by County/State and Race/Ethnicity, FY 2018 Uniform Table 2A

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>State</th>
<th>Oahu</th>
<th>Hawaii</th>
<th>Maui</th>
<th>Kauai</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>American Indian / Native Alaskan</td>
<td>49</td>
<td>0.6%</td>
<td>23</td>
<td>0.5%</td>
<td>15</td>
</tr>
<tr>
<td>Asian</td>
<td>1,302</td>
<td>17.1%</td>
<td>941</td>
<td>22.2%</td>
<td>135</td>
</tr>
<tr>
<td>Black / African American</td>
<td>199</td>
<td>2.6%</td>
<td>144</td>
<td>3.4%</td>
<td>26</td>
</tr>
<tr>
<td>Native Hawaiian / Other Pacific Islander</td>
<td>825</td>
<td>10.8%</td>
<td>481</td>
<td>11.4%</td>
<td>210</td>
</tr>
</tbody>
</table>
In 2017, SAMHSA provided a state-by-state-breakdown of the estimated prevalence of individuals diagnosed with a SMI. The estimate for Hawaii was 3.43 percent. The next table provides the percent served as revised by this 3.43 percent estimate.


**Table 4**

Estimated Adult SMI Prevalence by County, FY 2017, and Number Served FY 2018

<table>
<thead>
<tr>
<th>County</th>
<th>Adult Population 2017</th>
<th>Estimated Adults SMI Statewide Prevalence (3.43%)</th>
<th>Number SMI Served FY 2018</th>
<th>Percent SMI Served (3.43%) Prevalence of Each County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Total</td>
<td>1,421,658</td>
<td>48,763</td>
<td>7,633</td>
<td>15.7</td>
</tr>
<tr>
<td>Oahu</td>
<td>990,060</td>
<td>33,959</td>
<td>4,236</td>
<td>12.5</td>
</tr>
<tr>
<td>Hawaii</td>
<td>196,411</td>
<td>6,737</td>
<td>1,746</td>
<td>25.9</td>
</tr>
<tr>
<td>Maui</td>
<td>164,094</td>
<td>5,628</td>
<td>1,044</td>
<td>18.5</td>
</tr>
<tr>
<td>Kauai</td>
<td>71,093</td>
<td>2,438</td>
<td>607</td>
<td>24.9</td>
</tr>
</tbody>
</table>

This is a reference for the latest available U.S. Census American Community Survey which provided the data for Hawaii’s population estimates in these tables.

Criterion 5: MANAGEMENT SYSTEMS

Financial Resources, Staffing, and Training for Mental Health Service Providers Necessary for the Plan

In FY 2017, the total AMHD State and Federal expenditures for community-based, inpatient, and administrative services were $140,600,697 (Table 1). The AMHD State expenditures for administrative, community-based and inpatient services was $135,481,125 for General Funds and $3,938,361 for Special Funds for a total of $139,419,486. The FY 2017 AMHD amount of Federal Funds was $1,074,021 for community-based services and $107,190 for administrative services for a total of $1,181,211.

Table 1

<table>
<thead>
<tr>
<th>FY 2017 AMHD Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
</tr>
<tr>
<td>Central/Leeward Oahu TSS</td>
</tr>
<tr>
<td>East Honolulu TSS</td>
</tr>
<tr>
<td>West Honolulu TSS</td>
</tr>
<tr>
<td>Windward TSS</td>
</tr>
<tr>
<td>Hawaii County CMHC Branch</td>
</tr>
<tr>
<td>Kauai CMHC Branch</td>
</tr>
<tr>
<td>Maui CMHC Branch</td>
</tr>
<tr>
<td><strong>Subtotal - CMHC</strong></td>
</tr>
<tr>
<td>POS &amp; Other Community Services</td>
</tr>
<tr>
<td><strong>Subtotal – Community Support</strong></td>
</tr>
<tr>
<td>Court Evaluation Branch</td>
</tr>
<tr>
<td><strong>Subtotal Community Services</strong></td>
</tr>
<tr>
<td>Hawaii State Hospital</td>
</tr>
<tr>
<td><strong>Subtotal – Direct Services</strong></td>
</tr>
<tr>
<td>Administration</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

In FY 2018, the total AMHD State and Federal expenditures for community-based, inpatient, and administrative services was $142,818,551 (Table 2). The AMHD State expenditures for administrative, community-based, and inpatient services was $135,589,136 for General Funds and $5,745,710 for Special Funds for a total of $141,334,846. The FY 2018 AMHD amount of Federal Funds is $1,138,819 for community-based services and $99,886 for administrative services for a total of $1,143,705.
General funds remained stable from FY 2017 to FY 2018; however, there was an increase of two percent in FY 2018 total expenditures and an overall 46 percent increase in Special funds between FY 2017 and FY 2018. Both Tables 1 and 2 will be used to calculate the Maintenance of Effort, along with expenditures from the Hawaii State Department of Health, Child and Adolescent Mental Health Division.

Table 2
FY 2018 AMHD Expenditures

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>GENERAL FUNDS</th>
<th>SPECIAL FUNDS</th>
<th>FEDERAL FUNDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/Leeward Oahu TSS</td>
<td>4,107,954</td>
<td>3,707,339</td>
<td>400,615</td>
<td>0</td>
</tr>
<tr>
<td>East Honolulu TSS</td>
<td>1,710,244</td>
<td>1,550,792</td>
<td>159,452</td>
<td>0</td>
</tr>
<tr>
<td>West Honolulu TSS</td>
<td>2,718,471</td>
<td>2,694,151</td>
<td>0</td>
<td>24,320</td>
</tr>
<tr>
<td>Windward TSS</td>
<td>3,055,380</td>
<td>2,531,638</td>
<td>523,742</td>
<td>0</td>
</tr>
<tr>
<td>Hawaii County CMHC Branch</td>
<td>6,010,013</td>
<td>5,942,387</td>
<td>67,626</td>
<td>0</td>
</tr>
<tr>
<td>Kauai CMHC Branch</td>
<td>2,722,431</td>
<td>2,722,431</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maui CMHC Branch</td>
<td>2,239,798</td>
<td>2,170,957</td>
<td>68,841</td>
<td>0</td>
</tr>
<tr>
<td><strong>Subtotal - CMHC</strong></td>
<td><strong>22,564,291</strong></td>
<td><strong>21,319,695</strong></td>
<td><strong>1,220,276</strong></td>
<td><strong>24,320</strong></td>
</tr>
<tr>
<td>POS &amp; Other Community Services</td>
<td>39,085,749</td>
<td>33,200,816</td>
<td>4,525,434</td>
<td>1,359,499</td>
</tr>
<tr>
<td><strong>Subtotal – Community Support</strong></td>
<td><strong>61,650,040</strong></td>
<td><strong>54,520,511</strong></td>
<td><strong>5,745,710</strong></td>
<td><strong>1,383,819</strong></td>
</tr>
<tr>
<td>Court Evaluation Branch</td>
<td>1,093,225</td>
<td>1,093,225</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Subtotal Community Services</strong></td>
<td><strong>62,743,265</strong></td>
<td><strong>55,613,736</strong></td>
<td><strong>5,745,710</strong></td>
<td><strong>1,383,819</strong></td>
</tr>
<tr>
<td>Hawaii State Hospital</td>
<td>73,743,166</td>
<td>73,743,166</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Subtotal – Direct Services</strong></td>
<td><strong>136,486,431</strong></td>
<td><strong>129,356,902</strong></td>
<td><strong>5,745,710</strong></td>
<td><strong>1,383,819</strong></td>
</tr>
<tr>
<td>Administration</td>
<td>6,332,120</td>
<td>6,232,234</td>
<td>0</td>
<td>99,886</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>142,818,551</strong></td>
<td><strong>135,589,136</strong></td>
<td><strong>5,745,710</strong></td>
<td><strong>1,483,705</strong></td>
</tr>
</tbody>
</table>
Table 3 shows the plan for FY 2020-2021 AMHD Mental Health Block Grant Funds expenditures.

### Table 3
**FY 2020-2021 AMHD Planned Expenditures**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Mental Health Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other 24 Hour Care</td>
<td>Mental Health Kokua</td>
<td>$600,000.00</td>
</tr>
<tr>
<td>Ambulatory/Community Non-24-Hour Care</td>
<td>Day Treatment Program</td>
<td>$269,379.00</td>
</tr>
<tr>
<td>Administration</td>
<td>Staff Development</td>
<td>$50,000.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>$919,379.00</strong></td>
</tr>
</tbody>
</table>

**Table 6b: Non-Direct Service Activities**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Mental Health Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Council on Mental Health</td>
<td></td>
<td>$40,000.00</td>
</tr>
<tr>
<td>Management Information Systems</td>
<td></td>
<td>$100,000.00</td>
</tr>
<tr>
<td>Infrastructure Supports</td>
<td></td>
<td>$30,000.00</td>
</tr>
<tr>
<td>Partnerships, Community Outreach, Needs Assessment</td>
<td></td>
<td>$650,000.00</td>
</tr>
<tr>
<td>Quality Assurance &amp; Improvement</td>
<td></td>
<td>$50,000.00</td>
</tr>
<tr>
<td>Research &amp; Evaluation</td>
<td></td>
<td>$40,000.00</td>
</tr>
<tr>
<td>Training &amp; Education</td>
<td></td>
<td>$40,000.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>$950,000.00</strong></td>
</tr>
</tbody>
</table>

**AMHD Allocation GRAND TOTAL**

**$1,869,379.00**

### STAFFING

As of July 2019, AMHD employed a total of 1,135 staff members including 803 staff at the Hawaii State Hospital, 238 staff at the Community Mental Health Centers (CMHCs), 12 staff at the Court Evaluation Branch, and 82 staff in Administration. Despite Hawaii having one of the lowest unemployment rates in the country (2.8% as of June 2019) compared to 3.6 percent (as of June 2019) the unemployment rate in the U.S., the AMHD administrative positions have remained relatively stable. Nursing and psychiatric shortages continue, especially in rural areas.

### TRAINING

**Planned Trainings for Mental Health Service Providers for FY 2020-2021 are:**

- Annual Security Awareness Training;
- Business Compliance Training, Parts I & II;
- Cultural Competency Training;
• Health Insurance Portability & Accountability Act Privacy Training;
• Health Insurance Portability & Accountability Act Security Awareness;
• LGBTQ Training, Part I: To Treat Me, You Have To Know Who I Am;
• LGBTQ Training, Part II: Sexual and Gender Minority Health Report;
• Motivational Interviewing;
• Ohana CCS Case Management Delivery Process;
• Own Your Behaviors, Master Your Communication;
• Promote and Support ASIST (Applied Suicide Intervention Skills Training)
• Recovery Basics;
• Safe Driver Training;
• Surviving an Active Shooter Event; and
• Violence Prevention/De-Escalation of Emotionally Charged Situations.
Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question
In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?  
   - Yes
   - No

   Please indicate areas of technical assistance needed related to this section.

   Technical assistance is not needed at this time.

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Footnotes:
Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.

57 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

58 Ibid

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?

5. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not needed at this time.

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Footnotes:
Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.59

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.60

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? 

   Yes  No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?

   Yes  No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?

   Yes  No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

   Yes  No

5. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

   Technical assistance is not needed at this time.

Footnotes:


60 http://csgjusticecenter.org/mental-health/

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Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question
In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.\(^1\) SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises, adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization.\(^2\)

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.


---

Please check those that are used in your state:

1. **Crisis Prevention and Early Intervention**
   - a) [ ] Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) [ ] Psychiatric Advance Directives
   - c) [ ] Family Engagement
   - d) [ ] Safety Planning
   - e) [ ] Peer-Operated Warm Lines
   - f) [ ] Peer-Run Crisis Respite Programs
   - g) [ ] Suicide Prevention

2. **Crisis Intervention/Stabilization**
   - a) [ ] Assessment/Triage (Living Room Model)
   - b) [ ] Open Dialogue
   - c) [ ] Crisis Residential/Respite
   - d) [ ] Crisis Intervention Team/Law Enforcement
   - e) [ ] Mobile Crisis Outreach
   - f) [ ] Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. **Post Crisis Intervention/Support**
   - a) [ ] Peer Support/Peer Bridgers
   - b) [ ] Follow-up Outreach and Support
   - c) [ ] Family-to-Family Engagement
   - d) [ ] Connection to care coordination and follow-up clinical care for individuals in crisis
   - e) [ ] Follow-up crisis engagement with families and involved community members
Recovery community coaches/peer recovery coaches

Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not needed at this time.

Footnotes:
16. Recovery - Required

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual’s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  
   Yes ☐ No ☐

b) Required peer accreditation or certification?  
   Yes ☐ No ☐

c) Block grant funding of recovery support services.  
   Yes ☐ No ☐

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system?  
   Yes ☐ No ☐

2. Does the state measure the impact of your consumer and recovery community outreach activity?  
   Yes ☐ No ☐

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Hawaii’s adult mental health service delivery system is based on the concept of recovery. The treatment for these individuals is focused on the needs of the individual, not merely on symptom relief and stabilization, but also on individual empowerment with skills needed to lead satisfying, hopeful, and contributing lives. The Adult Mental Health Division (AMHD) applies the guiding principles of recovery to its programs by seeking to:

- Promote the inclusion of individuals with Serious Mental Illness (SMI) throughout the system;
- Provide services that facilitate recovery;
- Provide services that enable individuals with SMI to live in the least restrictive, most integrated community setting appropriate to meet their needs;
- Provide support services for, and encourage the participation of the families of individuals with SMI as appropriate; and
- Ensure that statewide service standards and definitions are based on professional standards and evidence-based practices that are adapted to account for linguistic, cultural, rural, and urban differences.

The recovery planning process begins as early as intake and ideally occurs in every meeting between the consumer and their recovery team members leading up to (and proceeding from) each Master Recovery Plan meeting. The planning process identifies and describes the Consumer’s strengths and goals, behavioral challenges and needs, and prioritizes identified needs. It establishes measurable long/intermediate and short-term goals as appropriate, identifies approaches or interventions based on identified strengths and facilitates consumers meeting those goals. The Recovery Plan review evaluates the Consumer’s progress toward those goals on identified target dates throughout the course of care.

Review of each consumer’s Recovery Plan occurs at least once every six months, or whenever there is a significant change. For example, a change in problem identification, focus of treatment, level of care, or services provided, and are structured to maximize consumer, family and community involvement. Further, examples of triggers for revision of the Master Recovery Plan include: suicide attempt, Emergency Room (ER) visit; significant clinical change; homeless or immediate risk of losing housing; at risk of revocation of Conditional Release order; loss of significant member of consumer’s support system; decreased or no treatment participation; and substance use relapse.

The AMHD encourages all consumers and their families to participate in trainings on self-determination, self-advocacy, and peer provided services. Services that support consumers in their recovery include: Recovery (Treatment) planning; Clubhouse services (including Psychosocial Rehabilitation); Work incentives training including Supported Employment; and peer provided supports including (Peer Coaching, Peer Specialists and Peer Educators).

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The AMHD is committed to including those with a dual diagnosis of serious mental illness and substance use disorder in its programs and services. For instance, recovery and recovery supports are included in its community service contracts and are similar to integrated treatment provided for adults with SMI.

5. Does the state have any activities that it would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not needed at this time.

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Footnotes:
Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question
The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA’s mission to reduce the impact of M/SUD on America’s communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court’s Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

**Please respond to the following items**

1. Does the state's Olmstead plan include:
   - Housing services provided.  
     Yes  
     No
   - Home and community based services.  
     Yes  
     No
   - Peer support services.  
     Yes  
     No
   - Employment services.  
     Yes  
     No

2. Does the state have a plan to transition individuals from hospital to community settings?  
   Yes  
   No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
   Please indicate areas of technical assistance needed related to this section.
   Technical assistance is not needed at this time.

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Footnotes:
Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children’s needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children’s Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

65 The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America’s #1 Public Health Problem.

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED? ☑ Yes ☐ No
   b) The recovery and resilience of children and youth with SUD? ☑ Yes ☐ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a) Child welfare? ☑ Yes ☐ No
   b) Juvenile justice? ☑ Yes ☐ No
   c) Education? ☑ Yes ☐ No

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization? ☑ Yes ☐ No
   b) Costs? ☑ Yes ☐ No
   c) Outcomes for children and youth services? ☑ Yes ☐ No

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☑ Yes ☐ No
   b) Mental health treatment and recovery services for children/adolescents and their families? ☑ Yes ☐ No

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system? ☑ Yes ☐ No
   b) for youth in foster care? ☑ Yes ☐ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

INTEGRATED SYSTEM OF CARE

Most of the youth served by Child and Adolescent Mental Health Division (CAMHD) attend public schools, and may be involved with the child welfare system, juvenile justice system, or other DOH Divisions, including Alcohol & Drug Abuse (“ADAD”), and Early Intervention Services (“EIS”). A large percentage of the CAMHD population is enrolled in one of the QUEST Integration Health plans and may receive special healthcare services. The CAMHD Care Coordinators work with all other child-serving agencies to integrate services and programs across agencies in the best interest of youth and their families.

Three major state agencies - the Child and Adolescent Mental Health Division (CAMHD), the state Department of Education, and the Med-QUEST Division of the Department of Human Services - jointly provide for a comprehensive community-based system of care for children and adolescents in need of mental health services in Hawaii. The services of each agency and CAMHD’s collaborative and integrated partnerships with these agencies are described below.

DEPARTMENT OF HEALTH

Early Intervention Services. The Department of Health, Family Health Services Division, Early Intervention Section (EIS) provides
services for children from birth to three years of age with special needs. Early Interventionists assist children in the following five developmental areas: Communication (talking, understanding), Cognitive (paying attention, solving problems), Physical (sitting, walking, picking up small objects), Social or Emotional (playing with others, having confidence), Adaptive (eating, dressing self).

The Alcohol and Drug Abuse Division (ADAD) provides leadership in the development and delivery of quality substance abuse prevention, intervention and treatment services for the residents of Hawaii. ADAD’s treatment efforts are designed to promote a statewide culturally appropriate, comprehensive system of services to meet the treatment and recovery needs of individuals and families. ADAD is the primary and often sole source of public funds for substance abuse treatment. ADAD’s services are provided by a network of providers throughout the state.

The Developmental Disabilities Division (DDD) provides supports and services for persons with intellectual and/or developmental disabilities, which includes principles of self-determination and incorporates individualized funding, person-centered planning, and services provided in homes and in the community. DDD services are provided primarily through the Medicaid 1915(c) Home and Community Based Services Waiver.

Project Laulima (Many hands working together)

The Child & Adolescent Mental Health Division applied for a system of care grant to develop more integrated and comprehensive services to children and youth with co-occurring mental health needs and developmental disabilities. Project Laulima worked to improve access and service quality. The Project brought together the Developmental Disabilities Division and Child and Adolescent Mental Health Division of the DOH, the Department of Education, the Department of Human Services, and several family and youth organizations to improve collaboration and coordination to meet the multi-agency needs of children and youth with both mental health needs and developmental disabilities. Project Laulima focused on the development of new policies and programming, providing service accountability, capacity building, workforce development, and comprehensive training initiatives.

Child and Adolescent Mental Health Division (CAMHD)

CAMHD provides services to youth who a) have been certified as qualifying under the Individuals with Disabilities Educational Act (IDEA) for special education services and who are in need of related mental health services to benefit from their free and appropriate publication; and b) youth who meet the eligibility requirements for CAMHD’s Support for Emotional and Behavioral Development (SEBD) program.

Through its 7 Family Guidance Centers and a Family Court Liaison Branch, CAMHD provides case management services to youth and families through the state through the assigned Care Coordinator.

Community-based Family Guidance Centers

CAMHD’s community-based Family Guidance Centers (FGCs) are responsible for providing high quality, culturally competent, evidence-based treatment services to eligible children and adolescents. The FGCs are strategically located in geographic areas that correspond with the Department of Education school districts. Three FGCs are located on Oahu, where close to 72% of the state’s population reside. Also, there is one FGC each on the rural neighbor island counties—Kauai, Maui, and the Big Island, with partial coverage for the islands of Molokai and Lanai. Most of the FGCs also have satellite offices. The geographic placement of FGCs and their satellite offices help to address the needs of Hawaiʻi’s ethnic and racial diversity, which differs by geographic location.

Each FGC is led by a Center Chief, and is staffed with a psychiatrist, one or more psychologists, a quality assurance specialist, a fiscal officer, and social workers and mental health care coordinators to provide intensive case management. Services provided by the centers include clinical team management, intensive case management, direct service provision, authorization for contracted services, and utilization and quality monitoring. The FGCs work in partnership with youth and their families to design and implement individualized service plans.

The Family Court Liaison Branch (FCLB) provides screening, assessment, evaluative, diagnostic, treatment, and consultative services to youth with mental health challenges in the state juvenile justice system. FCLB provides mental health treatment linkages between the Family Court, Hawaiʻi Youth Correctional Facility, and the State’s Detention Home. The FCLB works in partnership with families and the court system to design and implement individualized service and treatment plans suitable to the specialized needs of children and youth involved with the Hawaiʻi juvenile justice system. FCLB differs from CAMHD’s other branches because it does not have a geographical limitation, and provides direct services in collaboration with other state agencies and Family Court. FCLB staff spends considerable time and effort in conducting mental health assessments of youths at the direction of Family Court judges and in advocating for treatment of such youth in less restrictive settings, where appropriate.

Individualized care planning for children/youth with serious mental health disorders

Each youth’s treatment is directed by a service plan that supports the use of medically-necessary evidence-based interventions in the least restrictive environment. CAMHD service planning is an individualized and ongoing process that is youth-guided and family/guardian centered.

Coordinated Service Plan (CSP). The Coordinated Service Plan identifies the specific strategies that will achieve broadly defined goals for the youth and family, and integrates strategies across the many agencies involved. The CSP process builds upon the strengths of the youth and family and requires the full engagement and involvement of youth, family/guardian, and key
individuals involved in the youth’s life including existing or potential service providers. Its purpose is to coordinate efforts across public agencies and other supports and services.

Mental Health Treatment Plan (MHTP). CAMHD’s contracted providers are responsible for the development, implementation, review, revision and adjustments to the MHTP. The MHTP should be individualized for each youth and should be developed through a collaborative process driven by the family/guardian and youth that includes the contracted provider, family, and assigned CAMHD Mental Health Care Coordinator. The MHTP will identify evidence-based treatment interventions that are the most promising options for meeting a youth’s individual goals and objectives.

CAMHD’s comprehensive service array is comprised of a spectrum of effective, community-based services and supports:

- Mental Health Evaluation
- Psychological Testing
- Psychosexual Assessment
- Psychiatric Evaluation
- Medication Management
- Individual Therapy
- Group Therapy
- Family Therapy
- Multi-Systemic Therapy (MST)
- Functional Family Therapy (FFT)
- Intensive In-Home Therapy
- Intensive In-Home Paraprofessional Support
- Transitional Family Home
- Community-Based Residential, Levels I, II and III
- Partial Hospitalization
- Hospital-Based Residential
- Respite Supports
- Therapeutic Respite Home
- Intensive Independent Living Skills
- Independent Living Skills Paraprofessional Support
- Ancillary Services
- 24-Hour Crisis Telephone Stabilization
- Crisis Mobile Outreach
- Therapeutic Crisis Home
- Intensive Independent Living Skills
- Independent Living Skills Paraprofessional Support
- Ancillary Services
- 24-Hour Crisis Telephone Stabilization
- Crisis Mobile Outreach
- Therapeutic Crisis Home

CAMHD Care Coordination

All CAMHD youth have their services coordinated by a care coordinator to ensure timely, appropriate and coordinated service delivery. The Care Coordinator (CC) is the case manager who is responsible for engaging the youth and family and assisting parents with coordinating the youth’s education, health care and mental health services. Parent Partners are also available to provide peer support to parents in this regard. CCs are responsible for referring the youth for appropriate CAMHD services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality services, and continuous monitoring of the effectiveness of interventions to assure that youth receive medically necessary care.

The CC coordinates regular home visits, school visits, and community contacts as indicated in the Coordinates Service Plan (CSP). When appropriate, responsibilities also include coordination of care with Family Court, and Department of Human Services and other state and community agencies. The CC is responsible for facilitating the integration, coordination, and monitoring of behavioral health services across programs and domains and for communicating important clinical developments to the Branch Utilization Review Team. Contractors are responsible for coordination of services that are provided within their agency and regular communication about their services to the CC. Coordination and communication are particularly important in settings where there are multiple staff providing services for a youth. Contractors are also expected to coordinate efforts with the youth’s school and community settings. Ongoing engagement, communication and coordination with families are a necessary practice as families are an integral part of the therapeutic process.

Core Components of the CAMHD System

These core components underlie the values CAMHD strives to operationalize in its practices. The CAMHD expects the same commitment from contractors to support these components in their respective practices.

1. Commitment to the Hawaii CASSP Principles
CAMHD is committed to the CASSP Principles and expects the same commitment from contracted providers.

Respect for Individual Rights
Individualization
Early Intervention
Partnership with Youth and Families
Family Strengthening
Access to Comprehensive Array of Services
Community-based Service Delivery
Least Restrictive Interventions
Coordination of Services

2. Commitment to Interagency Collaboration & Coordination
CAMHD is committed to work with all other child-serving agencies to integrate services and programs across agencies in the best interest of youth and their families.

3. Commitment to Evidence-Based Practices
Mental health services provided within the CAMHD system are expected to be evidence-based. Interventions with youth are meant to incorporate elements of those treatments identified as most promising based on credible scientific data.

4. Commitment to Performance Management
The CAMHD is committed to ongoing evaluation of performance and the use of data to continue the development and management of the system as well as to improve provider development. Its performance management practices involve an extensive system for examining performance and using findings to make informed decisions about services and needed adjustments to program implementation.

5. Commitment to Access & Continuity of Care
The CAMHD has the belief that every child/youth is capable of recovery and resiliency. CAMHD seeks to promote individualized care which empowers youth and their families to achieve their goals, and maximizes their opportunities to live full lives in their own communities. The CAMHD is committed to the philosophy of providing treatment at the most appropriate and least restrictive level of care necessary for effective and efficient treatment to meet the youth’s bio-psychosocial needs. We see the continuum of care as a fluid treatment pathway, where youth may enter treatment at any level and be transitioned to more or less intensive levels of care as their changing clinical needs dictate. At any level of care, such treatment should be individualized and should take into consideration the youth’s stage of readiness to change and participate in treatment.

7. CAMHD Clinical Model
To ensure appropriate, effective and efficient treatment, CAMHD maintains clinical oversight of each youth served. Each youth is assigned a Care Coordinator who will facilitate the planning, coordination of services and monitoring of treatment through consultation with the Branch Clinical Lead.

Each youth is assigned a “Clinical Lead” – either a CAMHD psychologist of psychiatrist - who will oversee their care and authorize services. The Clinical Lead provides clinical direction of the treatment provided to youth through their collaboration and consultation with the youth’s assigned Care Coordinator.

Each CAMHD branch Utilization Review (UR) Team includes all supervisory clinical staff (Clinical Psychologist, Child Psychiatrist, and Mental Health Supervisors) and the branch Quality Assurance Specialist. The role of the UR team is to assure that there is a clear clinical rationale for continuing the service and that all continuing stay criteria are being met.

CAMHD has established thresholds for the appropriate and effective length of stay for each service. CAMHD analyzed its data and determined the time frames in which the majority of youth showed maximum improvement. These time frames serve as the threshold for which a second level of review is needed in order to continue the service, since only a minority of youth showed continued improvement beyond this point in time.

Child and Adolescent Mental Health Performance Standards
In order to assure high quality services, CAMHD has invested heavily in developing comprehensive Performance Standards and Policies and Procedures that CAMHD staff and providers must all follow. The Child and Adolescent Mental Health Performance Standards (CAMHPS) is a manual developed by CAMHD for use in the development and provision of behavioral health services for youth. The standards and guidelines define service content standards and assure the efficiency and effectiveness of services. The CAMHPS Manual covers 32 pages of General Performance Standards and 156 pages of Service Specific Performance Standards. The Child and Adolescent Mental Health Performance Standards can be found at: https://health.hawaii.gov/camhd/files/2018/06/Teal-Book-2018.pdf

DEPARTMENT OF EDUCATION

Children and youth who have educational disabilities receive school-level supports and services through their home school. The school provides assessment and diagnostic services whenever concerns arise that children or youth have a disability that might affect their education. If indicated, the school provides classroom strategies and specific mental health services. If more intensive services than those available at the home school arise, the school arranges access to the CAMHD services.

Children and youth who are having emotional challenges that are not affecting their education receive mental health services from their family private insurance or a Department of Human Services Med-QUEST provider. The Med-Quest Health Plans provide medically necessary services for assessment and mental health treatment. If more intensive services than those available through
the Medicaid Health Plan arise, the youth is referred to the CAMHD system.

Generally, the charge of the state education agency (SEA) is to monitor and enforce compliance with state and federal mandates, including IDEA, and to monitor and enforce compliance and to provide leadership and guidance through technical assistance to ensure that local educational programs are compliant and of high quality. Traditionally local education agencies (LEAs) provide the implementation of programming that leads to meaningful educational outcomes for students and their families. The Hawaii Department of Education performs the function of a local education agency (e.g., operating program services) while also maintaining oversight and technical assistance responsibilities as the state education agency. Hawaii’s public schools form a single, statewide district that spans six islands and seven geographic districts: Central, Honolulu, Leeward and Windward on Oahu; and Hawaii, Maui (including Molokai and Lanai islands) and Kauai (including Niihau Island). Each complex consists of a high school and the elementary and intermediate/middle schools. There are 287 public schools, 31 of which are charter schools.

Aligned with IDEA legislation, Hawaii public schools offer a continuum of alternative placements where students receive special education or related services, including regular classes, special classes, special schools, home instruction and instruction in hospital settings. With the 2004 IDEA reauthorization, Hawaii added a provision for supplementary services such as a resource room or the provision of itinerant instruction in the regular classroom placement. Hawaii’s education system takes great effort to provide special education and related services at the student’s neighborhood or home school.

Hawaii’s Department of Education (DOE) incorporates a Comprehensive Student Support System (CSSS) to meet the academic, physical, social, and emotional development of all of its students. The CSSS responds to student needs that may correspond to one of five levels: 1) basic support for all children, 2) informal support through collaboration, 3) services through school-level and community programs, 4) specialized services from DOE and other agencies, and 5) intensive and multi-agency services. Students whose needs are at level 4 may receive special education services or services through the School-Based Behavioral Health (SBBH) program.

School Based Behavioral Health (SBBH) provides evidence-based mental and behavioral health interventions to students with the most challenging mental and behavioral health concerns when it impacts their learning or the learning of others. SBBH program staff includes Behavioral Specialists, School Counselors, School Social Workers, Clinical Psychologists, and School Psychologists, who are located within schools/complexes. They assist school teams in understanding students’ challenging behaviors and disabilities and in developing strategies and supports to help students benefit from their education. Parents, as members of the IEP/MP teams, participate in developing the IEP/MP goals and objectives. Functional Behavioral Assessment and Behavioral Support Plans. School teams (IEP and MP), work collaboratively with other SBBH program staff (School Psychologists, Clinical Psychologists, Mental Health Supervisors, School Social Workers, and Psychological Examiners) to properly address the student’s functioning and develop classroom strategies as well as behavioral supports and interventions. CAMHD’s geographically located Family Guidance Centers roughly correspond with the DOE districts.

Positive Behavior Supports Program. The Positive Behavior Supports Program develops local capacity at individual schools to:
• develop proactive behavioral practices,
• use school discipline as an instrument for student success,
• formalize team-based problem solving for addressing behavioral concerns and challenges,
• develop a continuum of procedures for acknowledging appropriate behaviors,
• develop a continuum of procedures for discouraging inappropriate behaviors,
• have on-going monitoring and evaluation procedures, and
• develop the local expertise and capacity of the school leadership team to address simple to complex behavioral challenges of students.

Primary School Adjustment Project (PSAP). The Primary School Adjustment Project is a school-based early identification and intervention program which seeks to enhance learning and adjustment skills to reduce social, emotional, and school adjustment difficulties for children in grades kindergarten through three. It is a preventative mental health project based on the belief that early intervention can prevent the development of more serious difficulties in later years.

Community Children’s Councils (CCC). The Community Children’s Councils were created in the Felix Implementation Plan as one of the key partnerships in the development of a full array of services to special needs children and their families. The mission of the CCC is to provide local forums statewide for all community members to come together as equal partners to discuss and positively affect multiple systems issues for the benefit of all children, families, and communities. Full participation of families is a high priority for the CCCs. They are led by parent and professional co-chairs and include representation from public and private child serving agencies, private providers, and other community members such as recreational services, businesses, churches, and others.

The purposes of the CCCs are to:
• function as community-based planning and evaluating groups
• provide support and training to parents of special needs children
• provide solutions to concerns raised by community members or refer to proper authority for resolution
• identify any gaps in service delivery and offer possible solutions
• provide feedback to policy makers regarding the effect of policies on service delivery in the local community
• provide system advocacy activities to support, sustain and maintain the quality of services needed in the local community
permanency for children where permanency has been a significant challenge.

increase permanency for children in foster care 9 months or longer. These multiagency collaborations are aimed at establishing programs. SPA and Family Wrap Hawai`i are two strategies that the CWSB is implementing to decrease time in foster care, and CAMHD is a key participant in the Child Welfare Service Branch's Safety, Permanency and Wellbeing (SPA) and Wraparound programs. CAMHD has had a Memorandum of Agreement with the Med-QUEST Division that provides that CAMHD serve the Medicaid eligible youths. In 1999, the Memorandum was modified to include services to all youth who are eligible under Hawai'i's Felix Consent Decree and who are Medicaid eligible. Med-QUEST identifies eligible SEBD (Support for Emotional and Behavioral Development) youth. In 1999, the Memorandum was modified to include services to all youth who are eligible under Hawai'i's Felix Consent Decree and who are Medicaid eligible. Med-QUEST identifies children and youth who are SEBD eligible and refer the youth to CAMHD for intensive care coordination and access to CAMHD's comprehensive array of community-based services.

Special Education (SpEd) is specially designed instruction and related services to meet the unique needs of eligible students with disabilities under the IDEA/Chapter 60. Services include academic services, speech-language services, psychological services, physical and occupational therapy, and counseling services. The Department provides these services at no cost to families to students aged 3 to 22 who demonstrate a need for specially designed instruction.

The CAMHD has developed a more collaborative model in working with the Department of Education to facilitate early identification of CAMHD-eligible youth. In 2015, for example, several high-profile cases that required coordination of mainland behavioral health placements demonstrated the need for coordination between CAMHD and the DOE. We have remodeled the process for these placements and shortened the timeframe by one half. This required coordinated planning from DOE and DHS. DOE has agreed to pay for educational charges for all placements, no matter the requesting agency. Out of this process has grown a formalized one-to-one accountability between the CAMHD Administrator and a Deputy Superintendent of the DOE. Policy problems will be handled at this level. The Deputy Superintendent will be a standing member of Hawaii Interagency State Youth Network of Care (HI-SYNC) which will assure decision making power on this multi-agency forum.

DEPARTMENT OF HUMAN SERVICES

The majority of Hawaii's children have access to health coverage. The Med-QUEST Division of the state's Medicaid Agency (Department of Human Services), contracts with health plans to provide health services to the Medicaid eligible population. The health plans provide medically necessary mental health assessments and treatment services to children and youth. Since 1994, CAMHD has had a Memorandum of Agreement with the Med-QUEST Division that provides that CAMHD serve the Medicaid eligible SEBD (Support for Emotional and Behavioral Development) youth. In 1999, the Memorandum was modified to include services to all youth who are eligible under Hawai'i's Felix Consent Decree and who are Medicaid eligible. Med-QUEST identifies children and youth who are SEBD eligible and refer the youth to CAMHD for intensive care coordination and access to CAMHD's comprehensive array of community-based services.

Hawaii Children's Insurance Program. Hawaii's free public health insurance programs are QUEST and QExA, managed by the Department of Human Services. For children and youth to be eligible, they must be 0 to 19 years old, meet household income level up to 300%, and qualify as U.S. citizens, lawful permanent residents, refugees, or citizens of the Marshall Islands, Federated States of Micronesia, or Republic of Palau. Covered services include regular check-ups, emergency care, immunizations, prescription medicines, doctor visits, eyeglasses, counseling and dental care. A child is covered for one year if he or she stays in the household and doesn't get other health insurance.

The Child Welfare Services Branch (CWSB) provides services to children and their families when the children are reported to have been abused and/or neglected, or to be at risk for abuse and/or neglect. These services include child protection, family support, foster care, adoption, independent living, and licensing of resource family homes, group homes, and child placement organizations. CWSB is implementing four Title IV-E Waiver Demonstration Project initiatives on Oahu and Hawai'i Island to further safely reduce the number of children in foster care as well as time spent in foster care.

CAMHD is a key participant in the Child Welfare Service Branch's Safety, Permanency and Wellbeing (SPA) and Wraparound programs. SPA and Family Wrap Hawai`i are two strategies that the CWSB is implementing to decrease time in foster care, and increase permanency for children in foster care 9 months or longer. These multiagency collaborations are aimed at establishing permanency for children where permanency has been a significant challenge.
MULTI-AGENCY COLLABORATIONS

CAMHD has built meaningful partnerships across systems to improve the child, youth and young adult functioning in home, school and community. A few of the collaborative efforts are highlighted here.

CAMHD works closely with our other state agencies through the Hawaii Interagency State Youth Network of Care (HISYNC) group. HISYNC meets monthly and brings together leaders from all the state child-serving agencies including: ADAD, EIS, the Department of Education’s (DOE) School Based Behavioral Health (SBBH) and Community Children’s Council (CCC), Child Welfare Services (CWS), Office of Youth Services (OYS), Med QUEST Division, Family Court/Juvenile probation, and Ohana Services, the Parent Partner service provider for CAMHD. HISYNC meetings provide opportunities for these groups to share and compare data about system outcomes, and to discuss policy changes that could improve the system. Providers who experience difficulties collaborating with one of these state child-serving agencies are encouraged to raise their concerns with CAMHD leaders for
A Memorandum of Agreement (MOA) with Office of Youth Services (OYS) allows CAMHD to serve youth who would otherwise be ineligible for services. For example, if Probation says a youth needs services but the youth is not Medicaid eligible, the MOA stipulates that OYS will cover the cost. For youth who are not yet deemed eligible, the MOA allows CAMHD to provide services to them while they are going through the Medicaid registration and SEBD (CAMHD eligibility) process. The MOA allows Probation to recommend CAMHD care instead of recommending something else.

Overall, as a state system, Hawaii is not incarcerating as many youth as before. The interagency MOA and interagency meetings are assisting with reducing the number of youth with mental health problems from being incarcerated. The down side is that, instead of youth getting locked up, CAMHD saw an increase in the number of youth being sent to the mainland discordant with this change. Nevertheless, Hawaii is heading in the right direction.

CAMHD sought and was awarded a system of care grant, Kaeru Services, to focus on returning youth from out-of-state residential treatment programs back to their home communities and prevent the future out-of-state displacement of youth. The program will utilize a combination of an intensive care planning process and a clinical intervention model. Implementing Kaeru Services will involve strengthening the infrastructure of the Hawaii child-serving system so that it better exemplifies system of care principles. This will include a better integration of family and youth voice and choice at all levels of the system, increased cultural and linguistic competence, and improved interagency collaboration. The projected outcomes of this program include the successful return of youth placed in out-of-state placements; the reduction of future placements of youth in out-of-state care; a reduction in the cost resulting from fewer out of state placements; improvement in the delivery of clinical services and improvement in quality of life outcomes.

Hawaii Youth Correctional Facility (HYCF) started a Training Academy where all their staff undergo a rather extensive curriculum. CAMHD provides the mental health component of the curriculum. CAMHD trains all HYCF staff on a variety of mental health issues from a non-correctional perspective. The training includes Motivational Interviewing, suicide prevention, adolescent development, and trauma-informed care. CAMHD has participated three times in the Training Academies over the past two years.

CAMHD’s therapeutic presence at Detention Home has been routinized. Previously, only referred youth were seen by a therapist, but now every youth is seen and has contact with a CAMHD Clinician.

A new development at the Judiciary’s Home Maluhia Shelter is that CAMHD’s Family Court Liaison Branch (FCLB) therapist now follow the youth home to provide continuity and may conduct family therapy.

CAMHD has a partnership with the Western Interstate Commission on Higher Education (WICHE) which provides interns at Detention Home who can provide therapeutic services, conduct psychological testing for underlying factors or things not covered under a regular evaluation, such as a personality inventory.

CAMHD screens every youth for emotional/behavioral/mental health problems that enters Detention Home or correctional centers. CAMHD meets every quarter with Family Court judges to discuss the intersection between mental health services and the juvenile justice system to address and resolve system issues.

CAMHD participates in a Statewide Interagency Workgroup that established a Statewide Protocol for addressing commercially sexually exploited children. Every agency—FBI, HPD, Judiciary, Child Welfare Services (CWS), Office of Youth Services (OYS) had their own protocols for sexually exploited youth. Then the protocols were collated into a master protocol that guides how the agencies work together. For example, at the front end, CWS uses a screening tool to identify trafficked youth and their protocol is to refer to CAMHD. Then CAMHD’s protocol accepts the referral and provides trauma-informed care such as Trauma-Informed Cognitive Behavioral Therapy. Sex trafficked youth, from their own perspective, do not see themselves as such, and may believe they are in the usual boyfriend/girlfriend relationships. They do not self-identify as sex trafficked. The screening tool is hugely important in that it identifies whether the youth are being coerced or exploited.

CAMHD has developed aftercare for youth discharged from Benchmark (sexually reactive individuals), so they can have regular mental health contact to ease transition back to the community. CAMHD provides aftercare for up to 3 months and gets the youth connected to community services.

7. Does the state have any activities related to this section that you would like to highlight?

Recently, the issue of providing adequate services to youth experiencing a crisis had been a focus of the Hawaii Interagency State Youth Network of Care (HISYNC) collaborative group. There had been situations in which one or more of the HISYNC members experienced major difficulty finding a safe way to care for and stabilize a youth. This led to an agreement between CAMHD, the Alcohol and Drug Abuse Division, Child Welfare Services and the Office of Youth Services formed a Consortium to jointly fund a new program, the Residential Crisis Stabilization Program.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not needed at this time.
Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state’s suicide prevention plan in the last 2 years?  Yes  No

2. Describe activities intended to reduce incidents of suicide in your state.
   The 2018 – 2025 Hawai‘i Suicide Prevention Strategic Plan to Reduce Suicide 25% by 2025 has the following objectives: increase awareness and communication around suicide prevention as a public health problem that is preventable; increase statewide capacity for training across multiple levels and disciplines including diverse and marginalized populations; promote suicide prevention as a core component of Hawai‘i’s overall system of care; increase hope, help, healing, and wellbeing among those personally touched by suicide and among those with lived experience; increase State and community capacity to effectively and efficiently respond to individuals and communities affected by suicide and those with mental health challenges; conduct and support high quality research and evaluation to inform suicide prevention programs, interventions, policies, and overall Statewide direction; and ensure policies and protocols set the proper foundation for suicide prevention initiatives.

Suicide Prevention trainings were provided in organizations such as mental health, substance use, education, foster care, juvenile justice programs, health care providers, hospitals, law enforcement, faith-based community and workplaces.
Other activities included; an International Survivors of Suicide Conferences; and the American Foundation for Suicide Prevention Hawaii “Out of the Darkness” community and campus walks. During September, Suicide Prevention Month in Hawaii, there were proclamation signing ceremonies with the governor and county mayors, and with all military branches, vigils, media appearances, community prevention presentations, and other community awareness events.

In 2019, a Suicide Prevention Conference brought together 400 local and national survivors, advocates, educators, policymakers, and health professionals around the issue of suicide.

3. Have you incorporated any strategies supportive of Zero Suicide?  Yes  No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  Yes  No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?  Yes  No

If so, please describe the population targeted.

The 2019 Legislature passed Act 180 that appropriates $150,000 for statewide youth suicide early intervention, prevention, and education initiatives. The EMS and Injury Prevention System Branch (EMSIPSB) is collaborating with the Department of Education to provide on-line suicide prevention training to 22,000 teachers, counselors and others with direct contact with youth.

The EMSIPSB in collaboration with the University of Hawaii, Department of Psychiatry (DOP) and military partners, will provide a suicide prevention training for trainers (T4T) with a focus on increasing gatekeeper training capacity on the neighbor islands.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not needed at this time.

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Footnotes:
Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question
The success of a state’s MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

• The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;

• The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;

• The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;

• The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;

• The state public housing agencies which can be critical for the implementation of Olmstead;

• The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and

• The state’s office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state’s ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  
   Yes  No

2. Has your state identified the need to develop new partnerships that you did not have in place?  
   Yes  No

   If yes, with whom?

   The Adult Mental Health Division (AMHD) plans to enter into a Request for Proposal for Mental Health Emergency Worker partnerships in each county of the state. Also, the AMHD plans to develop new partnerships with contracted purchase of service providers who oversee Adult Residential Care Homes.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

   Mental Health Emergency Worker
   The Adult Mental Health Division (AMHD) is planning to give law enforcement officers the resources they need when encountering an individual in crisis and there is a question about their mental health or substance abuse status. A Request for Proposal is being developed to establish Mental Health Emergency Workers (MHEW) in each county. The program is designed to assist law enforcement officers in responding to individuals who, with the assistance of a MHEW, could be diverted from arrest in favor of a mental health evaluation, and if appropriate, transported by ambulance to a hospital emergency department for involuntary psychiatric evaluation.

   Motivational Interviewing
   In 2018, the First Circuit Court, Adult Probation Division of Hawaii received a grant to facilitate motivational interviewing. Since then, the Adult Probation Division has trained staff in their Division and are now reaching out to other Divisions. Motivational Interviewing (MI) is a communication style that is useful when working with consumers who are resistant to change. This client-centered counseling style also helps consumers explore and overcome ambivalence by finding and strengthening intra-personal
motivation to promote changes in their behavior. Recently, the AMHD entered into an intergovernmental agreement with the Adult Probation Division to provide MI coaching, training for administrative staff who in turn will train other AMHD staff on MI.

Care Home Capacity
In 2020, it is proposed that the AMHD include in its array of services funding for Adult Residential Care Homes (ARCHS) for adults in need of care home placement. These ARCHS are community-based, non-institutional, licensed residential care homes and provide a lower level of care than an Expanded Adult Residential Care Home (nursing home level of care). The AMHD consumers residing in these homes would require minimal daily health monitoring care, and supervision.

The Child and Adolescent Mental Health Division (CAMHD) has been facilitating the Hawaii Interagency State Youth Network of Care (HI-SYNC) a collaborative group of Hawai‘i’s child-serving state agencies, including (but not limited to) the CAMHD, Family Health Services Division, Early Intervention Section (EI) & Developmental Disabilities Division (DDD), the Department of Education’s School Based Behavioral Health (SBBH) and Special Education (SpEd) Services, the Department of Human Services’ (DHS) Child Welfare Services (CWS) and Office of Youth Services (OYS), and the Hawai‘i State Judiciary’s Family Court. The group is convened monthly to discuss barriers and improvements to the state system of care. The Hawaii Interagency State Youth Network of Care (HI-SYNC) collaborative partnership of child-serving agencies is an active and effective body. For example, in the 2018 legislative session, the CAMHD supported a measure introduced by the Office of Youth Services, aimed at (1) establishing the Kawaiola Youth and Family Wellness Center and (2) transforming the approach of juvenile justice to a therapeutic model. In initial discussions with OYS, CAMHD identified several potential opportunities for CAMHD involvement at the Kawaiola facility, including possible collaboration with OYS to develop a request for proposals process and contract with outside agencies for behavioral and emotional health services and possible provision of certain types of intensive evidence-based treatments to youth clients (21 years and under) at Kawaiola, presenting with high-risk behaviors (e.g., suicidality, substance use, aggression).

The collaborative is actively supported by all members. During the 2018 legislative session, a concurrent resolution was introduced to permanently establish the HI-SYNC, develop regionally-based multi-agency committees across the state and legitimize the need for an interagency network to address complex needs of families within the state. The measure was supported by all the members and successfully passed.

Recently, the issue of providing adequate services to youth experiencing a crisis had been a focus of the group. There had been situations in which one or more of the HISYNC members experienced major difficulty finding a safe way to care for and stabilize a youth. This led to an agreement between CAMHD, the Alcohol and Drug Abuse Division, Child Welfare Services and the Office of Youth Services formed a Consortium to jointly fund a new program, the Residential Crisis Stabilization Program.

HISYNC collaboratively reports on performance outcomes on services for youth, including services provided by the school system. Each agency tracks its own performance measures on maintaining robust community-based services that meet the needs of youth. The annual reports, the Hawaii Youth Interagency Performance Report (HYIPR), highlight each agency’s population, utilization, cost and performance outcomes. The Report is shared widely in the community to demonstrate transparency and accountability of the system of care in providing for Hawai‘i’s vulnerable youth.

A strong and long-time CAMHD partner, the University of Hawaii, Department of Psychology, brings its behavioral science evaluation, management information systems and clinical expertise to bear for CAMHD. The Psychology Department has the unique advantage of being an external partner with access to the internal clinical and data management processes at CAMHD. As such, it often provides key direction on how to improve clinical services and client outcomes.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not needed at this time.

Footnotes:
Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Please consider the following items as a guide when preparing the description of the state’s system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.
   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   THIS SECTION IS WRITTEN BY THE CHAIR OF THE STATE COUNCIL ON MENTAL HEALTH.
   A long-standing member of the Council is in a dual role position; he is an active participant on the SCMH and the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS). The member is also a leader, advocate, and service provider in the community who is a prominent voice on the needs of the community for SUD treatment. Minutes from the HACDACS meetings, initiatives in the community, barriers to treatment, service gaps, and effects of the opioid epidemic are shared at meetings. Additionally, Council members that sit in provider and consumer seats share their personal experiences with this critical issue that inform the actions of the Council.

   The Council has successfully integrated substance misuse prevention and treatment into Council activities. Members of the community are invited to the Council to discuss current issues, share success stories in treatment services, and identify barriers in communities. Members of the Council are very cognizant of the barriers to treatment in the more rural communities in Hawaii, and ensure discussion and activities are persistent and timely. We often post current articles and trainings related to SUD on our website to ensure that the larger community is made aware.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?  

   Yes ☐ No ☐

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   The Council’s duties and responsibilities include:
   1. The development and implantation of a strategic plan that incorporates data from the community, stakeholders, and consumers.
   2. The approval to convene short-term Permitted Interaction Groups that complete activities related to:
      a. Legislative information, advocacy, and critical bills that effect people in recovery and individuals with SMI or SED;
      b. Social and website advocacy with maintenance of a Council website, information sharing with the community in relation to important articles and trainings;
      c. State plan review and input.
   3. The review of information provided by the Adult Mental Health Division and Child and Adolescent Mental Health Division in

Planning Councils: The Road to Planning Council Integration. 69

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

relation to allocation of funds and resources, statewide needs, and programs affecting two or more service areas.

4. The review of and discussion of information provided by Service Area Board updates to identify critical issues that can be advocated for or further discussed by the Council.

5. The review and input on the Community Mental Health Block Grant Plan with recommendations.

6. At least once a year, the Council monitors, reviews, and evaluates the allocation and adequacy of mental health services within the state.

7. Serves as an advocate for adults with serious mental illness, children with serious emotional disturbance and other individuals with mental illness or substance use disorders.

The Council meets once a month, with or without quorum established. We are tasked to identify and discuss the needs of persons with mental health challenges. At each meeting, the Council allots times for community members to raise issues for the Council’s consideration. We also invite leaders in the community to discuss concerns or barriers to treatment. This can also include requesting agencies and organization in the community to provide reports on their activities, outcomes, and processes. With that, we are more prepared to understand the nuances of the wider system of care and can make recommendations for how supports could be improved to benefit persons with behavioral health challenges. We have invited representatives from the Crisis Line of Hawaii, Susannah Wesley Community Center (Human Trafficking), Kaiser Permanente (Suicide Prevention), Hawaii Internet Crimes against Children, and a former Radio and Television Reporter who spoke on the Media and destigmatizing mental illness.

The Council, in collaboration with the Department Health has been active in policy development. We attend the Mental Health Task Force chaired by Representative John Mizuno when it is in session which assists us in advocacy and legislative issues. We have also had the privilege of sitting down with various legislatures with the work of our Legislative Permitted Interaction Group.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not needed at this time.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.  

Footnotes:

There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation.

The Council assisted in developing and reviewing the state plan and report two months prior to the report date. The Council approved the convening of a Permitted Interaction Group that reviewed the state plan and report and comments were sent to the chair and assigned staff. The chair incorporated the suggestions in the report. The final report was reviewed at a state Council meeting with the members.
August 28, 2019

TO: Ms. Asha Stanly  
Public Health Advisor  
CMHS/DSCSD

FROM: Marie Vorsino, LMHC, Psy.D.,  
Chair of the State Council on Mental Health  
P.O. Box 3378  
Honolulu, HI 96801-3378

SUBJECT: Community Mental Health Services Block Grant Plan

Dear Ms. Stanly:

The Hawaii State Council on Mental Health was provided the opportunity to review the Hawaii State Department of Health's FY2020-2021 Community Mental Health Services Block Grant Plan Application. I am writing this letter without consent of the State Council on Mental Health as we did not have quorum at our August 2019 meeting. At our September 10th meeting the members will vote and if approved I will provide a statement with the approval of the council members.

We appreciated the opportunity to review the application as it provides us with a strong platform to set priority areas in our yearly strategic planning process, support legislative initiatives that the Department of Health and/or provider agencies have brought to our attention, and advocate for service participants in our communities to be provided the best quality of care.

The report noted several areas of strength for both the adult and child divisions under the Department of Health. As identified, the Adult Mental Health Division’s telehealth initiative has been successful in meeting the needs of individuals who live in rural areas and are unable to meet in person with a psychiatrist. Telehealth has also assisted in improving access to psychiatrists in communities where they are limited or not in community. The E-ARCH Program has helped to transition patients to community residential care that do not meet acute psychiatric criteria to remain at the Hawaii State Hospital. This much needed level of service has assisted 40 individuals to transition to a lower level of care supported care in the community.
The Child and Adolescent Mental Health Division (CAMHD) also identified several areas of strength in the services provided to youth and families. Of note, is the CAMHD’s dedicated commitment to the CASSP Principles which have been the foundational premise of their services and philosophy to care since the early 1990’s. Additionally, CAMHD provides culturally competent services in an intensive case management paradigm driven by a robust clinical model of care. CAMHD is data driven and has strategically aligned itself to be a leader in the utilization of data to assess client services, coordinate with providers, and project future client needs. Service providers are required to provide integrated treatment for co-occurring substance abuse and mental health treatment disorders. The RAISE Program is also ahead of the game in service delivery to adolescents experiencing their first episode of schizophrenia. The Director of the RAISE program provided a presentation to the SCMH this past year and we were very impressed with the services provided to youth and their families.

On the other side of the coin, as in all systems of care, we do have unmet service needs and critical gaps in our current system. The AMHD and CAMHD also identified unmet service needs and critical gaps in our system. The AMHD identified the following areas: significant shortages in our healthcare workforce which impacts access to care, the delivery of care, and health outcomes; shortage of psychiatrists across the state, especially Molokai and Hawaii Island; and, a shortage of affordable housing, transitional housing, and other community-based services to support individuals with behavioral health challenges. The AMHD appears committed to prioritizing the service gaps based on availability of funds. Specifically, they will assess the efficiency of their system, establish population-based services to promote recovery, resiliency and positive outcomes for individuals with SMI; recruit and retain qualified staff, and increase the engagement of consumers and access to services across systems for individuals with SMI. As a council, we look forward to hearing the progress on the aforementioned initiatives in monthly updates by an AMHD representative.

As CAMHD is transitioning a new administrator into the position, we look forward to hearing their progress on the identified initiatives proposed in the application, including: increasing access to mental health services for homeless youth; supporting recovery through family peer-to-peer support; and sustaining and expanding evidence-based, trauma informed mental health care.

The SCMH is also committed to incorporating and prioritizing these initiatives into the development of our three-year strategic plan, which is in the process of being developed with the council. We will continue to partner with the division to advocate for the needs of persons participating in care. We thank you for this opportunity to support the block grant application for the Hawaii Department of Health.

Sincerely,

Marie Vorsino, LMHC, Psy.D.
Chair, State Council on Mental Health
Environmental Factors and Plan

Advisory Council Members
For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020  End Year: 2021

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership*</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email(if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shannessy Ahu</td>
<td>State Employees</td>
<td>Vocational Rehabilitation</td>
<td>1901 Bachelot Street Honolulu HI, 96817</td>
<td><a href="mailto:smitchell@dhs.hawaii.gov">smitchell@dhs.hawaii.gov</a></td>
</tr>
<tr>
<td>Kathryn Boyer</td>
<td>State Employees</td>
<td>Department of Human Services, Social Services Division</td>
<td>810 Richards Street Honolulu HI, 96813 PH: 808-586-5698 FX: 808-586-4806</td>
<td><a href="mailto:kboyer@dhs.hawaii.gov">kboyer@dhs.hawaii.gov</a></td>
</tr>
<tr>
<td>Charlene Naomi Crozier</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>83A Hailea Place Pukalani HI, 96768 PH: 808-280-8160</td>
<td><a href="mailto:naomi65@mac.com">naomi65@mac.com</a></td>
</tr>
<tr>
<td>Louise Crum</td>
<td>State Employees</td>
<td>Criminal Justice</td>
<td>4675 Kapolei Parkway Kapolei HI, 90707 PH: 808-954-8225</td>
<td><a href="mailto:louise.k.crum@courts.hawaii.gov">louise.k.crum@courts.hawaii.gov</a></td>
</tr>
<tr>
<td>Cynthia Dang</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Oahu Service Area Board on Mental Health and Substance Abuse</td>
<td>P.O. Box 893018 Milllani HI, 96789 PH: 808-492-5818</td>
<td><a href="mailto:leanpathways@gmail.com">leanpathways@gmail.com</a></td>
</tr>
<tr>
<td>Arwyn Jackson</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td>P.O. Box 894209 Milllani HI, 96789 PH: 262-424-9795</td>
<td><a href="mailto:arwynjackson@gmail.com">arwynjackson@gmail.com</a></td>
</tr>
<tr>
<td>Ciara Kahahane</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>801 Kakala Street, Apt. 805 Kapolei HI, 96707 PH: 808-208-0248</td>
<td><a href="mailto:ciarakah@hawaii.edu">ciarakah@hawaii.edu</a></td>
</tr>
<tr>
<td>Candice Kirby</td>
<td>Parents of children with SED/SUD</td>
<td></td>
<td>P.O. Box 3026 Kailua-Kona HI, 96740 PH: 808-345-6068</td>
<td><a href="mailto:candice.kirby80@gmail.com">candice.kirby80@gmail.com</a></td>
</tr>
<tr>
<td>Christopher Knightsbridge</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>3010 Vista Place Honolulu HI, 96822 PH: 808-208-0248</td>
<td><a href="mailto:christopher.knightsbridge@gmail.com">christopher.knightsbridge@gmail.com</a></td>
</tr>
<tr>
<td>Eileen Jean Lau-James</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td>2575 Kuhio Avenue, 701 Honolulu HI, 96815 PH: 510-207-0900</td>
<td><a href="mailto:wormwooddove@hotmail.com">wormwooddove@hotmail.com</a></td>
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<tr>
<td>Timothy Lino, Ed.D.</td>
<td>State Employees</td>
<td>Department of Education</td>
<td>475 22nd Avenue, Honolulu HI, 96816</td>
<td>PH: 808-305-9730</td>
</tr>
<tr>
<td>Alexandra Macias</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td>2905 Booth Road, Honolulu HI, 96813</td>
<td>PH: 310-408-3339</td>
</tr>
<tr>
<td>Beatrice Martinez</td>
<td>State Employees</td>
<td>Hawaii Public Housing Authority</td>
<td>1002 N. School St., Bldg. G Honolulu HI, 96817</td>
<td>PH: 808-832-4688</td>
</tr>
<tr>
<td>Carol Matayoshi</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Hawaii Service Area Board on Mental Health and Substance Abuse</td>
<td>535 Kehaulani Street Hilo HI, 96720</td>
<td>PH: 808-936-9328</td>
</tr>
<tr>
<td>Lani Nagao</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Kauai Service Area Board on Mental Health and Substance Abuse</td>
<td>2850 Kapena Street, Lihue HI, 96766</td>
<td>PH: 808-246-0663</td>
</tr>
<tr>
<td>Richard Ries, Psy.D.</td>
<td>Providers</td>
<td>University of Hawaii, Center for Cognitive Therapy</td>
<td>1511 Nu'uanu Avenue, 28 Honolulu HI, 96817</td>
<td>PH: 808-295-3999</td>
</tr>
<tr>
<td>Christopher Rocchio</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td>60 N. Beretania Street, 3603 Honolulu HI, 96817</td>
<td>PH: 808-679-9876</td>
</tr>
<tr>
<td>Scott Shimabukuro</td>
<td>State Employees</td>
<td>Child and Adolescent Mental Health Division</td>
<td>3627 Kilauea Avenue, Room 101 Honolulu HI, 96816</td>
<td>PH: 808-733-9333</td>
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<tr>
<td>Chiree Souza</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Maui Service Area Board on Mental Health and Substance Abuse</td>
<td>2116 Pu'uloahala Road Wailuku HI, 96793</td>
<td>PH: 808-269-8178</td>
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<tr>
<td>Marie Vorsino, Psy.D.</td>
<td>Providers</td>
<td>Parents and Children Together</td>
<td>1485 Linapuni Street, Ste.105 Honolulu HI, 96819</td>
<td>PH: 808-847-3285</td>
</tr>
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</table>

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
### Environmental Factors and Plan

#### Advisory Council Composition by Member Type

**Start Year:** 2020  
**End Year:** 2021

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<td>Youth/adolescent representative (or member from an organization serving young people)</td>
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* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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**Footnotes:**

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Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

**Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51)** requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   
   a) Public meetings or hearings? ☐ Yes ☐ No
   
   b) Posting of the plan on the web for public comment? ☐ Yes ☐ No
      
      If yes, provide URL:
      http://health.hawaii.gov/amhd/plans/blockgrant/
   
   c) Other (e.g. public service announcements, print media) ☐ Yes ☐ No

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Footnotes: