

Hawaii

UNIFORM APPLICATION

FY 2022/2023 Combined MHBG Application Behavioral Health
Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT and COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 10/01/2021 11.35.18 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State SAPT DUNS Number

Number 90266185

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Department of Health

Organizational Unit Alcohol and Drug Abuse Division

Mailing Address Kakuhihewa Building, 601 Kamokila Boulevard, Room 360

City Kapolei

Zip Code 96707

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Eddie

Last Name Mersereau

Agency Name Department of Health, Behavioral Health Administration

Mailing Address Kakuhihewa Building, 601 Kamokila Blvd., Room 360

City Kapolei

Zip Code 96707

Telephone

Fax

Email Address Edward.A.Mersereau@doh.hawaii.gov

State CMHS DUNS Number

Number 809935679

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Hawaii State Department of Health

Organizational Unit Behavioral Health Administration

Mailing Address P.O. Box 3378

City Honolulu

Zip Code 96801-3378

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Amy

Last Name Curtis

Agency Name Department of Health, Behavioral Health Administration

Mailing Address P.O. Box 3378

City Honolulu

Zip Code 96801-3378

Telephone 808-586-4770

Fax

Email Address Amy.Curtis@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 9/1/2021 1:09:09 AM

Revision Date 9/30/2021 9:55:24 PM

VI. Contact Person Responsible for Application Submission

First Name YARA

Last Name SUTTON

Telephone 808-453-6940

Fax

Email Address yara.sutton@doh.hawaii.gov

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

Footnotes:

1. Person Responsible for Substance Abuse Information Relating to SABG Treatment:

Name: Amihan Aiona

Telephone: (808) 692-7508

Email: amihan.aiona@doh.hawaii.gov

2. Person Responsible for Substance Abuse Information Relating to SABG Prevention:

Name: Edward Mersereau

Telephone: (808) 692-7507

Email: edward.a.mersereau@doh.hawaii.gov

3. Written comments on the SABG portion of this FFY 2022-2023 Combined Block Grant Application may be submitted to the Department of Health, Alcohol and Drug Abuse Division, 601 Kamokila Blvd., Rm. 360, Kapolei, HI 96707, Attention: Block Grant Application.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2022

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
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Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
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Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
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Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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 Coastal 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 Clean 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).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
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, amendment, 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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Elizabeth A. Char, M.D.

Signature of CEO or Designee¹: _____

Title: Director of Health

Date Signed: _____

mm/dd/yyyy

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:

1. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, this section includes a separate file: "HI 22-23 App - SABG Steps 1 and 2, Other Sections 9-30-21.PDF" with additional SABG responses to the following sections of the Hawaii FFY2022-2023 Combined Application as these SABG-related sections were not reopened by the 10/1/21 SABG deadline:

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

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

Table 3 SABG Persons in need/receipt of SUD treatment

- 1. The Health Care System, Parity and Integration - Question 1 and 2 are Required (SABG)
- 2. Health Disparities - Requested (SABG)
- 6. Program Integrity - Required (SABG)
- 11. Quality Improvement Plan- Requested (SABG)
- 12. Trauma - Requested (SABG)
- 13. Criminal and Juvenile Justice - Requested (SABG)
- 16. Recovery - Required (SABG)
- 18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG
- 22. Public Comment on the State Plan – Required (SABG)



EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

September 21, 2020

MEMORANDUM

TO: Elizabeth A. Char, M.D.
Director of Health

SUBJECT: Designation of Signature Authority to the Current Interim Director of Health or Director's Designee for the Substance Abuse Prevention and Treatment Block Grant Application, Synar Report and Related Documents

The Interim Director of the Department of Health is hereby designated as the State of Hawai'i's signature of authority for the Substance Abuse Prevention and Treatment Block Grant (SABG) Application, Annual Synar Report and related documents submitted to the Substance Abuse and Mental Health Services Administration. The Interim Director of Health is hereby authorized to sign all Funding Agreements, Certifications and Assurances that must be signed and submitted for the SABG Application, Annual Synar Report and related documents. This designation will remain in effect until such time as it may be rescinded.

David Y. Ige
Governor, State of Hawai'i

DAVID Y. IGE
GOVERNOR OF HAWAII



ELIZABETH A. CHAR, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

August 24, 2021

MEMORANDUM

TO: Cathy Ross *CR*
Deputy Director of Health

Marian Tsuji
Deputy Director, Behavioral Health Administration *MT*

FROM: Elizabeth A. Char, M.D.
Director of Health *EAC*

SUBJECT: Designation of Alternate Signature Authority for the Substance Abuse Prevention and Treatment Block Grant Application (SABG), Annual Synar Report and Related Documents, and Related Documents for Other Substance Abuse and Mental Health Services Administration Grants (SAMHSA)

Governor David Ige has designated signature authority to me, as the Director of the Department of Health (DOH), for the SABG Application, Synar Report and related documents, and other SAMHSA grants. In case of my absence and unavailability, the Deputy Director of Health, who is the DOH second in command, is authorized to sign all Funding Agreements, Certifications and Assurances for the SABG Application, Synar Report and related documents and other SAMHSA grants. If the Deputy Director and I are both absent and unavailable, then the Deputy Director of Behavioral Health Administration (BHA) is authorized to sign all Funding Agreements, Certifications and Assurances for the SABG Application, Synar Report and related documents, and documents for other SAMHSA grants to be submitted to the SAMHSA because the Alcohol and Drug Abuse Division is directly under the BHA Deputy Director.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2022

U.S. Department of Health and Human Services
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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. §5794), 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.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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 Coastal 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 Clean 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).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
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, amendment, 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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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 other Certifications summarized above.

State: Hawaii

Elizabeth A. Char, M.D.

Name of Chief Executive Officer (CEO) or Designee:

Signature of CEO or Designee¹: 
Director of Health

Title:

Date Signed: AUG 25 2021
mm/dd/yyyy

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:

**FFY2022-2023 Behavioral Health Assessment and Plan
Hawai'i Single State Authority (SSA)
SABG Responses to the Following Sections of the Hawaii FFY2022-2023 Combined
Application
September 30, 2021**

This section includes additional SABG responses to the following sections of the Hawaii FFY2022-2023 Combined Application as these SABG-related sections were not reopened by the 10/1/21 SABG deadline. The Hawaii SSA, also known as the Department of Health, Alcohol and Drug Abuse Division, usually responded to these sections in prior SABG Applications.

- Step 1 (SA only): Assess the strengths and organizational capacity of the service system to address the specific populations.
- Step 2 (SA only): Identify the unmet service needs and critical gaps within the current system.
- Table 3 SABG Persons in need/receipt of SUD treatment
- Factor 1. The Health Care System, Parity and Integration - Question 1 and 2 are Required
- Factor 2. Health Disparities - Requested
- Factor 6. Program Integrity - Required
- Factor 11. Quality Improvement Plan- Requested
- Factor 12. Trauma - Requested
- Factor 13. Criminal and Juvenile Justice - Requested
- Factor 16. Recovery - Required
- Factor 18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG
- Factor 22. Public Comment on the State Plan - Required

Step 1 (SABG): Assess the Strengths and Organizational Capacity of the Service System to Address the Specific Populations

Description of Substance Abuse Service Systems

The Hawaii State Alcohol and Drug Abuse Division (ADAD) is the Single State Agency (SSA) that manages the Substance Abuse Prevention and Treatment Block Grant (SABG) for Hawaii. ADAD's efforts are designed to promote a statewide culturally appropriate, comprehensive system of substance abuse services to meet the treatment and recovery needs of individuals and families; and to address the prevention needs of communities.

ADAD is under the Hawaii State Department of Health (DOH), Behavioral Health Administration (BHA). BHA also includes the Adult Mental Health Division (AMHD) and Child and Adolescent Mental Health Division (CAMHD). While mental health and substance abuse services are organizationally under the DOH-BHA umbrella, ADAD's operations are not integrated with AMHD and CAMHD, and ADAD is physically sited in a separate and distant location from the mental health divisions. Also, while mental health services for adults and children are administered by separate divisions, ADAD oversees and funds substance abuse services for both adults and adolescents.

ADAD is the primary source of public substance abuse treatment funds in Hawaii. Some substance abuse treatment services are publicly funded through the Hawaii Medicaid 115 waiver program called QUEST, which is administered by the Department of Human Services. Each QUEST managed care plan determines the substance abuse treatment providers with which it will contract. Treatment services are provided to QUEST clients within the limits of the benefits in the plan.

ADAD's major functions include: grants and contracts management; monitoring implementation of treatment services and prevention activities; clinical consultation; accreditation of substance abuse treatment programs; training and certification of substance abuse counselors and program administrators; policy development; planning and coordination of services; needs assessments for substance abuse services; and information systems management.

The state of Hawaii is in a period of economic expansion with unemployment rates reaching historical low levels. Albeit this economic expansion and low unemployment rate, the State remains cautious and recognizes that economic conditions can change rapidly and can be influenced by internal factors (such as changes in state procurement and contracting policy and procedures) and external factors (such as availability of federal funding). Within ADAD, staff turnover and attrition continue to pose challenges to ADAD's operations and may be related to the State's current low unemployment rate.

ADAD utilizes the State procurement process to direct available Block Grant and State funds to support the provision of services for the substance abuse continuum of care. In planning for substance abuse services, ADAD focuses on four planning areas that are consistent with the State's island counties. Oahu (City and County of Honolulu) is the major planning area that comprises 69.9 percent of the State's population of 1,455,271 based on estimates from the U.S.

Bureau of the Census, Population Estimates Program. The other three planning areas consist of the neighbor island counties of Hawaii, Maui (which includes the islands of Maui, Molokai, and Lanai), and Kauai. The population percentage of each of these counties is as follows: Hawaii County, 13.8 percent; Maui County, 11.3%; and Kauai County 5.0 percent. Based on the Census Bureau, 78.2 percent of Hawaii's population is comprised of minorities ("minority population" is defined by the Census Bureau as the population identifying their race and ethnicity as something other than non-Hispanic White race only) and 24.0 percent of Hawaii's population self-identify as multi-racial.

As required by the State procurement process, ADAD holds request for information (RFI) sessions to obtain community input on substance abuse services that ADAD intends to procure. The information that is acquired through the RFI is incorporated into requests for proposals (RFPs) that ADAD develops and issues in accordance with State procurement procedures. The RFPs also: (1) encompass SABG requirements for services for specified target groups; (2) reflect existing needs assessment data and other pertinent data sources; and (3) require applicants to substantiate the need for their proposed programs and services and identify their target populations for which services will be provided. ADAD reviews, evaluates, and scores the proposals submitted by community-based organizations, and awards service contracts based on the evaluation criteria set forth in the RFP requirements.

While procurement and contracting cycles vary depending on the type of service and funding availability, the typical service contract is approximately two to four years. This would generally commit the State to these services for the entire contract period. However, after the first contract year, contract continuation is subject to funding availability, satisfactory performance of contracted services, and the determination by the State that the services are still needed.

Substance Abuse Treatment Services

Supported by Block Grant and/or State general funds, ADAD provides access to substance use disorder (SUD) continuum of care (COC) treatment services to include residential services (including nonmedical residential detoxification), motivational enhancement services, intensive outpatient, outpatient, therapeutic living programs, opioid addiction recovery services, group recovery homes, continuing care services, clean and sober housing, transportation, child care, translation/interpretation services, and HIV early intervention services for persons in substance abuse treatment programs. Adult populations receiving specialized services supported by Block Grant and/or State general funds include dual diagnosed, pregnant women and women with dependent children (PWWDC), people who inject drugs (PWID), offenders on supervised release, furlough, probation or parole, and the homeless.

Starting October 1, 2019 ADAD implemented a 24/7 Hawaii Coordinated Access Resource Entry System (Hawaii CARES) which provides support with substance use lowering the barriers to access treatment and offers avenues of referral to on-demand SUD treatment services; these referrals will define the appropriate type of service and service location. The intent is to create a system of care that includes all SUD COC treatment service providers, both those contracted and those not contracted with the State. This will provide a system of care that lowers the barriers to access treatment and offers avenues of referral to on-demand SUD treatment services; these

referrals will define the appropriate type of service and service location. An additional CARES objective is to reduce the need or engagement of a waitlist. In order to reduce a waitlist need, the State intends that all clients, who enter into the SUD COC network, will be referred to a state contracted service provider or will be referred to a non-network provider; thus, increasing access to services for all clients. In June of 2020 the Hawaii CARES line combined two former statewide services: the ACCESS Line and the Crisis Line of Hawai'i and now provides additional services that include phone counseling and support to residents in crisis as well as providing information on mental and behavioral health services.

For information on specialized services for pregnant women and women with dependent children, please see Sec. 10, Criterion 3: Pregnant Women and Women with Dependent Children in this application.

Persons Who Inject Drugs (PWIDs) are provided with specialized services through ADAD's contracted opioid addiction recovery services program that includes outreach services to encourage PWIDs to utilize the program's treatment services and to accept referrals and linkages to appropriate resources in the community. All ADAD-funded treatment programs are contractually required to comply with ADAD's Wait List Management and Interim Services Policy and Procedures that include service provisions for PWIDs. If an ADAD-funded treatment program does not have the capacity to admit a PWID to treatment within 14 days of the initial request for treatment, the program must refer the individual to Hawaii CARES to be linked and referred to another treatment program that can admit the wait-listed individual to treatment within 14 days. If no treatment program has the capacity to admit the PWIDs within 14 days, then the program must provide interim services within 48 hours or refer the PWID to the ADAD-designated Opioid Therapy Outpatient Treatment Program to receive interim services. PWID clients in interim services must be admitted to treatment within 120 days of the initial request for treatment.

All ADAD-funded treatment programs are contractually required to comply with Sec. 1924(a) of Public Law (P.L.) 102-321, to routinely make available tuberculosis (TB) services to all their clients either directly or through arrangements with public or nonprofit agencies. If the substance abuse treatment program is unable to accept a person requesting TB services, the program shall refer the person to a provider of TB services. TB services include but are not limited to the following: counseling; testing to determine whether the individual has contracted TB and to determine the appropriate form of treatment; and treatment. The Department of Health's Communicable Disease Division, Tuberculosis Control Branch provides needed TB services to ADAD clients in treatment for substance abuse.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment's (CSAT) list of "designated states" for the Federal fiscal year (FFY) 2020 SABG, Hawaii is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000 population. (See 42 USC §300x-24(b) and 45 CFR §96.128). Since 2002, SAMHSA has prohibited non-designated States from expending any Block Grant funds for HIV early intervention services. But in September 2011, SAMHSA made a program policy change to allow States that were "designated" within the last three years the option to continue to set aside 5% of their SABG award for HIV early intervention services. This option does not

apply to Hawaii since Hawaii was not “designated” within the last three years. Thus, no SABG funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance abuse treatment programs.

Supported by the State general funds, ADAD ensures access to SUD COC treatment services for adolescents through contracted school-based and community-based substance abuse treatment programs. School-based treatment services are provided at nearly all the public middle and high schools in each of the State’s four counties. The school-based treatment allows for 1-8 hours per week of outpatient treatment. The community-based treatment allows for 1-9 hours per week of intensive outpatient and 1-8 hours per week of outpatient treatment services.

The Youth Treatment Implementation Grant (YT-I) awarded to ADAD has provided the State the opportunity to expand access for SUD COC treatment services and mental health services to youth ages 12-26. Through the YT-I grant, ADAD has collaborated with the Child and Adolescent Mental Health Division (CAMHD) to create expansion and coordination for multiple systems. This grant has presented the opportunity to create a direct referral process between SUD and mental health (MH) service providers. This link between SUD treatment providers and MH providers has created an expansion to access of Multi-Systemic Therapy (MST). Another activity is the creation of a residential crisis shelter for youth; this is another collaboration between ADAD, CAMHD, Office of Youth Services, and the State’s Adolescent Drug Court.

The State Opioid Response Grant (SOR) addresses the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids as well as illicit drugs such as heroin). The goal is to develop and provide opioid misuse prevention, treatment, and recovery support services for the purposes of addressing the opioid abuse crisis within the state of Hawaii and based on needs identified in the State’s strategic plan. With support from Governor Ige and collaboration with over 100 stakeholders and community representatives, ADAD has implemented the Hawaii Opioid Initiative (the HOI). The HOI initiates activities in seven (7) focus areas all targeted to reduce risk factors and increase protective factors throughout the state for opioid and other substance misuse. The HOI in its second year of implementation achieved several objectives which include expanded registration in the Patient-Driven Payment Model (PDPM), broadened naloxone training and distribution, and coordination of state-wide installation of medication drop boxes. The HOI in its third year of implementation seeks to develop strategies for inclusion of Native Hawaiian cultural intervention treatment programs, wellness plans and holistic living into the system of care.

Substance Use Disorder Prevention Services

The goal of the substance use disorder prevention service system is to reduce the prevalence, incidence and consequences of alcohol, tobacco and other drugs (ATOD) by addressing community conditions that promote alcohol and other substance use and by enhancing community conditions that buffer individuals from the consequences of substance use disorders. ADAD supports the implementation of the Strategic Prevention Framework (SPF), a cost-

effective, structured planning process that can be applied to prevention systems at both the state and local level. Focused on systems development, the SPF reflects a public health, or community-based, data-driven approach to selecting and delivering effective prevention interventions appropriate for the community. The SPF has been used effectively by community-based organizations and community coalitions to mobilize and create community-level change. Mobilization has included the implementation of evidence-based environmental strategies which establish or change written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population. Partnership for Success (PFS) grant funds from the Center for Substance Abuse Prevention (CSAP) have contributed further to enhancing the prevention system infrastructure and supporting efforts to implement the SPF and building the capacity of community coalitions and organizations to address alcohol and other substances. (Please see <https://spfhawaii.org>)

Guided by the SPF process, ADAD awards available resources to align prevention priorities, leverage resources, build capacity and enhance community-level infrastructure to reduce and prevent the use of ATOD among at risk persons in high need areas. Federal and State dollars are allocated through service contracts with community-based non-profit organizations and public agencies to provide an effective, accessible community-based system of prevention services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs. Funded prevention programs primarily focus on the provision of evidence-based curricula and practices categorized in at least one of the six the CSAP strategies for youth and their families. Prevention interventions are comprehensive and culturally appropriate for universal, selected and/or indicated populations and strive to produce sustainable positive outcomes.

Prior to making decisions regarding funding allocations, ADAD requests public agencies and non-profit community-based organizations to provide feedback related to gaps in the current prevention system with respect to services, populations, substances, collaborations and capacity needs. Additionally, ADAD is in the process of implementing the SPF process on the state level with the State Epidemiology Outcomes Workgroup (SEOW) and the SPF Evaluation Team to identify substance use disorder prevention priorities. The SEOW's [2019 Hawaii State Epidemiologic Profiles](#) (modified Jan. 15, 2021) are now available.

During this application planning period, ADAD plans to use the SAPT Block Grant along with State dollars and PFS grand funds to expand prevention services within the IOM Categories, especially the selective and indicated categories, among disparate populations, and within the behavioral health continuum of care. The Request for Proposal applicants would align their initiatives with the State's comprehensive strategic plan through their own process of implementing the SPF.

In previous years, the general target populations identified for services are at-risk youth, ages 9-17 and young adults ages 18-24 and their families, schools and communities. Additionally, depending on the geographic area or community where prevention services are delivered, providers may target and include for prevention services populations identified below:

- Children and youth whose parents are experiencing substance use disorders;

- Children and youth who have experienced academic difficulties or chronic failure in school;
- Children, youth and families who are economically disadvantaged;
- Children, youth and families who have committed or are at risk of committing a violent or delinquent act;
- Children, youth and families who have experienced mental health problems;
- Youth at risk for suicide;
- Lesbian, Gay, Bisexual, Transgender, Questioning, and In transition individuals (LGBTQI);
- Homeless children, youth and families;
- Military personnel and dependents; and
- Native Hawaiian.

ADAD plans to continue services to the populations stated above; however, it may change slightly based on data results upon completion of the State level SPF process.

The lengthy procurement process has recently begun for primary prevention services to start on September 30, 2022. Prevention service contracts will be awarded based on the best configuration of services to promote a statewide, culturally appropriate, comprehensive substance use disorder prevention system of services to meet the needs of Hawaii's communities. Considerations for the allocation of funds to the applicants include, but are not limited to, assessed need for the proposed services; existing prevention issues and priorities; geographic areas and populations at risk; underserved geographic areas or populations; gaps in services within a geographic area; the community's readiness to implement prevention services; and the community-based organization's capacity for working with community stakeholders including children and youth, and Native Hawaiian organizations.

ADAD promotes the coordination of resources to further support and strengthen the prevention service system. State and local government agencies and community-based organizations coordinate to leverage resources and services to address risk factors, increase protective factors, expand innovative prevention approaches, and improve the quality of comprehensive community-based prevention efforts to prevent substance use disorder and its related issues. ADAD funds the Hawaii Prevention Resource Center (HI-PRC) which houses the State's most comprehensive resource on prevention of alcohol, tobacco and other substance use/abuse and related issues available through its lending library, resource clearinghouse, and technical assistance services, as well as the [Hawaii Prevention Resource Center](#) website. Further, ADAD collaborates with other Department of Health programs, the Hawaii Department of Education, and consultants from the University of Hawaii to develop and administer an integrated Hawaii Student Health Survey in selected public high and middle school classrooms across the State. The analyzed survey data is instrumental in guiding ADAD planning activities for prevention services

Programs and service activities related to reducing minors' use of and access to tobacco and alcohol overseen by ADAD include compliance support activities and public education and policy development focusing on limiting youth access to alcohol, strictly enforcing underage drinking laws, and promoting zero tolerance for underage drinking while creating positive outlets

for youth. In addition to support the required Synar Amendment Compliance and Enforcement activities, ADAD maintains a cost-reimbursement contract agreement with the U.S. Food and Drug Administration (FDA) for field enforcement of FDA regulations [21 CFR 897014 (a) and (b)] prohibiting tobacco and tobacco product sales to minors and carrying out inspection of retail outlets throughout the State using FDA Commissioned Officers and underage volunteers in controlled, observed undercover buy operations.

Certifications for Substance Abuse Professionals

ADAD certifies substance abuse counselors and program administrators pursuant to State law (HRS §321-193(10)) and regulations (Hawaii Administrative Rules, Title 11, Department of Health, Chapter 177.1). In efforts towards advancing the workforce development of substance abuse professionals, ADAD expanded its certification services. In July 2011, ADAD began offering certification services for the Certified Prevention Specialist, Certified Clinical Supervisor, Certified Criminal Justice Addictions Professional, and Certified Co-Occurring Disorders Professional-Diplomate. Information on the certification process and requirements is available at ADAD's [revised certification website](#).

Hawaii is a member board of the [International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc.](#) (IC&RC/AODA). The IC&RC is a voluntary international organization comprised of substance abuse credentialing boards representing 43 states, the U.S. military, various Indian Health Service Organizations, U.S. territories, and a range of countries. As a member board, Hawaii subscribes to the international standards prescribed by the IC&RC and published in the IC&RC guidelines.

Counselors certified in Hawaii have reciprocity with other IC&RC member boards, providing the other member board offers a similar type credential.

ADAD provides numerous training and educational opportunities annually for those obtaining an initial credential, and for those renewing their credentials, required bi-annually. ADAD also collaborates with other organizations and service professionals to provide trainings which have been approved for contact hours that may be applied towards meeting the educational requirements for certification and renewal.

Step 2 (SABG): Identify the Unmet Service Needs and Critical Gaps within the Current System

Current Unmet Needs and Critical Gaps

First, service gaps in Hawaii exist as a result of geographically remote locations with limited access to services, provider shortages, and disconnected systems of care. Geographically, the Hawaiian Islands present unique challenges. The need to fly to other islands if necessary to obtain needed specialty services remains a constant issue for the State. For example, many individuals requiring inpatient psychiatric treatment on neighbor islands must be flown to Oahu, at significant cost to the State and disruption to the individual and their families. The service array on a specific island is often insufficient to meet the acute or chronic care needs of its population, particularly in relationship to Mental and Substance Use Disorder (M/SUD) health care. The transportation issue limits or prohibits islands from easily sharing resources, as might be an alternative in other states. In addition, rural areas suffer from a lack of access to services since most physicians are in the Honolulu area.

Second, the stigma associated with substance misuse remains a barrier to treatment, and therefore a key component to prevention and intervention planning. The language used to speak about substance use is critical to decreasing the negative impact of stigma. To decrease this negative impact, ADAD's substance abuse treatment contracts are named "health and wellness plans."

Third, a lack of coordinated entry among Hawaii treatment providers continues to result in fragmented collaboration among providers. This fragmented collaboration has resulted in continued barriers of client access to a full continuum of care (COC) for substance use disorder (SUD) treatment services, which is an opportunity for providers, who may not have communicated as regularly in the past, to collaborate in new ways and simultaneously promote the standardization of assessments and referrals, and more quickly connect people to appropriate and tailored services. With the FY2021-2023 treatment contracts, the State plans to continue to utilize the Hawaii CARES, with the objectives of reducing treatment access barriers and creating a system that provides a COC to deliver SUD treatment modeled after the American Society of Medicine (ASAM) criteria for SUD services.

ADAD seeks data from various information resources in planning for the provision of substance abuse services, identifying service needs and critical gaps, and developing priorities and goals. These information resources include surveys, groups and agencies engaged in data collection, alcohol and drug service providers, community forums, and officially appointed advisory bodies in operation.

There are data limitations in utilizing national surveys such as the National Survey on Drug Use and Health (NSDUH) and Monitoring the Future survey to obtain information on Hawaii's population. The number of Hawaii residents sampled in national surveys is often too small to yield meaningful data, particularly at the state or community level, or Hawaii may be totally excluded from a survey due to its relatively small population size, distance from the mainland U.S., and the high cost of survey implementation in a multi-island state.

As initially described under Step 1 in this application, ADAD utilizes the State procurement process to direct available Block Grant and State funds to support the provision of services for the substance abuse continuum of care as well as to seek information on service needs in Hawaii's four counties. As required by the State procurement process, ADAD issues Request for Information (RFI) to obtain community input from stakeholders and substance abuse treatment providers on services that ADAD intends to procure. It is an opportunity especially for service providers to express what they perceive the gap areas to be in the current system. The information that is acquired through the RFI is then incorporated into RFPs that ADAD develops and issues in accordance with State procurement procedures and to ensure compliance with SABG requirements for services for specified target groups. The RFPs also reflect existing needs assessment data and other pertinent data sources, as well as require applicants to substantiate the need for their proposed programs and services and identify their target populations for which services will be provided.

Proposals from community-based organizations are reviewed and scored by ADAD based on evaluation criteria set forth in the RFP requirements, and service contracts are then executed. While procurement and contracting cycles vary depending on the type of service and funding availability, the typical service contract is currently approximately two years. This would generally commit the State to maintaining these services for the entire contract period. However, after the first contract year, continuation of a contract is subject to the availability of funds, satisfactory performance of the contracted services, and the determination by the State that the services are still needed.

Substance Abuse Treatment and Recovery Support Services

Starting October 1, 2021, ADAD will start the first year of its two-year contract period for treatment and recovery support services from October 1, 2021 to September 30, 2023, with the possibility of extensions for two additional years. The SABG application planning period of July 1, 2021 to June 30, 2023, covers the first and second year of ADAD's new two-year contracts for treatment and recovery support services. The federal fiscal year (FFY) 2021 SABG award is being utilized to support the first year of ADAD's new two-year contracts. The FFY 2022 SABG will be utilized to continue the treatment and recovery support services provided by ADAD's current contracted providers during the second year of the new contract period. This helps to maintain continuity and provide stability for service providers and clients especially during recent years of uncertain funding on the Federal and State levels. Contract modifications, in accordance with the State procurement process, are executed throughout the contract period to adjust funding levels of contracts based on availability of SABG and State funds, service needs, and providers' utilization of funds.

The planning process for the current two-year contract period followed State procurement requirements and procedures which preceded the first year of the contract period. Planning activities for ADAD's two-year contract period included publishing an electronic RFI in 2020. ADAD utilized information from the RFI to identify unmet needs and critical gaps within the Hawaii treatment infrastructure.

The following is a description of data sources that were used in planning for substance abuse treatment and recovery services by types of service populations funded by the SABG and/or State funds for the two-year contact period (with the possibility of extensions) from October 1, 2021 to September 30, 2023.

Adult Population: In planning for substance abuse treatment and recovery support services for the adult population, ADAD reviewed state fiscal year (SFY) 2020 data from ADAD's Web Infrastructure for Treatment Services (WITS) system, an electronic health record and billing system for ADAD-contracted substance abuse treatment and recovery service providers. For the population 18 years of age and older, 14.5% received treatment for alcohol as the primary substance while 60.3% received treatment for methamphetamines and 8.9% for marijuana. Another 7.9% received treatment for heroin. Other opiates as primary substance accounted for 5.7% for adults. These data indicate that the need for substance abuse treatment exists throughout the State. These data further suggest that methamphetamine remains the primary substance of abuse. However, substantial numbers of persons exhibit addiction to both alcohol and other drugs.

ADAD released the “Alcohol and Drug Treatment Services in Hawai`i, 2018” report produced by the University of Hawaii Center on the Family under a contract with ADAD. The report focuses on substance use disorder treatment services provided by agencies that were funded by ADAD during State fiscal years 2015, 2016 and 2017. The report presents information on characteristics (e.g., age, county of residence, gender, ethnicity, employment status, and special conditions) of the adolescents and adults who were admitted to treatment programs. The report also includes information on the use of different modalities of services and data relating to treatment service outcomes. The report is available on the ADAD website at https://health.hawaii.gov/substance-abuse/files/2018/12/TREATMENT_2018_WEB.pdf.

Pregnant Women and Women with Dependent Children: In planning for specialized substance abuse treatment and recovery support services for pregnant women and women with dependent children, ADAD reviewed the National Survey on Drug Use and Health (NSDUH) data, the Treatment Episode Data Set (TEDS) Admissions to and Discharges from Publicly Funded Substance Use Treatment Report of 2019 (released June 2021), and 2019 Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) data from the Department of Health, Family Health Services Division.

NSDUH national data focused on substance use treatment among women of childbearing age for whom substance use poses risks to vulnerable offspring. According to weighted prevalence 2015-2018 NSDUH data for the U.S., 9.8% of pregnant women aged 12 to 44 drank alcohol in the past month, with 64.7% drinking in the past year, and 4.5% binge drinking in the last 30 days. The 2019 TEDS data indicates that 67.9% of female admissions aged 12-17 were admitted with marijuana/hashish as the primary substance, followed by methamphetamines at 11.5%. For pregnant females aged 18 and older, 31% of admissions listed heroin as the primary substance, followed by methamphetamines at 22.4%.

The PRAMS Report showed that an estimated 6.8% of mothers in 2019 reported alcohol use during pregnancy; and an estimated 5.8% reported cigarette smoking during pregnancy. From 2019 there was an average annual estimate of 8,500 resident births.

Opioid Addiction (encompasses services for intravenous drug users): In planning for opioid addiction treatment and recovery services, ADAD reviewed data from the WITS system. The data indicated, by primary substance of abuse, that heroin accounted for 7.9% of SFY 2020 treatment admissions for adults, up from 6.4% of in SFY 2017. Other opiates as primary substance accounted for 5.7% for individuals aged 18 and older, a slight decrease from 6.2% in SFY 2017. Based on WITS data for SFY 2020, ADAD's contracted providers reported total admissions of 5,187 ADAD-funded clients of which 5.4% had heroin as the primary substance.

On July 2017, Governor David Ige officially launched the State Opioid Action Initiative. This initiative brought together stakeholders from the public and private sector and adopted both a public health and public safety focus. The overarching goal was to develop and implement a proactive coordinated statewide Action Plan on opioid and other substance misuse issues. The stakeholders produced the Hawaii Opioid Action Plan (Dec. 2017) that serves as a roadmap for a proactive and sustainable response to the opioid crisis seen in other states, a significant accomplishment but only a beginning. Now adopted as the Hawaii Opioid Initiative (the HOI) the State is in its third year of implementation. The second version (HOI 2.0) are available [here](#). The 2020 HOI Evaluation Report along with the third version's (HOI 3.0) goals and objectives may be found [here](#).

Treatment Services/Groups Supported by State Funds Only: The services described above will continue to be supported by both SABG and State funds. ADAD's upcoming two-year substance use treatment contracts (with the possibility of two-year extensions) also cover services supported only by State funds for certain populations. These State-funded services include school-based and community-based substance abuse treatment services for adolescents, integrated addiction care coordination and substance abuse treatment services for offenders on supervised release, furlough, probation or parole, substance abuse treatment and recovery support services for the homeless, group recovery homes, and HIV early intervention services for persons in substance abuse treatment programs. In planning for services for these populations, data sources utilized (in addition to those described above) included ADAD's WITS SFY 2018 treatment program admissions data, and 2019 PRAMS data.

Another way ADAD supports services for substance use disorders is through recovery housing. The [2020 Homeless Point in Time Count for the State of Hawaii](#), conducted by Partners In Care (PIC) for Oahu and Bridging the Gap (BTG) for Hawaii, Maui and Kauai counties, found 6,458 homeless individuals of which 3,879 were unsheltered. Given the lack of affordable housing in Hawaii, encouraging the startup of more recovery houses is key to providing a stable living environment that assists the progress that was achieved through treatment services and serve as a transition towards independent living.

According to CSAT's list of "designated states" for the FFY 2022-2023 SABG, Hawaii is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000. (See 42 USC §300x-24(b) and 45 CFR §96.128). Thus, no SABG funds are allocated for HIV early

intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance abuse treatment programs.

Tuberculosis. Effective October 1, 2017, contracted substance use treatment providers are required to adopt a policy regarding tuberculosis (TB) and Hepatitis C which states that it provides for TB and Hepatitis C screening, referral and education as appropriate. The provider shall routinely make available TB services to all clients either directly or through arrangements with public or nonprofit agencies. If the provider is unable to accept a person requesting services, the provider shall refer the person to a provider of TB services. TB services shall include, but not be limited to: counseling; testing to determine whether the individual has contracted the disease and to determine the appropriate form of treatment. Providers shall also maintain documentation for each employee of an initial and annual TB skin test or chest X-ray. Providers shall also give training for staff on the risks of TB and Hepatitis C for those abusing substances. Providers shall also submit, in the format specified by ADAD, TB screening/test results as part of the client's health record wherever applicable. For contractors who provide clean and sober housing, their policies and procedures must specify that all clients admitted are required to have a current TB clearance. As part of the general requirements for therapeutic living programs, providers shall also have on file documented evidence that every direct care staff or any individuals having contact with residents has an initial and annual TB clearance following current DOH policy. Providers are also to adopt an interim services policy that provides services to Pregnant Women and Injection Drug Users until they are admitted to the treatment program. At a minimum, such interim services shall include counseling and education about (a) HIV, Hepatitis C, and TB; (b) the risks of needle sharing; (c) the risks of transmission to sexual partners and infants; (d) steps that can be taken to ensure that HIV and TB transmission does not occur; and (e) referral for HIV or TB treatment services if necessary.

The application period of July 1, 2021 to June 30, 2023 also covers the planning period for ADAD's upcoming two-year contract period for treatment and recovery support services from October 1, 2021 to September 30, 2023, with the possibility of a two-year extension. Planning and information gathering activities were completed throughout 2018 for development of the 2021 RFP for adult and adolescent substance abuse treatment services. RFI were published during 2020 to obtain community input on services needed. ADAD published the RFP in Dec. 2020 for new contracts to begin October 1, 2021. The most recent data and pertinent information available from local, State and national data sources will be utilized to inform the next set of RFPs to address community needs and gaps for the treatment and recovery support service system.

Substance Use Disorder Prevention Services

National and local data sources are used to inform the process to identify service needs and develop priorities and goals for the substance use disorder prevention services in Hawaii. ADAD relies heavily on community-based service providers, contracted consultants and experts, trained epidemiologists for assessments, data collection, and data analysis to identify primary prevention program needs and gaps. Representatives from community-based organizations and other stakeholders participate in formal and informal discussions and meetings to provide insights and feedback regarding local conditions, behaviors and trends related to substance use

disorder issues. The implementation of prevention program services funded by SABG and State general funds is documented and tracked in the Hawaii-Web Infrastructure for Treatment Services (HI-WITS). ADAD recognizes that the local information gathered and reported through HI-WITS may be flawed or biased relative to the contracted service providers' depth of experience, knowledge and understanding of needs assessment, evaluation and data collection and interpretation. The University of Hawaii is contracted to provide technical assistance and training to contracted service providers to ensure more effective reliable primary prevention program data collection and reporting.

The State Epidemiologic Outcomes Workgroup (SEOW) led by the University of Hawaii Office of Public Health Studies Epidemiology Team has been instrumental in assisting ADAD in making data informed decisions regarding plans and resource allocations to enhance the prevention system. The functions and membership of the SEOW have been sustained through the Strategic Prevention Framework – Partnerships for Success (SPF-PFS) five-year grants awarded by CSAP to ADAD in 2013 and 2018. The workgroup is comprised of voluntary members, primarily directors, epidemiologists or data managers, from government, educational and community agencies involved in research or data collection. The SEOW provides additional support to sustain SPF efforts, fill knowledge gaps, and develop a platform for data sharing and a data sharing protocol that enables timely and efficient sharing of epidemiological data relating substance use disorder and its consequences. Quarterly meetings, training workshops and conferences are organized by the SEOW to share and review different data sources and reports in efforts to apply the lessons learned in substance use disorder data collection and reporting to broader behavioral health issues.

Compiling and analyzing various data sources, the SEOW created and periodically updates community profiles that provide an insight and basis for potential prevention program design and direction. Please see the [UH Public Health Analytics Collaborative site](#) for the updated 2019 profiles (modified Jan. 15, 2021). The original data sources for the profiles include the Hawaii Youth Risk Behavior Survey (Hawaii YRBS), the National Survey on Drug Use and Health (NSDUH), the Behavioral Risk Factor Surveillance System (BRFSS), Uniform Crime Report (UCR) data, Fatality Analysis Reporting System (FARS) data, and the Pregnancy Risk Assessment Monitoring System (PRAMS). To address the issues of substance use disorder on a broader scale, all substances, age groups and indicators are taken into consideration for the priority selection process and the following are some of the indicators selected to be highlighted in the State and County Epidemiological Profiles:

- Youth consumption within past 30 days (alcohol, marijuana, cocaine, any illicit drug)
- Adult consumption within past 30 days (alcohol, marijuana, any illicit drug)
- Consumption before the age of 13 (alcohol, marijuana)
- Adult binge use (alcohol)
- Consumption within last 3 months of pregnancy (alcohol)
- Youth substance use disorder or dependence (alcohol, any illicit drug)
- Adult substance use disorder or dependence (alcohol, any illicit drug)
- Youth perceived risk from marijuana use
- Drivers in fatal crash that were alcohol positive
- Youth driving after alcohol consumption

- Adult driving after alcohol consumption
- Deaths by drug overdose
- Mental health admissions reporting any use of alcohol

As first identified during the State Incentive Grant (SIG) period and further supported by more recent survey results and data analysis of the SEOW, alcohol use is more prevalent among youth ages 9-17 and young adults ages 18-20 than any other substance, so therefore, underage drinking (UAD) remains a prevention priority focus statewide. Although the prevalence of UAD has been in decline for Hawaii overall, neighbor islands, Native Hawaiians, sexual and gender minorities, and homeless and runaway youth are disproportionately impacted. The most recent Youth Risk Behavior Survey (YRBS 2019) data shows that youth living in counties outside of the highly urbanized City and County of Honolulu are more likely to consume alcohol. Hawaii, Maui and Kauai Counties have higher prevalence rates in alcohol indicators for middle and high school students. These indicators include: ever having a drink of alcohol; current drinkers; first drink before the age of 13, and; binge drinking for both girls and boys. Hawaii County ranks the highest for all indicators except binge drinking.

Data also shows that Native Hawaiian youth have a greater risk of alcohol use compared to other racial groups. Among the major racial groups where data were available, [Native Hawaiian high school students consistently showed the highest prevalence in all alcohol-use indicators, according to the 2019 YRBS](#): 56.2% reported they had ever used alcohol, 29.9% were current drinkers, 11.6% of boys and 18.5% of girls participated in binge drinking and 19.8% of alcohol users had their first drink before 13 years of age. UAD also disproportionately affects gender and sexual minority youth. According to the Department of Health (DOH) 2017 Hawaii Sexual and Gender Minority Health Report, over 1 in 10 high school students self-identified as lesbian, gay, bisexual and questioning (LGBQ). Using YRBS multi-year high school data (2011 – 2015), the report found that 45% of LGBQ youth were current alcohol users, compared to 25% of heterosexual youth. Moreover, LGBQ youth were twice as likely to participate in binge drinking compared to heterosexual youth (20% versus 10%).

Homelessness is another major public health problem within the State. [The 2018 Street Youth Study](#), released by the University of Hawaii, surveyed 151 homeless and runaway youth aged 12-24 in the City and County of Honolulu. The study found that street youth are about five times more likely to report “fair” or “poor” overall health compared to the general population. When looking specifically at youth drinking, 53% of youth in the study reported using within the 30 days prior to the interview; among younger youth (aged 12-17) the prevalence of current drinkers was 44.4%.

Needs and gaps related to readiness, capacity, and resources to provide services to identified high need areas and special populations to sustain an effective prevention service system for Hawaii continue to exist. Often community-based organizations are challenged to select and deliver effective programs for specific populations such as the homeless adolescent, LGBTQI, and Native Hawaiian populations. Though a commitment continues to incorporate cultural values and traditions without compromising the integrity of identified evidence-based programs, there is a lack of locally developed and evaluated evidenced-based, culturally appropriate substance use disorder prevention programs and curricula. Additionally, the limited capacity and financial

resources of community-based organizations to manage and maintain compliance with the fiscal reporting, management requirements and special conditions of state and federal contract agreements, provide challenges for the substance use disorder prevention system at the community level. Even though prevention services may be delivered more effectively by local, small agencies or individuals in certain communities or for specific populations, the smaller organizations often lack the business plan and infrastructure necessary for billing and reporting processes. A related gap to be addressed is the workforce capacity, expertise and staff required to conduct the financial or programmatic aspects of government contracts and sustain operations. Communities have expressed the need for attention to workforce development and further support for increasing the skills and numbers of certified prevention specialists.

According to the Hawaii SEOW, Hawaii has data limitations and gaps in the substance use disorder and mental health areas, specifically prescription drug misuse, substance use disorder by ethnic sub-groups, specific populations, and mental health related comorbidities. The following list of data gaps, identified by the SEOW, if addressed could expand the knowledge base of specific populations, substances, risk, and protective factors and assist in effective allocation of substance use disorder prevention resources.

- Data by ethnicity

The ethnic make-up of Hawaii is unique compared to the rest of the states. The majority of the individuals are of Asian race. In addition, a substantial proportion of the population consists of Native Hawaiians and Pacific Islanders. Since each ethnicity has different culture, history, traditions, and social characteristics, it would be more useful if the data was segregated by ethnic sub-groups (Native Hawaiians, Micronesian, Samoan, Vietnamese, Japanese, Chinese, etc.).

- Special populations

Current data sources do not identify current college enrollment, resulting in the need to collect data specifically for college students and individuals above and individuals below 21 years of age. Limited data available for youth drug use indicate that sexual minority youth may be using certain substances at higher rates than their heterosexual peers. Based on the few findings regarding ethnic differences, groups with consistently higher use, specifically Native Hawaiian and Caucasian youth, have been seen over several years.

- Consistent indicators

A consistent set of indicators to measure each substance is useful in comparing the priorities by substance; however, certain substances, such as alcohol are thoroughly measured whereas others, such as heroin, are not. Further, certain indicators for alcohol use are not available consistently for every year. For example, the indicators for youth disapproval of alcohol use, youth driving while under the influence of alcohol, family communication around substance use, and percentage of youth seeing a prevention message were canvassed in previous years' questionnaires but are no longer available.

Continued data collection for all indicators would allow for better cross-year comparisons.

- Adult indicators

Although youth substance use patterns may predict the substance use behaviors in the adult phase of an individual, a set of summary statistics is still more accurate than estimated data. Currently there are more indicators measured amongst youth than adults. Consistent indicators should be used to track prevalence.

- Mental health related

Additional mental health related indicators other than mental health admission records will be useful in examining the mental health and substance use disorder association.

- Additional Substances

Additional data is needed on other substances such as methamphetamine, heroin, synthetics, and prescription drugs. Although prescription drug misuse is designated as a national epidemic, Hawaii has limited data on this topic. Currently the only indicator available is “use of any prescription drug within a lifetime.”

Under the lead of the SEOW, community partners, and other stakeholders, ADAD plans to address the needs and gaps identified above and enhance the substance use disorder prevention system and services in Hawaii during the SFY20 and SFY21. The ADAD will allocate available resources to community-based agencies to implement evidence-based programs, practices and policies that will impact the highest need communities and special populations. Funded prevention strategies and programs will be culturally appropriate and tailored to target populations and behaviors. Evaluation practices will be used to understand whether and how programs should be altered for specific ages or population characteristics. ADAD also plans to focus technical assistance efforts toward building capacity at the local level to enhance the potential for agencies to diversify funding to sustain substance use disorder prevention efforts and promote healthy communities across Hawaii.

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated in Need	Aggregate Number in Treatment
1. Pregnant Women	8500	49
2. Women with Dependent Children	5160	280
3. Individuals with a co-occurring M/SUD	7980	487
4. Persons who inject drugs	2123	80
5. Persons experiencing homelessness	6458	509

Please provide an explanation for any data cells for which the state does not have a data source.

Each data cell has a data source.

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

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.

Regarding the integration of substance use disorders with co-occurring disorders:

Starting October 1, 2019, ADAD's treatment purchase of service contracts were modified to where providers are now paid for giving motivational enhancement and addiction care coordination services. Motivational Enhancement Services provide counseling for the purpose of establishing commitment to behavior change. It may include motivational interviewing techniques, curriculum-based activities and cognitive-behavioral strategies to challenge thoughts, attitudes and beliefs. Motivational Enhancement Services consist of individual or educational group counseling.

Addiction Care Coordination actively assists and supports client access to needed health, behavioral health and other community supports in a way that ensures communication among and between the client and any stakeholders in the client's wellness to improve positive outcomes. The overall goal of Addiction Care Coordination is to support the client's development of protective factors, supports, and other skills to achieve overall health and well-being. Addiction Care Coordination is a service that is coordinated with, and coordinates on behalf of, treatment and recovery support services for the client. Addiction Care Coordination includes any of the following:

- a) Face-to-face or electronic contact with the client.
- b) Direct or electronic contact with professionals significant individuals who are stakeholders in the treatment and/recovery support process and vital to positive outcomes of episode care.

Addiction Care Coordinators must also meet certain education, training, experience and/or credentialing requirements.

ADAD is also meeting monthly with the Department of Human Services, MedQUEST Division who is the state Medicaid agency, to coordinate review of substance use disorder service payment and eligibility, and to possibly integrate substance use services into their Section 1115 Waiver request.

Regarding the integration of substance use disorders with mental health and primary health care:

ADAD also continues to implement the Screening, Brief Intervention and Referral to Treatment (SBIRT) project through a separate discretionary grant from SAMHSA. The SBIRT model advocates for enhanced relationships between behavioral health, women's health, and primary care, and is an essential tool for building connections necessary to increase resilience, informed decision making, and transitional skills needed to prevent relapse. ADAD is currently

implementing SBIRT through purchase of service contracts in primary care settings. Collaboration between the State Department of Health and the Department of Human Services for the broader implementation of SBIRT is also underway. SBIRT interventions will be delivered to adults 19 and over.

In 2017, with the endorsement of the State Governor, the Hawaii Department of Health launched the Hawaii Opioid Initiative (HOI). Through collaboration with over 100 stakeholders, the HOI focuses on seven (7) areas for the overarching goal to develop and implement a proactive coordinated statewide action plan on opioid and other substance misuse issues. The second version (HOI 2.0) are available [here](#). The 2020 HOI Evaluation Report along with the third version's (HOI 3.0) goals and objectives may be found [here](#).

Since July 2011, ADAD has offered certification services for the Certified Prevention Specialist, Certified Clinical Supervisor, Certified Criminal Justice Addictions Professional, and Certified Co-Occurring Disorders Professional-Diplomate. Information on the certification process and requirements is available at ADAD's certification website.

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.

ADAD's WITS system has been enhanced to enable ADAD-contracted substance abuse treatment providers to directly submit electronic claims to third party payers and to process electronic claims decisions such as payments and adjustments received from third party payers. The enhancement was successfully tested for each of the State's Medicaid payers (HMSA, Aloha Care, Ohana Care, United Health Care, and Kaiser) and will continue to be implemented by each ADAD treatment provider.

ADAD continues it's collaboration with the MedQuest Division (MQD) of the Department of Human Services, towards standardization of billing policies and procedures for statewide substance use disorder (SUD) continuum of care (COC) treatment services. The goal is to crosswalk services and rates to improve coordination of service delivery.

3.

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

4. Who is responsible for monitoring access to M/SUD services by the QHP?

As of this writing, no detailed monitoring process has been identified.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? **Yes**

6. Do the M/SUD providers screen and refer for:

- a) Prevention and wellness education **Yes**
- b) Health risks such as
 - ii) heart disease **No**

- iii) hypertension **No**
- iv) high cholesterol **No**
- v) diabetes **No**
- c) Recovery supports **Yes**

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? **Yes**

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? **Yes**

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

ADAD will not be involved in reviewing any complaints or possible violations of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Hawaii State Department of Commerce and Consumers Affairs and its Regulated Industries Complaints Office is the State agency responsible for reviewing such complaints or possible violations.

According to SAMHSA's Special Report entitled "Medical Necessity in Private Health Plans," the lack of a Federal definition of "medical necessity" poses difficulties for the enforcement of the MHPAEA.

ADAD continues to work with the Department of Human Services, MedQUEST Division who is the state Medicaid agency, to coordinate review of substance use disorder service payment and eligibility, and to possibly integrate substance use services into their Section 1115 Waiver request.

10. Does the state have any activities related to this section that you would like to highlight? **No**

Please indicate areas of technical assistance needed related to this section

No technical assistance is requested at this time.

2. Health Disparities – Requested (SABG)

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**
- b) Ethnicity **Yes**
- c) Gender **Yes**
- d) Sexual orientation **Yes**
- e) Gender identity **Yes**
- f) Age **Yes**

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**

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? **Yes**

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**

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

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? **Yes**

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

With respect to Section 2, item 1, ADAD's substance use disorder treatment providers are contractually required to utilize the Web-Based Infrastructure for Treatment Service (WITS) system, an electronic health record and billing system to report to ADAD client data and types of services provided in order to receive payment for services. WITS is also used to collect treatment episode data set (TEDS) information required by SAMHSA. WITS can generate information on race, ethnicity, gender and age of clients, as well as admissions, program enrollments and disenrollments, discharges, follow-up and waitlist information. WITS does not currently collect data on sexual orientation or gender identity.

The DOH Surveillance, Evaluation & Epidemiology Office (SEEO) of the Chronic Disease Prevention & Health Promotion Division (CDPHPD) in 2017 released its inaugural health report on Hawai'i's Sexual and Gender Minority communities. Hawai'i's sexual and gender minorities—including, but not limited to, transgender people, bisexual persons, lesbian women, and gay men—have unique health experiences and needs, and the report highlights some of the disparities in health outcomes affecting these communities, and shares opportunities to reduce these gaps in health equity. The report is found [here](#). A 2018 report was also released that focused on transgender youth.

ADAD released the "Alcohol and Drug Treatment Services in Hawai'i, 2018" report produced by the University of Hawaii Center on the Family under a contract with ADAD. The report focuses on substance use disorder treatment services provided by agencies that were funded by ADAD during State fiscal years 2015, 2016 and 2017. The report presents information on characteristics (e.g., age, county of residence, gender, ethnicity, employment status, and special conditions) of the adolescents and adults who were admitted to treatment programs. The report also includes information on the use of different modalities of services and data relating to treatment service outcomes. The report is available on the ADAD website at https://health.hawaii.gov/substance-abuse/files/2018/12/TREATMENT_2018_WEB.pdf.

Enrollment in substance use disorder prevention services is tracked through ADAD's prevention data collection and monitoring system which is used to collect data from ADAD-funded prevention programs on types of prevention services provided and clients served. ADAD tracks enrollment in substance use disorder prevention services by each prevention provider and contract. The type of prevention services and/or objectives is different for each curriculum. ADAD does not track outcomes by race, gender, or age.

With respect to Section 2, item 2, ADAD-funded substance use disorder treatment providers are required to submit quarterly reports that include information on treatment units provided, number of clients served, number of individuals followed up on, client participation in self-help groups, staffing information, as well as accomplishments and challenges. Also, providers are required to report annually on various outcome measures.

Regarding substance use disorder prevention services, ADAD tracks services that address disparities based on the contracted providers' assessment of the individual communities. ADAD works with community-based agencies, the SEOW and service providers to assess the existence of disparities and develop plans to address and eventually reduce disparities in access, service use, and outcomes for the disparity-vulnerable subpopulations in the individual communities.

With respect to Section 2, item 3, for ADAD's substance use disorder treatment and recovery services contracts, the contracts' scope of work now includes translation or interpreter services as a reimbursable recovery support service. Services for language needs can be tracked through the WITS system. Many providers try to employ a multi-ethnic, multi-cultural staff to help meet the service needs of their clients.

Prevention service providers assess the needs of their individual communities and conduct ongoing assessment of program implementation and effectiveness to determine if identified needs change during the course of the service period.

With respect to Section 2, item 4, ADAD partners with other State, county, and community-based agencies to provide training and educational opportunities to address cultural competence for providers.

With respect to Section 2, item 5, ADAD's training plan does not include the Culturally and Linguistically Appropriate Services (CLAS) Standards. However, ADAD treatment contracts do pay for translation services if the client asks the provider for a language interpreter. ADAD also

provides training on community cultural diversity needs of population groups such as native Hawaiians, Micronesians, the LGBTQ community, and those affected by HIV/STDs.

With respect to Section 2, item 6, as described above, ADAD makes available translation or interpreter services as a reimbursable recovery support service provided by ADAD's contracted substance use disorder treatment and recovery providers.

6. Program Integrity - Required (SABG)

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**
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? **Yes**
3. Does the state have any activities related to this section that you would like to highlight?

With respect to Section 6, item 1, in planning and contracting for services to be funded by SABG and State funds, ADAD follows State laws and procedures established in the Hawaii Revised Statutes (HRS), Chapter 103F and implementing regulations in the Hawaii Administrative Rules (HAR) that govern for fairness and quality, the basic planning, procuring, and contracting of health and human services by executive branch departments and agencies. The objective of the HRS and HAR is to ensure the fair and equitable treatment of and opportunity for all service providers delivering health and human services on behalf of the State and federal government by using a standardized procurement process and by optimizing information sharing and coordinating, planning, and service delivery efforts. The Department of Accounting and General Services (DAGS), State Procurement Office (SPO) serves as the central authority on State procurement requirements, policies, and procedures.

Federal program requirements are conveyed to intermediaries and providers through the narrative and description included in the Request for Proposals (RFP) procurement method and 103F contract awards. ADAD also employs the following program integrity activities for monitoring the appropriate use of block grant funds and oversight practices:

- a. Budget review: Providers are required to submit a budget with each proposal or contract. All budgets are reviewed by ADAD's fiscal staff to ensure that they are reasonable, appropriate, feasible, and in compliance with State and federal requirements and guidelines.
- b. Claims/payment adjudication: Electronically submitted claims to ADAD are adjudicated and reviewed for completeness, accuracy, and meeting required payment criteria for the contracted service. Electronic invoices are reviewed for completeness, accuracy, and appropriateness before processing for payment.
- c. Expenditure report analysis: Invoices, expenditure reports and supporting documents are submitted to ADAD with hard invoices summarizing the expenditures by budgeted line items. Before and after each payment is made, ADAD's fiscal staff reviews and updates expenditure report information to ensure expenditures are appropriate, reasonable, and stay within the approved budget.
- d. Compliance reviews: Program compliance reviews are conducted through desktop and onsite monitoring of contracts. The annual close-out process for every ADAD contract requires contracted agencies to submit compliance documents such as an inventory report with invoices of purchases, Hawaii State and federal tax clearances, and single audit report. If there are

findings in the single audit report, the provider is required to submit a corrective action plan for approval. The corrective action plan is reviewed the following year for compliance.

e. Client level encounter/use/performance analysis: ADAD reviews encounter and utilization data and does performance analysis for contracts. Program and fiscal staff have meetings together to review data and make appropriate decisions based on utilization and performance reviews for provider contracts. Contract modifications are executed to address utilization and performance issues, meet providers' needs within the requirements and guidelines of the contract, and maintain proper usage of Block Grant and State funds for the provision of contracted services.

f. Audits: ADAD's fiscal audits include a close-out report, subsidiary ledger of expenditures for the year, sampling of transactions for allowability, appropriateness and allocability. Indirect cost rate, allocation policies and procedures, and lease rent agreements are also reviewed. ADAD also complies with the OMB Circular A-133, Single Audit Report.

ADAD also uses Cost Principles established by the Hawaii State Procurement Office to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered. The Cost Principles for HRS, Chapter 103F are available at <http://spo.hawaii.gov/vendors/vendor-guide/methods-of-procurement/health-human-services/competitive-purchase-of-services-procurement-method/cost-principles-table-hrs-chapter-103f-2/>.

With respect to Section 6, item 2, ADAD assists substance abuse treatment and prevention providers in adopting practices that promote compliance with program requirements, including quality and safety standards in a variety of ways. ADAD provides accreditation to substance abuse facilities that provide services 24 hours a day (designated as Residential Treatment Programs, aka Special Treatment Facilities and Therapeutic Living Programs) and are required to be licensed by the Department of Health's Office of Health Care Assurance (OHCA). The accreditation standards are based on HAR, Title 11, Department of Health, Chapter 98 (Special Treatment Facility). The program requirements include quality and safety standards.

ADAD certifies substance abuse counselors and program administrators. Certification services are also provided for the Certified Prevention Specialist, Certified Clinical Supervisor, Certified Criminal Justice Addictions Professional, and Certified Co-Occurring Disorders Professional-Diplomate. In collaboration with community-based organizations, other State agencies, and federal agencies and organizations, ADAD provides training opportunities for in-service and professional development for service providers. ADAD staff conduct desktop and onsite monitoring of compliance with State and federal requirements identified in contract agreements for treatment and prevention services. ADAD's prevention staff periodically review prevention providers' Community Action Plans (CAP) and provide assistance with CAP development and implementation.

Please indicate areas of technical assistance needed related to this section

No technical assistance is requested at this time.

11. Quality Improvement Plan- Requested (SABG)

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? **Yes**

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

No technical assistance is requested at this time.

12. Trauma - Requested (SABG)

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? **No**
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? **No**
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? **Yes**
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? **Yes**
5. Does the state have any activities related to this section that you would like to highlight.

ADAD does not have a specific policy directing providers to screen clients for a personal history of trauma; however, ADAD contracted treatment providers are required to complete American Society for Addiction Medicine Patient Placement Criteria (ASAM PPC) for clients in any level of treatment, as well as the Addiction Severity Index (ASI) for adults and the Adolescent Drug Abuse Diagnosis (ADAD) for adolescents. Both the ASI and ADAD have sections that address Family and Social Relationships as well as Psychiatric or Psychological Status.

ADAD plans to collaborate with Adult Mental Health Division in supporting peer support services (see Hawaii certification peer specialist at <http://health.hawaii.gov/amhd/consumer/hcps/>). The plan is to review the current support services and structure specificity that incorporate SUD. ADAD has collaborated with providers in approving educational credits for peer recovery training.

ADAD schedules and sponsors training for treatment providers specific to trauma-related issues and affected groups. Training topics include the following: cultural impacts and issues in treatment; becoming an exceptional counselor by recognizing trauma; healing the offender; Medication Assistance Treatment; opioid overdose prevention and response; integrating viral hepatitis; HIV & STDs info counseling; effecting change through the use of MI; positive re-framing and stress reduction; compassion fatigue for trauma-impacted providers; issues and barriers faced by gay, bisexual, and transgender/transsexual clients; and suicide intervention skills. In addition, ADAD co-sponsors trainings and conferences with organizations in the military, the Institute on Violence, Abuse & Trauma, Pacific Southwest Addictions Technology Transfer Centers, the DOH Adult Mental Health Division, University of Hawaii: School of Social Work, the Judiciary State System, the Department of Transportation, and the Department of Human Services.

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

No technical assistance is requested at this time.

13. Criminal and Juvenile Justice - Requested (SABG)

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

With respect to Section 13, item 1, coordination of services with the criminal justice systems is an integral component of ADAD's substance abuse treatment services for offenders on supervised release, furlough, probation or parole. Coordination is also integral to the Family Drug Court program.

ADAD uses only State funds to provide contracted IACC and substance abuse treatment services for offenders on supervised release, furlough, probation or parole. The supervised Release program, which is administered by the Hawaii State Department of Public Safety's Intake Service Center, is for pretrial offenders who have been assessed not to be a flight risk or a public safety risk and are released into the community pending adjudication.

For criminal Justice clients to receive ADAD's substance abuse treatment services, offenders must be referred by the Department of Public Safety's Intake Services Center or Correction Division, the State Judiciary's Adult Client Services Branch, or the Hawaii Paroling Authority. Such referrals must have been assessed as being at medium-to-high risk for recidivism on the Level of Service Inventory Revised (LSI-R) combined with the Adult Substance Use Survey (ASUS) or the risk assessment instrument being utilized. Self-referred clients and/or clients identified by treatment providers, that might meet the criteria for IACC services include: screening/clinical assessment; individual case management service planning; court/supervising criminal justice agency technical assistance and support; service referrals and placement into substance abuse treatment; monitoring of offenders in treatment; alcohol and drug testing; HIV/AIDS education including pre- and post-test counseling; arrangements for clean and sober housing; and case management discharge. Substance abuse treatment services for eligible offenders include: motivational enhancement; residential treatment; intensive outpatient; therapeutic living

program; clean and sober housing; continuing care; transportation; translation; and cultural activities.

ADAD also uses State funds to contract with the State Judiciary Family Court of the First Circuit to provide Family Drug Court services for pregnant women and women with dependent children whose children are placed at risk by their parents involvement in substance abuse and who have open cases with the Child and Welfare Services of the Department of Human Services. The Family Drug Court program provides intensive family case management services through substance abuse treatment matching and coordination of the entire system of care between treatment and the Family Court.

ADAD's contracted services for eligible adult offenders are intended to aid inter-agency collaboration in the treatment of substance, promote diversion from incarceration, increase supervision of offenders with substance dependence problems, control costs by assignment of clients to clinically appropriate services, and serve as the point of coordination of clinical and administrative/legal accountability. IACC services entail: coordinating the entire system of care for the offender including an intensive level of outreach beyond what treatment providers and probation and parole officers are able to provide in coordinating treatment, relapse prevention, and social services pre- and post-release. ADAD's contracted treatment programs for eligible adult offenders, in cooperation with the IACC services agency, are required to assist in linking the offender to education and vocational training to increase marketability of the offender in the work force, which shall include assessment of individual needs and services, pre-employment training classes, group and individual employment-related counseling, resume preparation, and career exploration and job search. ADAD's contracted treatment programs for eligible offenders are also required to develop and implement, in coordination with the IACC services agency and supervising criminal justice agency, an appropriate transition plan for each client in the final phase of treatment prior to discharge. The plan shall address recovery issues and relapse prevention.

Please note that in accordance with 42 USC 300x-31(3), ADAD is prohibited from expending SABG funds for the purpose of providing treatment services in penal or correctional institutions in the State.

With respect to Section 13, item 3, ADAD provides a Hawaii State credential as a Certified Criminal Justice Addictions Professional. ADAD provides criminal justice trainings, along with co-sponsoring local and national organizations, such as the Interagency Council on Intermediate Sanctions and the Pacific Southwest Addiction Technology Transfer Centers. Training center emphasis is on: cognitive behavioral therapy; suicide intervention and response, medication assisted treatment, opioid crisis, trauma-based care techniques and recidivism.

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

No technical assistance is requested at this time.

16. Recovery - Required (SABG)

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**
 - b) Required peer accreditation or certification? **No**
 - c) Block grant funding of recovery support services. **Yes**
 - d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? **No**
2. Does the state measure the impact of your consumer and recovery community outreach activity? **No**
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery and recovery support services for adults with SMI and children with SED in Hawaii are provided through the Adult and Mental Health Division and the Child and Adolescent Mental Health Divisions of the Department of Health, respectively. This item does not apply to the SABG Application. This item applies only to the MHBG Application. SAMHSA's MHBG provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. Please refer to their 2020-2021 MHBG Application Plan for information on this item.

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

Recovery and recovery support services for substance use disorders in Hawaii are provided through ADAD-contracted treatment services and include the following: Continuing Care, Clean and Sober Housing, Therapeutic Living Programs, Transportation, Translation service and Childcare.

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

1. With respect to Section 16, item 1.a., regarding training/education on recovery and recovery-oriented practice and systems including the role of peers in care, ADAD plans to collaborate with the Adult Mental Health Division in supporting peer support services (<http://health.hawaii.gov/amhd/consumer/hcps/>). The plan is to review the current support services and structure specificity that incorporates SUD. ADAD has collaborated with providers in approving educational credits for peer recovery training.

2. With respect to Section 17, item 1.b., regarding peer accreditation or certification, ADAD has begun developing a Peer Recovery Support Specialist certification (PRSS). This certification is modeled after the Peer Specialist certification from the Adult Mental Health Division. The PRSS is also written into ADAD's 2021 RFP for SUD COC treatment services. The PRSS certification will be administered by ADAD.

3. With respect to Section 17, item 1.d., regarding the involvement of persons in recovery/peers/family members in planning, implementation or evaluation of the impact of the

state's M/SUD system, ADAD plans to collaborate with the Adult Mental Health Division in supporting peer support services. The plan is to review the current support services and structure specificity that incorporates SUD. ADAD has collaborated with providers in approving educational credits for peer recover training.

4. With respect to Section 17, item 2, ADAD does not currently measure the impact of our consumer and community outreach activity.

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

No technical assistance is requested at this time.

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

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

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**
 - b) Juvenile justice? **Yes**
 - c) Education? **Yes**

3. Does the state monitor its progress and effectiveness, around:
 - a) Service utilization? **Yes**
 - b) Costs? **Yes**
 - c) Outcomes for children and youth services? **Yes**

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**
 - b) Mental health treatment and recovery services for children/adolescents and their families? **No**

5. Does the state have plans for transitioning children and youth receiving services:
 - a) to the adult M/SUD system? **Yes**
 - b) for youth in foster care? **Yes**

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.)

In accordance with the State procurement process, ADAD contracts with substance abuse treatment and recovery service providers to provide school-based outpatient substance abuse treatment to middle school and high school age adolescents statewide. During ADAD's Request for Proposal (RFP) planning process, communication is shared with the Hawaii State Department of Education (DOE) administration. Prior to submitting a proposal to ADAD, prospective service providers must obtain a Memorandum of Agreement that is signed by the principal of the specific school at which the substance abuse treatment services will be provided. The agreement specifies that the provider will have administrative and logistical support, and also specifies the responsibilities of both parties. The school-based treatment counselor becomes a part of the team established by the DOE to look at the individual needs of the adolescent.

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

ADAD has established standards for individualized care planning that are reviewed and revised every contract cycle. For ADAD's current contract period from October 1, 2019 to September 30,

2021 with the possibility of extensions for two more years, clinical performance and reporting requirements were included in the contracts for school-based and community-based substance abuse treatment services for middle-school and high-school age adolescents. Clients must meet either the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association criteria for substance abuse or dependence

Providers must also submit to ADAD the following information as part of each client's health record: (1) HIV Risk Assessment; (2) Alcohol and Drug Abuse Diagnosis; (3) Master Problem List; (4) Diagnosis/Diagnoses and complete multi-axial assessment (assessment for all five axes) according to the most current version of the DSM; (5) Severity ratings for all six dimensions according to the most current version of the ASAM PPC; (6) Clinical Summary which includes relevant data and analysis of data which supports the diagnosis/diagnoses, client placement and service recommendations; (7) Treatment/Recovery Plans; (8) Treatment/Recovery Plan Updates; (9) Progress Notes; and (10) Incident Reports.

For substance abuse treatment services for pregnant women and women with dependent children, ADAD-contracted providers are also required to develop and implement individualized family service plans and therapeutic nursery child plans for children admitted to treatment along with their mothers who have been admitted to residential or therapeutic living programs.

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

No technical assistance is requested at this time.

22. Public Comment on the State Plan – Required (SABG)

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? **No**

b) Posting of the plan on the web for public comment? **Yes**

If yes, provide URL:

This 2020-2021 Application Plan was made available for public review and comment at ADAD's website <http://health.hawaii.gov/substance-abuse/survey/> where, as needed, it will be updated to reflect any revisions that may be required by SAMHSA for approval.

c) Other (e.g. public service announcements, print media) **No**

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2022

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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 Coastal 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).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
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 182by:

- 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, amendment, 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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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: Marian Tsuji

Signature of CEO or Designee¹: _____

Title: Deputy Director of Health

Date Signed: _____

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

Footnotes:

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: Marian Tsuji

Signature of CEO or Designee¹: 

Title: Deputy Director of Health

Date Signed: 8/27/2021

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

Footnotes:



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378


In reply, please refer to:
File:

July 22, 2021

MEMORANDUM

TO: Cathy Ross
Deputy Director of Health

Marian Tsuji
Deputy Director, Behavioral Health Administration

FROM: Elizabeth A. Char, MD 
Director of Health

SUBJECT: Designation of Alternate Signature Authority for the Annual Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) Community Mental Health Block Grant and Projects for Assistance in Transition for Homelessness Applications

Governor David Ige has designated signature authority to me, as the Director of the Department of Health (DOH), for the Community Mental Health Block Grant (MHBG) Application and the Projects for Assistance in Transition for Homelessness (PATH) Application and related documents that are submitted annually to the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. In case of my absence and unavailability, the Deputy Director of Health, who is the DOH second in command, is authorized to sign all Funding Agreements, Certifications and Assurances and related documents that must be signed and submitted for the annual MHBG and PATH Application and related documents. If the Deputy Director and I are both absent and unavailable, then the Deputy Director of Behavioral Health Administration (BHA), is authorized to sign all Funding Agreements, Certifications and Assurances and related documents that must be signed and submitted for the annual MHBG and PATH Application and related documents. This designation will remain in effect until such time as it may be rescinded.



EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

April 26, 2021

TO: Elizabeth A. Char, M.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 and Projects for Assistance in Transition from Homelessness Applications and Other Related Documents

In your capacity as the Director of the Department of Health, I hereby designate you as the State of Hawai'i's signature authority for the Community Mental Health Block Grant and Projects for Assistance in Transition from Homelessness Applications that are 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 and Projects for Assistance in Transition from Homelessness Applications and related documents.

This designation shall remain in effect until such time as it may be rescinded.

David Y. Ige
Governor, State of Hawai'i

State Information

Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

Name

Marian Tsuji

Title

Deputy Director of Health

Organization

Hawaii Department of Health

Signature:

Date:

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

Footnotes:

1. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA found that no edits to this section were necessary.

State Information

Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

Name

Marian Tsuji

Title

Deputy Director of Health

Organization

Hawaii Department of Health

Signature:



Date:

AUG 27 2021

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

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 of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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

Footnotes:

1. This Planning Step 1 also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Planning Step 1 and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

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

ADULT MENTAL HEALTH SERVICE SYSTEM

Adult Mental Health Division

The Hawai'i State Department of Health, Adult Mental Health Division (AMHD) is considered the State Mental Health Authority (SMHA) that oversees the Hawai'i's public system of adult mental health services. Individuals with serious mental illness (SMI) are the primary target population for SMHA funded services. This population includes those with SMI that are uninsured or underinsured, legally encumbered, high utilizers of hospitals, frequently arrested, homeless, and/or individuals in crisis. Through licensing, monitoring, regulations, and policies, the AMHD establishes standards to ensure effective and culturally competent care that promotes recovery.

The AMHD is a division under the Hawai'i 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 Hawai'i State Hospital (HSH), and purchase-of-service (POS) contracted providers.

The AMHD uses state general and special funds to provide services to adults who meet the definition of having a SMI. Individuals with SMI who are eligible for mental health services may also receive mental health services through the Hawai'i 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, especially those with diverse backgrounds. The guiding principles of the AMHD reflect the cultures of Hawai'i and define the way in which services are delivered. The AMHD guiding principles are:

- Mental health treatment works.
- People recover every day in Hawai'i.
- 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. Community Program Specialists (CPS) have statewide responsibility for the development of services, program standards, and policies and procedures that align with evidence-based practices and professional standards. The CPS's 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), those who are legally encumbered, as well as those who may have a co-occurring mental and substance use disorder. AMHD consumers must continue to demonstrate significant functional impairment; one that seriously limits their ability to function independently in the community.

An assessment of the consumer's physical, psychological, and social functioning status is conducted to determine whether the individual is eligible for AMHD services. Referrals allow opportunities for clinicians to gain an understanding of the consumer and for the consumer to access the most appropriate mental health 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 Hawai'i 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 that deems them under insured or continue to be without insurance coverage.

Below is the number of consumers served by the AMHD in FY 2020

FY2020 Adult Consumers Served				
Age	Female	Male	Not Available	Total
0-12 Years				
13-17 years		1		1
18-20 years	72	77	2	151
21-24	155	196	9	360
25-44	1033	1701	44	2778
45-64	1234	1842	16	3092
65-74 years	438	556	5	999
75+ years	158	102	1	261
Not Available				39
Total	3124	4522	116	7762

Adult Mental Health Division, Array of Services

The Hawai'i State Department of Health (DOH). Behavioral Health Administration (BHA) is statutorily mandated to assure a comprehensive statewide behavioral health care system by leveraging and coordinating public, private and community resources. Through the BHA, the DOH is committed to carrying out this mandate by reducing silos, ensuring behavioral health care is readily accessible, and person-centered.

The BHA's Adult Mental Health Division (AMHD) continues to identify service gaps and assess needs, evaluate existing services, and plan, design, and implement new services with the goal of enhancing the state's current care continuum by better assisting individuals with behavioral health issues to be appropriately triaged through a statewide coordinated care continuum.

Individuals diagnosed with a serious mental illness (SMI) and who are eligible to receive mental health and/or substance use disorder services are acknowledged as "Consumers."

CASE MANAGEMENT

Case management services are provided by a multi-disciplinary team to coordinate and promote consumer recovery and resiliency by collaborating, linking and advocating for the referral, admission, continued stay, transfer, and discharge of consumers to various support services including AMHD-funded and non-AMHD funded services.

1. Case Management (Note: There are three types.)
 - a. Community-Based Case Management (CBCM)

Standard case management coordinated by team members on behalf of the consumer, with the consumer's input, and in a recovery-oriented manner. CBCM activities include, but are not limited to:

- Case management functions that support the development and implementation of the consumer's Individual Service Plan (ISP)/Master Recovery Plan (MRP), biopsychosocial rehabilitation, treatment services, medication management, nursing services, individual and group psychotherapy, and peer supports;
- Substance use interventions and treatment;
- Assisting the consumer with obtaining health insurance;
- Coordinating health insurance benefits;
- Assisting with residential housing placement;
- Assisting with court obligations; and
- Maintaining contact with the consumer's guardian, family and friends, as appropriate.

Islands served: Kauai, Maui, Molokai, Lanai, Oahu, Hawai'i Island

b. Intensive Case Management Plus – High Utilizer (ICM Plus – High Utilizer)

In addition to CBCM, this service includes intensive and highly integrated services provided to consumers who have experienced recurring crises, who are frequently hospitalized or incarcerated within a six (6) month period, and who require a higher level of service coordination to become or remain stable in their residential housing placement. ICM Plus – High Utilizer services allows the case manager to increase their support time and the option to add contingency management incentives.

Island served: Oahu

c. Intensive Case Management Plus – Homeless (Homeless ICM Plus)

In addition to CBCM, this service includes rapid linkage with continuing support services and is provided to consumers who are houseless, frequently arrested, are the subject of frequent calls for an MH-1 and have frequent emergency department visits.

Island served: Oahu

CASE MANAGEMENT SUPPORT SERVICES

1. Homeless Outreach

Engaging with homeless individuals and providing supports necessary to link individuals with mental health and social services. Homeless Outreach workers interact with homeless individuals who are suspected of living with a mental illness and assist them with obtaining an AMHD Eligibility Determination.

Island served: Kauai, Maui, Oahu, Hawai'i Island

2. Hawai'i Certified Peer Specialist (HCPS)

The primary goal of the HCPS program is to provide basic knowledge and skills for direct care service employment. The field placement/internship experience provides an environment for continued growth and the practical application of learned skills. 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. HCPS Interns must pass the HCPS examinations, both oral and written, and must complete approximately 80 hours of training and instruction. HCPSs are prepared for employment as certified peer specialists, forensic peer specialists, peer educators, and peer coaches.

Islands served: Kauai, Maui, Oahu, Hawai'i Island

3. Forensic Peer Specialist

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, Maui, Oahu, Hawai'i Island

4. Peer Coach

A Peer Coach is someone who (1) has lived experience as a recipient of mental health care or is a caregiver within the behavioral health system of care; and (2) has been certified to provide peer support by the National Federation of Families or other certifying body. Peer Coaches assist consumers to better understand their illness, plan for their recovery, navigate their way through the service delivery system, and assist consumers, their family/friend and/or guardian/caregiver to engage and participate in appropriate behavioral health treatment. This service is a component of the consumer's Individual Service Plan (ISP)/Master Recovery Plan (MRP) and is provided under the supervision of a behavioral health professional as required by Medicaid.

Islands served: Kauai, Maui, Oahu, Hawai'i Island

5. Representative Payee

Representative Payee services are intended to provide money management for consumers who have the capability to learn how to manage their own finances within two (2) years of initial service authorization. It is an educational component of AMHD's support service options which teaches consumers how to budget, save, and pay bills. Consumers learn to manage their financial resources and to be responsible for the debt they incur. Representative Payees ensure support payments are used for basic needs.

Islands served: Kauai, Maui, Oahu, Hawai'i Island

CRISIS SERVICES

1. Hawai'i CARES

Operates twenty-four (24) hours a day, seven (7) days a week as the statewide crisis and suicide hotline with membership in the National Suicide Prevention Lifeline (NSPL). Hawai'i CARES staff offer supportive listening and crisis counseling, and coordinate the dispatch and authorization for crisis mobile outreach services. Hawai'i CARES serves as the after-hours link for oral ex-parte orders.

Islands served: Kauai, Maui, Molokai, Lanai, Oahu, Hawai'i Island

2. Crisis Mobile Outreach (CMO)

Available twenty-four (24) hours a day, seven (7) days a week in a variety of settings including the individual's residence, local emergency facilities, in the community and other settings. CMO provides immediate triage, telephonic stabilization, mobile outreach, and face-to-face stabilization services to individuals in an active state of psychiatric crisis. Immediate response is provided to conduct a thorough assessment of risk, mental health status, immediate crisis resolution/stabilization, and if necessary, de-escalation. NOTE: CMO services are available to all individuals in Hawai'i.

Islands served: Kauai, Maui, Molokai, Lanai, Oahu, Hawai'i Island

3. Crisis Support Management (CSM)

Time-limited support and intervention services to ensure individuals receiving crisis intervention services continue to receive support and assistance until they are linked or referred to other support services in the community. CSM provides community-based interventions such as supportive counseling, linkage with medical and psychiatric care, crisis planning, and other similar activities designed to assist with stabilizing and/or preventing crisis. A 30-day follow up with the individual is required. CSM services are available to all individuals in Hawai'i.

Islands served: Kauai, Maui, Molokai, Lanai, Oahu, Hawai'i Island

4. Licensed Crisis Residential Services (LCRS)

Short-term, acute interventions provided to individuals experiencing or recovering from a psychiatric, psychological or behavioral health crisis, or who are actively experiencing a period of acute stress that impairs their capacity to cope with normal life circumstances. LCRS services address the psychiatric, psychological and behavioral health needs of the consumer. Services are provided as a structured residential alternative or diversion from psychiatric inpatient hospitalization. LCRS facilities are licensed by OHCA.

Islands served: Maui, Oahu, Hawai'i Island

5. Short/Long-Term Stabilization Beds

Short- and long-term stabilization beds (also known as Stabilization Bed Units or SBU) provide a sub-acute level of care for individuals whose behavioral health issues do not meet medically necessary criteria for acute hospitalization but whose presentation and current mental status are not conducive or appropriate for community-based services such as low intensity residential or outpatient services. Stabilization beds are designed to (1) stabilize the individual's mental health and substance use conditions and (2) assess then triage the individual to a clinically appropriate level of care through Hawai'i CARES. Stabilization bed components include care coordination, peer support, treatment, supervision and nursing services, including 23/59 observation.

Island served: Oahu

6. Mental Health Emergency Worker (MHEW) Program

The MHEW Program is designed to ensure that counties are in compliance with the requires of section 334-59(a)(1), Hawai'i Revised Statutes (HRS), which describes the process for law enforcement officers to follow when they encounter an individual who is mentally ill or suffering from substance use, is imminently dangerous to self or others, and is in need of care or treatment (also known as MH-1). MHEWs are appointed by the Director of Health or designee and are reappointed on a biannual basis or whenever there is a change in staff.

MHEWs are trained in emergency mental health assessment including signs and risks associated with SMI, substance abuse, suicide, trauma, domestic violence, and problems and risks unique to juveniles and elderly, as well as other issues relevant to the interaction between the person in crisis (also known as PIC) and law enforcement. MHEWs are trained in de-escalation/disarming techniques, have a working knowledge of case law with respect to civil rights protections related to involuntary evaluation and treatment, have completed training in police culture, police psychology, Assisted Community Treatment (ACT), police assisted diversion (PAD), and best practice standards regarding interactions between law enforcement officers and individuals experiencing mental health and substance use related crises. MHEWs are licensed in the state of Hawai'i and have practical supervised experience during the onboarding process that includes supervised MHEW calls.

Islands served: Maui, Oahu and Hawai'i Island

7. Central Receiving Division (CRD) Nursing Services

Advanced Practice Registered Nurses (APRNs), and Registered Nurses (RNs) review medication and medication needs, and provide basic medical care for detainees in the CRD. If applicable, the nurses to coordinate care with Jail Diversion and may make recommendations to the court on behalf of the detainee, such as providing court staff with mental health assessments. Nurses may also contact Hawai'i CARES if a detainee with serious mental illness and/or substance abuse issues need services.

Islands served: Maui, Oahu, Hawai'i Island

FORENSIC SERVICES

1. Court-Based Clinician

Clinical assessment and referral services in the District Court are provided by Court-Based Clinicians. 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 health disorders, many of whom have criminal justice involvement. Tasks include:

- Providing consultation and liaison services to the District Court, specialty courts and to criminal justice agencies,
- Providing consultation and liaison services to law enforcement and the Department of Public Safety (PSD),
- Providing consultation on challenging clinical cases involving detainees and inmates diagnosed with mental illness.
- Conducting clinical assessments and explain service referral options,

- Evaluating and monitor individuals with court-ordered conditions,
- Providing recommendations for risk management and strategies for risk reduction,
- Serving as a technical expert on admission procedures and eligibility criteria for mental health programs such as post-booking jail diversion and Oahu Mental Health Court, and
- When appropriate, assisting with transfer arrangements of a detainee to the HSH from a correctional facility via the MH-9 process.

Islands served: Kauai, Maui, Molokai, Lanai, Oahu, Hawai'i Island

2. Community-Based Fitness Restoration

Outpatient fitness restoration for defendants after being released on conditions on a 704-406(1) legal status with the goal of completing outpatient competency restoration and being safely restored to fitness within a community setting as an alternative to lengthy hospital commitments. Outpatient competency restoration offers an effective alternative to lengthy hospital commitments for consumers who can safely be restored to fitness within a community setting. This program is tailored to meet the unique needs of each individual, including linkages to community programs and resources, such as Clubhouses.

Islands served: Kauai, Maui, Molokai, Lanai, Oahu, H Hawai'i Island

3. Conditional Release Exit Support and Transition Program (CREST)

Involves a process for consumers on Conditional Release (CR) to prepare for potential CR discharge. CREST includes a multi-session group format with a primary focus on identifying warning signs and triggers, crisis planning, and coping skill development. 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, Maui, Molokai, Lanai, Oahu, Hawai'i Island

4. Court Ordered Forensic Evaluation Services

Involves consultation services to the Judiciary in accordance with Hawai'i Revised Statutes (HRS) and coordinated through the AMHD Court Evaluation Branch (CEB). The CEB maintains a list of certified examiners who complete court ordered evaluations of adults in Circuit and District Courts statewide, pursuant to HRS 704 including examination of mental disease, disorder or defect; penal responsibility; risk assessments; and examination of the defendant's mental condition. Examiners complete court ordered evaluations for juveniles via Family Court. In addition to providing testimony regarding the results of the examination, the examiner's written report is submitted to the court.

Islands served: Kauai, Maui, Molokai, Lanai, Oahu, Hawai'i Island

5. Forensic Coordination

Consultation regarding court related elements of treatment and follow-up and coordinated through the AMHD Community Mental Health Center (CMHC) Forensic Services Section. Forensic Coordinators are psychologists who assist individuals involved with the criminal justice system and assist with liaison services to treatment teams and criminal justice agencies by evaluating and monitoring the individual's risk level, engagement with treatment

planning, and adherence to court ordered conditions and may provide recommendations to the court and to the treatment team regarding risk management and risk reduction strategies to support community tenure. Forensic Coordinators assist with overseeing the Jail Diversion Program, Community Fitness Restoration Program, and the Conditional Release Transition Program.

Islands served: Kauai, Maui, Molokai, Lanai, Oahu, Hawai'i Island

PRE-JAIL DIVERSION SERVICES

1. Pre-Jail Diversion Program

Operates as a joint effort between the AMHD and the County police departments. When an individual is suspected of mental illness at a crime scene, the law enforcement officer may request consultation from a Mental Health Emergency Worker (MHEW). Consultation with law enforcement officers is an initiative to provide additional diversion opportunities for individuals involved in the criminal justice system. Consultation is available twenty-four (24) hours a day, seven (7) days a week.

Islands served: Kauai, Maui, Molokai, Lanai, Oahu, Hawai'i Island

POST-JAIL DIVERSION SERVICES

1. Honolulu Police Department (HPD) Central Receiving Division (CRD) Nursing Services

Provides two Advanced Practice Registered Nurses (APRNs) or Registered Nurses (RNs) for up to 80 hours per week at the HPD CRD. APRNs review medication and medication needs, make recommendations to the court on behalf of detainees, and contact Hawai'i CARES for referral for support services in the community.

Island served: Oahu

2. Post-Booking Jail Diversion Program

Provides supportive case management services intended to reduce criminal recidivism by diverting eligible, non-dangerous arrestees and detainees away from incarceration. Services include coordination with outreach and therapeutic supports, assistance with developing a jail diversion plan that addresses legal, public safety, and community tenure issues, and assisting consumers with obtaining basic needs including food, housing, clothing, transportation, and money as well as applying and receiving benefits and entitlements and, if appropriate, linking the consumer to peer support and other recovery-oriented activities.

Islands served: Kauai, Maui, Molokai, Lanai, Oahu, Hawai'i Island

PSYCHOSOCIAL REHABILITATION SERVICES

1. Clubhouse

The Clubhouse Model of Psychosocial Rehabilitation is a comprehensive and dynamic program of support and opportunities for consumers. 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.

The Clubhouse Model seeks to demonstrate that members who live with mental illness can successfully live productive lives and work in the community, regardless of the nature or severity of their illness. Clubhouse services include Transitional Employment (TE), Group Transitional Employment (GTE), Supported Employment (SE), Supported Education (SEd), advocacy, and case management. Additionally, Clubhouse includes day, evening, weekend and holiday activities where members are involved in operational activities that enhance their social skills.

All Clubhouse members strictly participate on a voluntary basis. Clubhouse members and staff work side-by-side to manage Clubhouse operations which provides opportunities for members to contribute in significant and meaningful ways by being included as an integral part of Clubhouse management and decision-making.

Clubhouses 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 to be treated.

Islands served: Kauai, Maui, Oahu, Hawai'i Island

2. Hawai'i Certified Peer Specialist (HCPS) Program

Provides basic knowledge and skills for direct care service employment. The 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. HCPS Interns must pass HCPS examinations, both oral and written, after earning approximately eighty (80) hours of training and instruction. HCPSs are prepared for employment as Certified Peer Specialists, peer educators, and Peer Coaches.

A subgroup of HCPSs receive specialized training and certification as Forensic Peer Specialists. Forensic Peer Specialists provide peer support to consumers with psychiatric and/or co-occurring challenges who are court involved. Forensic Peer Specialists may engage with consumers from initial contact with law enforcement, re-entry into the community following incarceration or hospitalization, and while living in the community.

Islands served: Kauai, Maui, Oahu, Hawai'i Island

3. Supportive Education (SEd)

Provides Clubhouse members with a full range of educational services from basic literacy to the earning of a General Equivalency Diploma (GED). Necessary supports such as educational counseling for college, technical education or other courses, study skills training, and social skills training are provided.

Islands served: Kauai, Maui, Molokai, Oahu, Hawai'i Island

4. Supported Employment (SE)

Provides consumers with opportunities for competitive paid employment with ongoing support. SE is based on 1) Individual Placement and Support (IPS) which is a "place-train" approach or 2) "choose, get, keep and leave (jobs)" as opposed to engaging in pre-vocational training. Elements of the SE Program include zero exclusion, consumer preference, rapid job search, integration with mental health services and personalized benefits planning in an integrated setting that includes the consumer, their case manager and treatment team, SE program staff, and the employer.

Islands served: Kauai, Maui, Oahu, Hawai'i Island

5. Transitional Employment (TE):

Provides Clubhouse members with opportunities for paid employment with flexible work hours depending on the needs of the consumer. If the Clubhouse member is unable to work their scheduled work shift, Clubhouse staff assumes the paid TE job in the member's (temporary) absence.

Islands served: Kauai, Maui, Molokai, Oahu, Hawai'i Island

RESIDENTIAL SERVICES

1. Expanded Adult Residential Care Home (E-ARCH)

E-ARCH is a care home placement supported by a nurse with a physical health focus and a case manager specializing in psychiatric and mental health care. E-ARCH primarily serves to successfully discharge consumers who are currently residing in the hospital who meet the intermediate care facility (ICF) level of care. This is NOT a respite housing option. E-ARCH Primary Care Givers are licensed by OHCA and must have multiple years of licensed care home experience working with adults who live with both SMI and complex health challenges.

Island served: Oahu

2. Specialized Residential Services Program (SRSP)

SRSP includes a minimum of 25 hours per week of rehabilitation programming such as group counseling, education, skill building, medication management, and fitness restoration. Ten (10) hours of weekly structured activities are offered as well as onsite daily nursing services, psychosocial rehabilitation programming, and access to day treatment and aftercare post discharge support. Medications are administered by a nurse on duty. Staff are onsite twenty-four (24) hours a day, seven (7) days a week. SRSP is OHCA licensed and providers are CARF accredited.

Islands served: Oahu

3. Therapeutic Living Program (TLP)

Residential/treatment support for consumers who continue to require on-site nursing and psychosocial rehabilitation services. TLP provides a minimum of 15 hours per week of psychological services including restorative therapy, recreational therapy, assistance with ADLs and assistance with life skills. Medications are administered by a nurse on duty. TLP is OHCA licensed and providers are CARF accredited.

Island served: Oahu

4. 24-hour Group Home

The 24-hour group home includes twenty-four (24) hours a day, seven (7) days a week of supervised housing. Services are prioritized for consumers discharged from the HSH and Kahi Mohala. Consumers referred and admitted to this level of housing are those who, without twenty-four (24) hour supervised care and support, are at risk for decompensation and hospitalization if placed at a lower level of housing. The ideal 24-hour group home resident is someone whose goal is to move to a more independent living setting (i.e., transitioning from a higher level of care to a lower level of care). At this level of care, medications are monitored and held by staff but consumers are expected to administer medications independently. Reminders to complete Activities of Daily Living (ADLs) and household chores are provided. Twenty-four hour group home providers are CARF accredited.

Islands served: Kauai, Maui, Oahu, Hawai'i Island

5. 8-16-hour Group Home

The 8-16 hour group home includes between eight (8) and sixteen (16) hours a day, seven (7) days a week of supervised housing. Services are prioritized for consumers discharged from the HSH and Kahi Mohala. Consumers referred and admitted to this level of housing are those who do not require 24-hour in-home staff support but do require at least minimal housing supports on a daily basis. The ideal 8-16-hour group home resident is someone who is able to complete several daily tasks, if not most, independently.

At this level of care, medications are monitored and held by staff but consumers are expected to administer medications independently. Reminders to complete ADLs and household chores are provided occasionally. Eight (8) to 16 hour group home providers are CARF accredited.

Islands served: Kauai, Maui, Oahu, Hawai'i Island

6. Semi-Independent

The semi-independent group home housing service provides group living with staff on-site eight (8) hours per week. The ideal semi-independent group home resident is someone who is capable of handling non-crisis issues for a day or two until a scheduled staff visit. This service focuses on home and community integration and enhances the independence, dignity, privacy, and personal choices of the consumer. Billing for this service is through cost reimbursement.

Islands served: Kauai, Maui, Oahu, Hawai'i Island

7. Supported Housing/Bridge Subsidy

Bridge subsidy is a temporary subsidy provided to consumers when participating in the Supportive Housing Program with the goal of assisting consumers to meet rental obligations until they are connected with federal, state, or county rental subsidies.

Supported housing provides consumers with the option to live in permanent housing of their choice. Staff assist the consumer in locating and maintaining independent housing in the community. A Supportive Housing Specialist will assist with completing residential housing applications, conducting mock interviews, and maintaining residency by providing “in vivo” response twenty-four (24) hours a day, seven (7) days a week based on the consumer’s need. The ideal supported housing resident is someone who is capable of living either alone (single occupancy) or in a home or apartment with a relative or a friend (dual occupancy) where no regular structured supervision from housing and mental health staff.

Islands served: Kauai, Maui, Molokai, Oahu, Hawai’i Island

8. Transitional Housing/Safe Haven

This HUD-funded transitional housing program, called Safe Haven, is primarily for consumers who are homeless. Twenty-four (24) hour supervision is provided along with primary care and case management services.

Islands served: Maui, Oahu, Hawai’i Island

TREATMENT SERVICES – INPATIENT

1. Hospitals (Inpatient, General, Non-Forensic)

The provision of inpatient care within a unit designed to service patients with SMI who 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 psychiatric conditions, and intensive interventions.

Islands served: Kauai, Oahu, Maui, and Hawai’i Island

2. Hospitals (Inpatient, Specialty/State, Forensic)

The provision of secure care within a hospital setting that is designed to (1) serve patients with SMI who require secure care beyond the acute phase of their illness with psychiatric rehabilitation services and with the goal of achieving the highest level of functioning possible before returning to community living; (2) assist individuals 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; and (4) provide recommendation to the referring judge or county department to facilitate court disposition.

Islands served: Oahu (Hawai’i State Hospital)

TREATMENT SERVICES – OUTPATIENT

1. Day Treatment

Structured day program for individuals diagnosed with co-occurring mental illness and substance use disorders (MI/SA). Day treatment is designed to assist the consumer with developing illness management skills to prevent relapse, increase strategies to cope and/or manage severe symptoms of mental illness and improve overall life skills deficits.

Programming consists of three (3) to six (6) hours of treatment per day depending on the assessed clinical needs of the consumer.

Islands served: Oahu, Maui

2. Intensive Outpatient Hospital (IOH) Services

Time-limited, non-residential, rehabilitative day treatment services that (1) provide treatment to consumers with SMI who require secure care beyond the acute phase of their illness by providing psychiatric rehabilitation services that assist the consumer in achieving the highest level of functioning possible; (2) assist consumers committed by the court to evaluate competency to stand trial, assess criminal responsibility, and provide recommendations to the referring judge or county department regarding court disposition or department resolution; and (3) provide psychiatric treatment and fitness restoration to enable consumers to competently participate in court proceedings. This is not a maintenance program. IOH is an enhanced co-occurring program and includes the integration of mental health and substance use programming. IOH services are operated within a TJC accredited hospital or behavioral health facility.

Islands served: Oahu

3. 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 severe and persistent 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 Hawai'i Island

OTHER SERVICES

1. Primary and Behavioral Health Integrated Care

The integrated primary and behavioral health care “Living Well Hawai’i” project serves Hawai’i residents with serious mental illness who receive healthcare services from the state-operated West Honolulu Treatment Service Section (Kalihi-Palama CMHC), and the Leeward-Central Oahu Treatment Service Section (Central Oahu CMHC) in collaboration with the Kalihi-Palama Community Health Center.

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 (SMI), co-occurring substance use disorders and medical co-morbidities.

Kalihi-Palama Community Health Center 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 Hawai’i State Department of Health (DOH) and a federal Substance Abuse and Mental Health Services (SAMHSA) grant.

Islands served: Oahu

2. 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, Lanai, and Hawai’i Island

STRENGTHS OF THE ADULT MENTAL HEALTH 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 and staff changes. However, AMHD has program that can be categorized as strengths of the service system:

Short-Term Stabilization Beds

Stabilizing Intensive Case Management (ICM) Program provides adults with a warm, welcoming, and safe environment where personnel are supportive, encouraging, and professional for individuals experiencing issues with homelessness, mental health and substance use. The Program focuses on individuals for approximately 14 days. This program has a team approach in addressing consumer needs, while stabilizing individuals towards independent and supportive services twenty-four (24) hours a day, seven (7) days a week.

Services are designed to rehabilitate with individualized treatment goals to support a successful community integration into least restrictive level of care while maintaining an abstinent lifestyle. is also provided which is a community-based case management service rendering treatment and restorative interventions in assisting consumers to gain access to necessary medical and rehabilitative services to reduce psychiatric, substance abuse addiction symptoms and homelessness while developing optimal community living skills. ICM services include, but

are not limited to, crisis assessment and intervention, individual restorative interventions for the development of symptom monitoring and management skills, administration and monitoring of medication, and self-medication, and treatment for substance abuse or other co-occurring disorders. Individuals are also linked to permanent housing, group home, shelter, social security benefits and workforce development.

Telepsychiatry

Through collaboration with the department of psychiatry (DOP) at the University of Hawai'i (UH), an enhanced telepsychiatry service has been established to provide care for patients. This model is crucial for establishing a future framework for telepsychiatry services for the underserved and difficult to access populations of Hawai'i. Telepsychiatry delivers 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.

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. HMIS prioritizes and allows communities to prioritize scarce housing resources for those with the greatest and most immediate needs is the coordinated entry system. This program has been recognized for reducing system-wide fragmentation in ending and preventing homelessness. It continues to streamline the process for all HUD-designated subpopulations and accessing resources to end homelessness.

The State Judicial System

Hawai'i'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.

Housing Coordinated Entry System

The Housing Coordinated Entry System is based on a strategy that houses individuals by priority and allows communities to prioritize scarce housing resources for those with the greatest and most immediate needs. This cohesive system enhances the quality of housing applicant screening and assessment, through a user-friendly Homeless Management Information System (HMIS) system that includes a customized and automated client assessment referral and secure data sharing.

This system has been recognized for reducing system-wide fragmentation in ending and preventing homelessness, and continues to streamline the process for all U.S. Department of Housing and Urban Development (HUD) designated subpopulations and open access to resources aimed at ending 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 7,762 consumers in FY2020, of which 8 percent 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 2020 U.S. Census, approximately 22.5 percent of Hawai'i'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.

In Hawai'i, 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 Hawai'i 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 Hawai'i State Department of Health, Tobacco Prevention and Education Program (TPEP) identified LGBTQ+ adults and Hawai'i's behavioral health population as priority populations to target for tobacco prevention and cessation resources in its recently released five-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.

CHILDREN’S MENTAL HEALTH SYSTEM

Hawai’i’s child serving system is generally centralized at the state level. For most operational areas, services are provided and funded by the state. Hawai’i’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. 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 years) receive the necessary mental health services to ensure their proper and full development (HRS §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 b) 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 CAMHD SERVICES

CAMHD serves Hawai'i 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 be physically present in the State of Hawai'i at the time of application and meet the following criteria:

- a. Be between the ages of 3 to 20 years old.
- b. Meet criteria for a mental health diagnosis as determined by a Qualified Mental Health Professional (QMHP).

The diagnosis must be listed in the Diagnostic and Statistical Manual of Mental Health Disorder, 5th Edition (DSM5)

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 referred to the State Department of Health's Developmental Disabilities Division. Those with mild Developmental Disorders that co-occur with a psychiatric disorder may qualify.
- c. Demonstrate significant functional impairment. This means the youth is showing significant difficulties functioning in several life domains as evident by the Child and Adolescent Functional Assessment Scale (CAFAS) to determine whether youth meet this criterion.
 - d. Be funded by one of the following:
 - Their QUEST-Integration insurance or
 - Office of Youth Services (OYS) through a referral from their probation officer or and Director of OYS staff or
 - Special Education/General Funds through a referral by their DOE Individual Educational Program (IEP) Team or
 - 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. OnTrack Hawai'i 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 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, peer 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 their 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 ILS 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.

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 24 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 MENTAL HEALTH SYSTEM

Commitment to the Hawai'i CASSP Principles

Based on the input from youth, families and stakeholders, CAMHD adopted the Hawai'i 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 Hawai'i 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.

Race and Ethnicity	N	% of Available
American Indian or Alaska Native	110	6.3%
Asian	855	48.9%
Asian Indian	2	0.1%
Burmese	0	0.0%
Cambodian	0	0.0%
Chinese	334	19.1%
Filipino	511	29.2%
Indonesian	0	0.0%
Japanese	276	15.8%
Korean	66	3.8%
Laotian	0	0.0%
Thai	0	0.0%
Vietnamese	15	0.9%
Other Asian	37	2.1%
Black or African-American	142	8.1%
Hispanic or Latino/a	301	17.2%
Mexican	89	5.1%
Puerto Rican	170	9.7%
Other Hispanic or Not Specified	68	3.9%
Native Hawaiian or Other Pacific Islander	1013	57.9%
Fijian	2	0.1%
Guamanian or Chamorro	7	0.4%
Micronesia	103	5.9%
Native Hawaiian	856	48.9%
Samoan or Tongan	106	6.1%
Tahitian	10	0.6%
Other Pacific Islander	15	0.9%
White	952	54.4%
Portuguese	277	15.8%
Other White or Not Specified	795	45.5%
Other Race or Ethnicity	76	4.3%
Multiracial	973	55.6%
Multiethnic	1022	58.4%
Not Available (% of Total)	232	(11.7%)

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 have 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.

Youth's Most Recent Primary Diagnosis (DSM-5) FY 2018	N	% of Available
Anxiety Disorders	94	5.2%
Bipolar and Related Disorders	23	1.3%
Depressive Disorders	354	19.8%
Disruptive, Impulse-Control, and Conduct Disorders	432	24.1%
Neurodevelopmental Disorders		
Attention-Deficit/Hyperactivity Disorder	292	16.3%
Autism Spectrum Disorder	7	0.4%
Intellectual Disability	1	0.1%
Other Neurodevelopmental Disorders	1	0.1%
Obsessive-Compulsive and Related Disorders	7	0.4%
Schizophrenia Spectrum and Other Psychotic Disorders	33	1.8%
Substance-Related and Addictive Disorders	7	0.4%
Trauma- and Stressor-Related Disorders		
Adjustment Disorder	261	14.6%
Posttraumatic Stress Disorder	186	10.4%
Other Trauma- and Stressor-Related Disorders	48	2.7%
Other Infrequent CAMHD Diagnoses ^a	14	0.8%
General Medical Conditions or Codes No Longer Used	31	1.7%
Not Available (% of Total)	190	(9.6%)

^aIncludes, 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."

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 CAMHDs 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 developed a secure electronic medical records system called MAX 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. Enhancements and streamlining of the MAX EMR system continues to evolve.

Hawai'i is geographically challenged in that it is a state of islands that are accessed by air transportation because the distances between islands are too great for bridges and traveling by boat between islands is too time consuming. By providing Telehealth capability at each of the CAMHD's Family Guidance Centers and major providers across the state, CAMHD has been 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 benefits youth in residential placement on one island that have family members living on another. Telehealth allows the family to have some contact with the youth and also provides 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 Hawai'i

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, Hawai’i 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, Queer & Questioning youth (LGBTQ)

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 LGBTQ 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 LGBTQ-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 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 LGBTQ Youth Resource Brochure for Oahu and Maui;
- 5) sponsored CAMHD staff's attendance at the 2015 and 2017 Building Competency in Serving LGBT Youth Conference;
- 6) presented to the Committee on the Department of Health Sexual and Gender Minority Workgroup;
- 7) edited CAMHD forms, policies, and procedures to ensure they are LGBT inclusive; and presented and/or hosted over 20 trainings in 2020/2021 on providing culturally competent services to LGBTQ youth.

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

OnTrack Hawai'i

CAMHD collaborated with the University of Hawai'i at Mānoa's [Psychology Department](#) in the [College of Social Sciences](#), the John A. Burns School of Medicine's [Department of Psychiatry](#) and the Hawai'i State Department of Health, Adult Mental Health Division, to formulate On-Track Hawai'i to expand services as the state's coordinated specialty care treatment clinic for youth experiencing a first episode of psychosis.

"OnTrack Hawai'i uses a team-based approach and patient-centered shared decision-making to develop a coordinated specialty care plan to treat affected youth and young adults. On-Track Hawai'i is the first of its kind in the State and aims to help clients improve their quality of life by helping clients get back on track at work, school, and relationships with friends and family."

OnTrack Hawai'i's goal is to reduce this timeframe.

Hawai'i youth and young adults experiencing symptoms of psychosis can find the following services through OnTrack Hawai'i:

- Individual and group therapy.
- Medication management using a shared decision-making model.

- Assistance and support to find employment or to return to school.
- Assistance and support for affected families.
- Case management.

OnTrack Hawai'i offers its services to individuals regardless of ability to pay. Its team works with clients to arrange coverage for services such as medication and other related services.

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 Hawai'i'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.

STRENGTHS OF THE HAWAI'I MENTAL HEALTH SERVICE SYSTEM

The DOH Behavioral Health Administration (BHA) works extensively with community partners to coordinate community-based mental health services.

Strengths of the Hawai'i mental health service system includes:

- A comprehensive statewide crisis network with Crisis Mobile Outreach (CMO) services available in all counties (including rural areas) for all individuals in Hawai'i;
 - The Licensed Crisis Residential Shelters (LCRS) located in three of four counties; and
 - The statewide integrated behavioral health crisis and treatment referral line (Hawai'i CARES). Hawai'i CARES is the telephonic entry point where behavioral health services are coordinated. Services such as crisis support, referrals for mental health assessment and treatment (including those with co-occurring substance use disorders), and referrals for substance use disorders assessment are provided. Hawai'i CARES provides support to both youth and adults.
- Training for peers through the Hawai'i Certified Peer Specialist (HCPS) training program.
- Training for Mental Health Emergency Workers (MHEWs) to support law enforcement.

AREAS FOR IMPROVEMENT

The AMHD continues to identify service gaps and assess needs, evaluate existing services, and plan, design, and implement new services with the goal of enhancing the state's current care continuum by better assisting individuals with behavioral health issues to be appropriately triaged through Hawai'i CARES, the statewide coordinated care continuum.

Areas identified for improvement include:

- Needing additional crisis stabilization bed units (SBUs);
- Increasing the number of HCPS and forensic peer specialist;
- Needing to expand our services for First Episode Psychosis; and
- Continuing to build AMHD and CAMHD capacity for those needing these services over age 18.

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 of care 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 of care. 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, SUD prevention, and SUD treatment goals at the state level.

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

Footnotes:

1. This Planning Step 2 also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Planning Step 2 and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

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

Hawai'i continues to face significant distribution challenges and shortages in the healthcare workforce. The coronavirus pandemic has challenged continued physician practice in Hawai'i and contributed to an increased gap in the number of needed physicians and available supply in our state. Given the more advanced ages of the physician population in Hawai'i, the coronavirus pandemic is expected to increase the relative shortage of physicians for the next several years as older physicians leave their practices. There are currently 10,227 physicians licensed in Hawai'i, with only 3,290 physicians actively providing patient care in Hawai'i. The physician effort only totals 2,812 full-time equivalents (FTEs) of direct care to patients as some of the doctors don't work full-time. The national demand model applied to the State of Hawai'i indicates a need for 3,529 FTEs demonstrating a shortage of 717 FTE for physician services.

The shortage of psychiatrists across the state is especially seen on the island of Moloka'i where there are no on-island psychiatrists. Hawai'i Island is so short on mental health resources that several Honolulu psychiatrists routinely fly there to attempt to close the gap in access to treatment. Even in Honolulu (Oahu), where most of the state's psychiatry offices are concentrated, patient need regularly outpaces practitioner availability.

In addition to the physician shortages, the local housing shortage is well documented. The availability of transitional housing and other community-based support services for those with behavioral health challenges is an ongoing issue that translates into a large homeless population. Aging adults with serious mental illnesses (SMI) and serious medical issues, including those with brain injuries from chronic substance abuse, is a growing population. This population is trapped between housing options that support serious mental illness, but not serious medical needs; and housing options that accept serious medical needs, but not serious mental illnesses. Building the infrastructure and making available transitional housing and other community-based support services for those with behavioral health and those with additional medical needs will be an ongoing challenge for Hawai'i for 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 (QOLI) results, and the Behavior Health Barometer.

Unmet needs and critical service gaps across the AMHD system of care identified were:

- Lack of hospital psychiatric bed availability for non-forensic consumers;
- Inconsistent quality of skills and vacancies among workers;
- Access to quality and quantity care in rural and geographically remote areas;
- Lack of psychiatrists across the state;
- Transportation to access appointments and employment on the Neighbor Islands;

- A Skilled Nursing Facility (SNF);
- More group homes statewide;
- Integrated mental health services;
- Creation of funding stream for gaps in care;
- Lack of community-based psychosocial rehabilitation services; and
- The need for Adult Residential Care Homes (ARCH) for the SMI population needing long-term care and daily in-home nursing assistance.

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 these needs at the local, county, and state levels.

- Address areas within the AMHD that will 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 engagement of and access to services across systems for individuals with SMI.

Other areas under review are:

Shortage of psychiatrists

- The State is collaborating with the University of Hawai'i for Psychiatric Residency Training at the Hawai'i State Hospital (HSH).
- The AMHD is looking at using social media and websites 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 telepsychiatry in several of its community mental health clinics.
- The AMHD is using Advance Practice Registered Nurses with prescriptive authority (APRN-Rx) to address the shortage of psychiatrists.

Crisis Services

- The AMHD has developed short-term stabilization beds on Oahu and Hawai'i Islands. The short-term stabilization beds and Intensive Case Management (ICM) Program provides adults with a warm, welcoming, and safe environment where personnel are supportive, encouraging, and professional for individuals experiencing issues with mental health and substance use crisis, and/or homelessness. The Program focuses on individuals for approximately 14 days. This program has a team approach in addressing consumer needs, while stabilizing individuals towards independent and supportive services twenty-four (24) hours a day, seven (7) days a week. Services are designed to rehabilitate with individualized treatment goals to support a successful community integration into the least restrictive level of care while maintaining an abstinent lifestyle.

- The State is looking into Urgent care for immediate follow-up. There will be up to three therapy sessions, full psychiatric evaluations, medication prescriptions and refills, and referrals for additional follow-up. This service will be located within a crisis triage center or Crisis Stabilization Unit (CSU).
- The Mental Health Emergency Worker (MHEW) program will be replicated for Hawai'i and Kauai counties.

Case Management and Community Support Services

- Intensive Case Management program will be expanding to provide intensive and highly integrated services to consumers who have experienced recurring crises, and/or frequently hospitalized or incarcerated within a six (6) month period, and who require a higher level of service coordination to become or remain stable in a residential housing placement.
- Forensic Peer Specialists (FPS) are being trained to provide peer support to consumers with psychiatric and/or co-occurring challenges involved in the criminal justice system. Support will be given from several intercepts including initial contact with law enforcement, processing through the courts, and finally re-entry into the community.
- A pool of qualified professionals has been expanded to include Advanced Practice Registered Nurse with prescriptive authority (APRN-Rx) to work in rural areas.

Community Housing Services

- Long-term Stabilization Beds are designed to (1) stabilize the individual's mental health and substance use conditions and (2) assess to triage the individual to a clinically appropriate level of care. Stabilization bed components include care coordination, peer support, treatment, and supervision and nursing services, which includes 23/59 observation which assists with resolution or determining longer term needs.
- Re-visit the long-term strategy that ensures smooth transitions for consumers through AMHD's housing continuum.
- Decrease lengths of stay in 24-hour group homes statewide and encourage greater movement to less 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 increase accuracy tracking current vacancies in 24-hour group homes as well as to assist providers with maintaining candidate waitlists which are reflective of AMHD priorities.
- Develop housing options that supports mental health as well has medical care for aging consumers and those with chronic medical needs.

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 will place supported employment programming with AMHD Clubhouses. Participants and staff will be a major priority for continuous recruitment and emergency hire for positions within the Division.
- Hire stable staffing that can develop jobs and provide job coaching skills to Clubhouse members.
- Hire staff who are willing to work flexible hours to accommodate holidays and weekend hours.

Long-Term Care

- In response to Hawai'i'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, with staff 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 is 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, Hawai'i 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 on beaches, taking their families with them.

Annually, the State of Hawai'i's Homeless Initiative program conducts a point-in-time (PIT) count when the number of homelessness are counted on one designated date. In 2020, the PIT count there were 6,458 people experiencing homelessness in Hawai'i on the night of the count and about 57% of those individuals were unsheltered. The statewide homelessness rate" for 2020 was about the same as 2019. The most common self-reported primary causes of homelessness by surveyed adults were inability to pay rent, job loss, and alcohol/drug use.^{1 2} No PIT count was conducted in 2021 due to the COVID-19 pandemic.

Oahu is the most populated island in the State of Hawai'i. Hawai'i Island, Maui (whose county includes the islands of Lanai & Molokai), and Kauai have smaller populations and thus, are collectively called "Neighbor Islands." The PIT counts for the State categorized accordingly.

Oahu PIT Count (for 2019 and 2020):

- The total number of people experiencing homelessness (sheltered and unsheltered) was 4,448. The sheltered count rose by 4%, and the unsheltered count declined by 2%.
- 881 (24%) adults were chronically homeless.
- 51% of the overall PIT Count identified NHPI as either their only race or part of their multiracial background. Native Hawaiian/Pacific Islanders (NHPIs) were over-represented by 210%. For comparison, Caucasians and Asians were underrepresented by -24% and -81% respectively.
- 1 in 4 homeless adults surveyed reported at least one mental health problem, and 1 in 10 are Veterans.

Neighbor Island (Hawai'i, Maui, and Kauai) PIT Count:

- The total number of people experiencing homelessness (sheltered and unsheltered) across all three islands was 2,010. The sheltered count declined by 7%, while the unsheltered count rose by 5%.
- 709 (35%) adults were chronically homeless.
- Persons in households without the presence of children under the age of 18 made up the largest share of the homeless population (66%).
- Hawai'i Island saw a 16% increase in overall level of homelessness compared to 2019. Kauai and Maui saw a decline in overall level of homeless by 4%, and 8% respectively.
- The total homeless veteran population increased by 9% to 132 veterans compared to 2019. This is the first increase in homelessness among veterans which had been declining from 257 in 2016 to 121 in 2019.

On Oahu alone the PIT count of homeless children was 256 of which 210 was sheltered and 145 were unsheltered.³ According to SAMHSA⁴, children experiencing homelessness also frequently experience the following:

¹ Hawai'i Health Data Warehouse, <http://hhdw.org/2020-homeless-point-in-time-count/>.

² State of Hawai'i Homeless Initiative, <https://homelessness.hawaii.gov/point-in-time-count/>.

³ 2020 Oahu Point in Time Count Comprehensive Report by Partners in Care Oahu, <https://www.honolulu.gov/rep/site/ohou/PIC2020PITCountReportFinal.pdf>

⁴ Grandin, M. (2014). *Homeless Experiences of Parents have a Lasting Impact on Children*. Retrieved from <http://samhsa.gov>

- 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 – Hawai’i) states that:

- Almost 3,000 Hawai’i public school students were homeless in the 2016-2017 school year.
- In 2018, more than three 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 Hawai’i children relied on the Supplemental Nutrition Assistance Program (SNAP) to meet their nutritional needs in FY2017.
- 90 percent of Hawai’i 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 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. Hawai’i’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 Health⁵ 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 Hawai’i’s mental health “system of care”. Hawai’i 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. The CAMHD is in the process of re-procuring family support services and proposes to continue provision of this recovery-focused program with the agency that is awarded the new contract.

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 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.

The 2021 Hawai’i State Legislature passed HB1322, SLH 2021, "Relating to Trauma Informed Care" to formulate a task force of public and private agencies to "create, develop, and adopt a statewide framework for trauma informed and responsive practice." CAMHD is the Hawai’i Department of Health lead on this effort and plans to use SAMHSA's guidelines to lead the task force.

⁵ National Federation of Families for Children’s Mental Health. (2008). *Family Peer-to-Peer Support Programs in Children’s Mental Health: A Critical Issues Guide*. Rockville, MD. Retrieved at <http://www.ffcmh.org/resources-peersupport>

CAMHD continues Project Kealahou which was originally funded by a SAMHSA grant to improve services and outcomes for CAMHD's female youth with histories of trauma. The girls in this project are at risk for running away, truancy, abuse, suicide, arrest and incarceration. Project Kealahou is 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 Kealahou developed trauma-informed and gender-responsive care for females ages 11-18 who had experienced psychological trauma. These services were Hawai'i'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.

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 *Hawai'i 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.

Hawai'i'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 Hawai'i State Department of Health released a first-of-its-kind study to assess the health of transgender youth of Hawai'i. According to *The Hawai'i 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 with 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 further engage the LGBTQ community to identify culturally competent strategies to promote access to mental health care for this underserved population. The collection and measurement of Sexual Orientation and Gender Identity of the CAMHD youth will be a critical step in evaluating services provided to LGBTQ youth. The CAMHD also intends to provide a multitude of training opportunities for staff, contracted providers, and system partners on cultural competence with LGBTQ youth.

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 Hawai'i 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. CAMHD utilizes telepsychiatry and ZOOM to conduct therapeutic and administrative meetings across the islands.

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 Hawai'i 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 Hawai'i 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 Hawai'i Interagency State Youth Network of Care (HI-SYNC) collaborative partnership of child-serving agencies is an active and effective body.

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.

Hawai'i, 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.

CAMHD received SAMHSA grant funding in mid-2021 to work collaboratively with child-serving partners to protect and improve children's mental health. This four-year grant, also known as the Data to Wisdom grant, includes goals focused on reducing out-of-home mental health services by:

- Improving youth outcomes through strengthening the state's data-driven decision making infrastructure;
- Increasing coordination across child-serving agencies;
- Improving adherence to Child and Adolescent Service System Program principles; and
- Bolstering in-home treatments that strengthen families.

A copy of the news release may be viewed here:

<https://health.hawaii.gov/news/newsroom/child-and-adolescent-mental-health-division-awarded-11-8-million-grant-to-improve-childrens-mental-health-services-statewide/>

The partners involved with the Data to Wisdom grant are: Hawai'i Department of Human Services Social Services & Med-QUEST Divisions, Office of Youth Services, Family Court of the Judiciary, Hawai'i Youth Services Network, EPIC Ohana, Inc., Child and Family Service, Kinai 'Eha,

University of Hawai'i at Mānoa Department of Psychology, University of Pennsylvania, Palo Alto
Veterans Institute for Research, and PracticeWise, LLC.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Community-Based Services
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Increase access to mental health services.

Strategies to attain the goal:

Monitor the number of consumers served in the adult mental health system of care compared to the prevalence of adults with serious mental illness.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number/percent of adult receiving AMHD services.
Baseline Measurement: Unduplicated number/percent of consumers served by AMHD by age, gender, race/ethnicity and county. The baseline measure is 7,762.
First-year target/outcome measurement: Increased by 5%
Second-year target/outcome measurement: Increased by 5%

Data Source:

Census data for Hawaii.
SAMHSA Uniform Reporting Service (URS) tables.

Description of Data:

The baseline measure of AMHD consumers will be increased by 5% over the baseline figure of 7,762 for the current period.

Data issues/caveats that affect outcome measures:

Priority #: 2
Priority Area: Community Tenure
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Decrease percentage of individuals discharged from the Hawaii State Hospital (HSH) who are readmitted within six months.

Strategies to attain the goal:

Improving continuity of care (inpatient to outpatient transitions)
Use of intensive case management for those at high risk
Community-based mental health services and supports focus on co-occurring conditions

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number/percent of consumers discharged from the Hawaii State Hospital (HSH) who are readmitted within six months

Baseline Measurement: Unduplicated number/percent of discharged individuals

First-year target/outcome measurement: Decreased by 5%

Second-year target/outcome measurement: Decreased by 5%

Data Source:

AMHD electronic medical record

Description of Data:

Number of individuals discharged from the Hawaii State Hospital (HSH) who are readmitted within six months

Data issues/caveats that affect outcome measures:

Impact of court ordered admissions

Priority #: 3

Priority Area: Crisis Stabilization

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Keep individuals stable within the community.

Strategies to attain the goal:

Utilization of short- and long-term stabilization bed units (SBUs) that incorporate intensive case management.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number/Percent of individuals receiving crisis stabilization services

Baseline Measurement: Unduplicated number/percent of individuals served by AMHD by age, gender, race/ethnicity, and by county.

First-year target/outcome measurement: Increase by 5%

Second-year target/outcome measurement: Increase by 5%

Data Source:

AMHD electronic medical record

Description of Data:

Baseline measure of AMHD consumers will increased by 5% for the period of SFY 2022-2023.

Data issues/caveats that affect outcome measures:

By increasing the number of crisis stabilization services in state, including in rural counties, we anticipate an increase in the number of individuals receiving crisis services.

Priority #: 4

Priority Area: Peer Specialist and Forensic Peer Specialist

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the use of peer specialists in community-based services.

Strategies to attain the goal:

Train more peer specialist
Include peer specialists as required team members in various community-based service contracts.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Hawaii Certified Peer Specialists (HCPS) to support individuals in the community

Baseline Measurement: There are 40 HCPS individuals who are currently working. The goal is to increase the number of individuals trained AND certified as HCPS.

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:

HCPS examination data.
Individuals assigned to a peer specialist.

Description of Data:

Number of HCPS in Hawaii from AMHD database.

Data issues/caveats that affect outcome measures:

Priority #: 5

Priority Area: Increase access to mental health treatment and support to houseless children and their families

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Accessible mental health treatment and support services for houseless children and youth.

Strategies to attain the goal:

Outreach, engagement and linkage to mental health services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of houseless children and youth provided with mental health services

Baseline Measurement: Baseline number is 100.

First-year target/outcome measurement: Increased by 2%

Second-year target/outcome measurement: Increased by 4%

Data Source:

Catholic Charities homeless mental health supports annual program report

Description of Data:

Number of houseless children provided with individual therapy

Data issues/caveats that affect outcome measures:

Houseless children and their families will be identified and linked to mental health services

Priority #: 6
Priority Area: 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:

Prevent or reduce progression toward serious mental illness (SMI)

Strategies to attain the goal:

Develop and offer empirically supported and coordinated specialty care to adolescents and young adults soon after their first episode of psychosis

Annual Performance Indicators to measure goal success

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
First-year target/outcome measurement: Increased by 5%
Second-year target/outcome measurement: Increased by 10%

Data Source:

Child and Adolescent Mental Health Division 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:

Priority #: 7
Priority Area: To provide services for children of pregnant women and women with dependent children (PWWDC) with substance abuse treatment needs up to twelve (12) years of age.
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

To provide services for children of pregnant women and women with dependent children (PWWDC) with substance abuse treatment needs up to twelve (12) years of age.

Strategies to attain the goal:

Scope of services for PWWDC contracts for the next two-year (October 1, 2021 - September 30, 2023) contract period to include treatment and supportive services for children up to twelve (12) years of age with substance abuse treatment needs.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Execution of PWWDC contracts with a scope of service to include a provision for treatment and supportive services for children up to the age of twelve (12).

- Baseline Measurement:** Effective October 1, 2019, there was at least one (1) contract executed in each of Hawaii's four counties (Oahu, Maui, Kauai, and Hawaii) to provide treatment and supportive services for PWWDC children up to 12 years of age with substance abuse treatment needs.
- First-year target/outcome measurement:** Maintain a minimum of one (1) contract per county in each of Hawaii's four counties (Oahu, Maui, Kauai, and Hawaii) to provide treatment and supportive services for PWWDC children up to 12 years of age with substance abuse treatment needs in FFY 2022.
- Second-year target/outcome measurement:** Maintain a minimum of one (1) contract per county in each of Hawaii's four counties (Oahu, Maui, Kauai, and Hawaii) to provide treatment and supportive services for PWWDC children up to 12 years of age with substance abuse treatment needs in FFY 2023.

Data Source:

Executed contract; contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete meet state compliance standards:

1. Contract Checklist for 103F Health and Human Services
2. FAMIS- Vendor Confirmation
3. Hawaii Compliance Express
4. Request for Taxpayer Identification Number and Certification
5. AG Form 103F1 (10/08)- Recitals
6. AG Form 103F7 (10/08)- Providers Acknowledgment
7. Scope of Services
8. AG Form 103F11 (10/08)- Time of Performance
9. AG Form 103F12 (10/08)- Compensation and Payment Schedule
10. AG Form 103F8 (9/08)- Certificate of Exemption from Civil Service
11. AG Form 103F9 (10/08) - Provider's Standards of Conduct Declaration
12. AG Form 103F (10/08) - General Conditions for Health & Human Services Contracts
13. Special Conditions
14. Allocation Schedule
15. Rate Schedule and/or Budget
16. Certification of Insurance
17. Proof of other related documents:
 - a. Statement of Attestation
 - b. Printout of Solicitation
 - c. Retro Memo (when applicable)

Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:

1. Contract Modification Checklist (ASO-C005 3/2012)
2. Contract Modification Summary Sheet (ASO C-002)
3. Contract Modification (ASO C-003)
4. Contractor's/Provider's Acknowledgment (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
8. Debarment of Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures:

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

- Priority #:** 8
- Priority Area:** To maintain enhanced services for people who inject drugs (PWIDs), namely opioid injection/intravenous drug users. Enhanced services include a broad spectrum of treatment options for opioid addiction.
- Priority Type:** SAT
- Population(s):** PWID

Goal of the priority area:

To maintain enhanced services for people who inject drugs (PWIDs), namely opioid injection/intravenous drug users. Enhanced services include a broad spectrum of treatment options for opioid addiction.

Strategies to attain the goal:

Scope of services for opioid service contracts for the next two-year (October 1, 2021 - September 30, 2023) contract period to include motivational enhancement, transportation, translation, and cultural activities.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Execution of opioid contracts with a scope of service to include a provision which expands services to PWIDs by reducing the severity and disabling effects related to opioid addiction services by broadening the spectrum of treatment options to best meet the needs of opioid users.
Baseline Measurement:	Effective October 1, 2019, there was at least one (1) contract executed to provide statewide enhanced services for PWIDs.
First-year target/outcome measurement:	Maintain a minimum of one (1) contract to provide enhanced services for PWIDs in FFY 2022.
Second-year target/outcome measurement:	Maintain a minimum of one (1) contract to provide enhanced services for PWIDs in FFY 2023.

Data Source:

Executed contract; contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete meet state compliance standards:

1. Contract Checklist for 103F Health and Human Services
2. FAMIS- Vendor Confirmation
3. Hawaii Compliance Express
4. Request for Taxpayer Identification Number and Certification
5. AG Form 103F1 (10/08)- Recitals
6. AG Form 103F7 (10/08)- Providers Acknowledgment
7. Scope of Services
8. AG Form 103F11 (10/08)- Time of Performance
9. AG Form 103F12 (10/08)- Compensation and Payment Schedule
10. AG Form 103F8 (9/08)- Certificate of Exemption from Civil Service
11. AG Form 103F9 (10/08) - Provider's Standards of Conduct Declaration
12. AG Form 103F (10/08) - General Conditions for Health & Human Services Contracts
13. Special Conditions
14. Allocation Schedule
15. Rate Schedule and/or Budget
16. Certification of Insurance
17. Proof of other related documents:

- a. Statement of Attestation
- b. Printout of Solicitation
- c. Retro Memo (when applicable)

Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:

1. Contract Modification Checklist (ASO-C005 3/2012)
2. Contract Modification Summary Sheet (ASO C-002)
3. Contract Modification (ASO C-003)
4. Contractor's/Provider's Acknowledgment (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
8. Debarment of Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures:

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

Priority #: 9

Priority Area: To provide recovery support services to include transportation and translation for adults, PWWDC, and PWIDs with substance abuse treatment needs.

Priority Type: SAT

Population(s): Other (Recovery Support Services)

Goal of the priority area:

To provide recovery support services to include transportation and translation for adults, PWWDC, and PWIDs with substance abuse treatment needs.

Strategies to attain the goal:

Scope of services for recovery supports for the next two-year (October 1, 2021 - September 30, 2023) contract period to include transportation and translation, stabilization beds, group recovery homes, clean and sober living, and therapeutic living programs for adults, PWWDC, and PWIDs with substance abuse treatment needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Execution of PWWDC, PWID, and adult contracts with a scope of service to include transportation and translation, stabilization beds, group recovery homes, clean and sober living, and therapeutic living programs.

Baseline Measurement: Effective October 1, 2019, there was at least one (1) contract executed for each of the target populations, i.e., adults, PWWDC, and PWIDs, to provide recovery support services including transportation and translation, stabilization beds, group recovery homes, clean and sober living, and therapeutic living programs.

First-year target/outcome measurement: Maintain a minimum of at least one (1) contract to provide recovery support services including transportation and translation, stabilization beds, group recovery homes, clean and sober living, and therapeutic living programs for each of the target populations, i.e., adults, PWWDC, and PWIDs, with substance abuse treatment needs in FFY 2022.

Second-year target/outcome measurement: Maintain a minimum of at least one (1) contract to provide recovery support services including transportation and translation, stabilization beds, group recovery homes, clean and sober living, and therapeutic living programs for each of the target populations, i.e., adults, PWWDC, and PWIDs, with substance abuse treatment needs in FFY 2023.

Data Source:

Executed contract; contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete meet state compliance standards:

1. Contract Checklist for 103F Health and Human Services
2. FAMIS- Vendor Confirmation
3. Hawaii Compliance Express
4. Request for Taxpayer Identification Number and Certification
5. AG Form 103F1 (10/08)- Recitals
6. AG Form 103F7 (10/08)- Providers Acknowledgment
7. Scope of Services
8. AG Form 103F11 (10/08)- Time of Performance
9. AG Form 103F12 (10/08)- Compensation and Payment Schedule
10. AG Form 103F8 (9/08)- Certificate of Exemption from Civil Service
11. AG Form 103F9 (10/08) - Provider's Standards of Conduct Declaration
12. AG Form 103F (10/08) - General Conditions for Health & Human Services Contracts
13. Special Conditions
14. Allocation Schedule

- 15. Rate Schedule and/or Budget
- 16. Certification of Insurance
- 17. Proof of other related documents:
 - a. Statement of Attestation
 - b. Printout of Solicitation
 - c. Retro Memo (when applicable)

Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:

- 1. Contract Modification Checklist (ASO-C005 3/2012)
- 2. Contract Modification Summary Sheet (ASO C-002)
- 3. Contract Modification (ASO C-003)
- 4. Contractor's/Provider's Acknowledgment (AF-103F7)
- 5. Attachments (when applicable)
- 6. Exhibits (when applicable)
- 7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
- 8. Debarment of Suspension
- 9. Availability of Funds
- 10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures:

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

Priority #: 10

Priority Area: To prevent and reduce the use and misuse of alcohol, tobacco and tobacco products, marijuana, and prescription drugs by youth and young adults, especially underserved populations (i.e., students in college, military families, LGBTQ, homeless, Native Hawaiian/other Pacific Islanders, Asian, rural, and underserved racial and ethnic minorities) in communities statewide.

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To prevent and reduce the use and misuse of alcohol, tobacco and tobacco products, marijuana, and prescription drugs by youth and young adults, especially underserved populations (i.e., students in college, military families, LGBTQ, homeless, Native Hawaiian/other Pacific Islanders, Asian, rural, and underserved racial and ethnic minorities) in communities statewide.

Strategies to attain the goal:

- a. Provide communities with resources, technical assistance and specific training directed to build capacity for data collection and the use of data, planning, evaluation, cultural competence, and other prevention topics identified to support the implementation of the Strategic Prevention Framework (SPF) to sustain local prevention efforts.
- b. Allocate available resources to community organizations and coalitions to implement individual and/or community-based prevention strategies to reduce risk factors and address local conditions associated with substance use by youth, young adults and their families.
- c. Provide technical assistance to communities to maximize local enforcement procedures governing the availability and distribution of alcohol, tobacco and other drugs, including educating community members and law enforcement officials about the benefits of enforcing alcohol, tobacco and drug policies and laws.
- d. Allocate available resources to support programs that increase knowledge about tobacco and tobacco products, alcohol, prescription drug misuse, marijuana use and other drug problems as well as to establish policies to address the negative consequences of use and to promote protective factors and resilience.
- e. Build capacity and increase competencies of the prevention workforce by promoting the Prevention Specialist Certification and providing opportunities for professional development.
- f. Obtain data from funded prevention programs on types of services and activities conducted and information on service populations.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Percent of contracted community-based organizations utilizing data driven decision making, capacity building and planning (SPF) to address local conditions and prevent substance use disorders (i.e., alcohol, tobacco and tobacco products, marijuana and prescription drugs) in their communities of underserved populations as demonstrated by completed, or in progress, logic models, Comprehensive Strategic Plans, and evaluation reports.

Baseline Measurement: 50% of the funded community organizations have initiated components of the SPF and have chosen effective prevention programs for implementation based on completed assessment and planning steps (FFY2020).

First-year target/outcome measurement: 60% of the funded community organizations, have completed, or have in progress, assessment, comprehensive strategic plans, and evaluation of prevention programs and interventions by end of FFY 2022.

Second-year target/outcome measurement: 70% of the funded community organizations, have completed, or have in progress, assessment, comprehensive strategic plans, and evaluation of prevention programs and interventions by end of FFY 2023.

Data Source:

Program Quarterly Reports; Program Monitoring Reports; Comprehensive Strategic Plans and evaluation reports submitted by contracted agencies; Surveys and questionnaires completed by contracted agencies.

Description of Data:

Review of status and evaluation progress as provided through written program reports and updated comprehensive strategic plans submitted by contracted organizations; Dates and content details of training and technical assistance provided to contracted agencies to enhance SPF implementation efforts.

Data issues/caveats that affect outcome measures:

Delayed implementation of the various components of the SPF due to inability of the state to provide sufficient training and technical assistance to communities; Delays in procurement process and procedures may shorten time for services to proceed; development of the consistent evaluation tool for prevention organizations may affect the degree of increased capacity to utilize the tool; local information gathered and presented may be flawed or biased relative to the service organizations' capacity and depth of experience, knowledge and understanding of needs assessment, evaluation and data collection and interpretation; inadequate resources and capacity to engage assistance and services of evaluators.

Indicator #: 2

Indicator: Number of technical assistance and training opportunities related to implementing the SPF, including identifying, implementing and evaluating evidence-based prevention programs and strategies, information on alcohol, tobacco, marijuana, and prescription drug use, and related topics provided to prevention specialists and community organizations.

Baseline Measurement: Five (5) opportunities provided during FFY2021.

First-year target/outcome measurement: Seven (7) opportunities for TA and training by end of FFY2022.

Second-year target/outcome measurement: Ten (10) opportunities for TA and training by end of FFY2023.

Data Source:

Registration flyers, Agendas, Sign In Sheets, Handouts and materials distributed, Participant Evaluation/Comment Forms; Number of certification units (CEs); Assessment completed by workforce development contractor.

Description of Data:

Summary reports with participant information and details of content delivered during training and/or technical assistance; registry of Certified Prevention Specialists; follow up surveys and interviews with participants.

Data issues/caveats that affect outcome measures:

Limited relevant and ongoing opportunities for onsite training and mentoring for trainees and prevention specialists seeking certification due to prohibitive costs or limited funds may affect the outcome measures.

Priority #: 11

Priority Area: To make available tuberculosis (TB) services for individuals receiving substance use disorder (SUD) treatment services.

Priority Type: SAT

Population(s): TB

Goal of the priority area:

To make available tuberculosis (TB) services for individuals receiving substance use disorder (SUD) treatment services.

Strategies to attain the goal:

Scope of services for SUD contracts the next two-year (October 1, 2021 - September 30, 2023) contract period to include availability of TB services for individuals receiving substance use disorder (SUD) treatment services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Execution of SUD contracts with a Scope of Work to include provision for the availability of TB services for individuals receiving substance use disorder (SUD) treatment services.
Baseline Measurement:	Effective October 1, 2019, there was at least one (1) contract executed in each of Hawaii's four counties Oahu, Maui, Kauai, and Hawaii) to make available TB services for individuals receiving substance use disorder (SUD) treatment services.
First-year target/outcome measurement:	Maintain a minimum of one (1) contract per county in each of Hawaii's four counties (Oahu, Maui, Kauai, and Hawaii) to make available TB services for individuals receiving substance use disorder (SUD) treatment services in FFY 2022.
Second-year target/outcome measurement:	Maintain a minimum of one (1) contract per county in each of Hawaii's four counties (Oahu, Maui, Kauai, and Hawaii) to make available TB services for individuals receiving substance use disorder (SUD) treatment services in FFY 2023.

Data Source:

Executed contract; contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete meet state compliance standards:

1. Contract Checklist for 103F Health and Human Services
2. FAMIS- Vendor Confirmation
3. Hawaii Compliance Express
4. Request for Taxpayer Identification Number and Certification
5. AG Form 103F1 (10/08)- Recitals
6. AG Form 103F7 (10/08)- Providers Acknowledgment
7. Scope of Services
8. AG Form 103F11 (10/08)- Time of Performance
9. AG Form 103F12 (10/08)- Compensation and Payment Schedule
10. AG Form 103F8 (9/08)- Certificate of Exemption from Civil Service
11. AG Form 103F9 (10/08) - Provider's Standards of Conduct Declaration
12. AG Form 103F (10/08) - General Conditions for Health & Human Services Contracts
13. Special Conditions
14. Allocation Schedule
15. Rate Schedule and/or Budget
16. Certification of Insurance
17. Proof of other related documents:
 - a. Statement of Attestation
 - b. Printout of Solicitation
 - c. Retro Memo (when applicable)

Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:

1. Contract Modification Checklist (ASO-C005 3/2012)
2. Contract Modification Summary Sheet (ASO C-002)
3. Contract Modification (ASO C-003)
4. Contractor's/Provider's Acknowledgment (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
8. Debarment of Suspension
9. Availability of Funds

Data issues/caveats that affect outcome measures:

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

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

Footnotes:

1. Table 1 also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Table 1 and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

2. All ADAD-funded treatment programs will continue to be contractually required to comply with Sec. 1924(a) of P.L. 102-321, to routinely make available tuberculosis (TB) services to all clients either directly or through arrangements with public or nonprofit agencies. The Department of Health's Communicable Disease & Public Health Nursing Division, Tuberculosis Control Branch will continue to provide needed TB services to ADAD clients in treatment for substance use disorders. ADAD's contract compliance monitoring protocol for treatment programs will continue to include the review of a program's policy and procedures and documentation on TB screening and testing of clients.

3. Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse are not identified as a priority for Table 1 because Hawaii is not a "designated State" according to CSAT's list of "designated states" for the FFY 2022-23 SABG. Since 2002, SAMHSA has prohibited non-designated States from expending any Block Grant funds for HIV early intervention services. But in September 2011, SAMHSA made a program policy change to allow States that were "designated" within the last three years the option to continue to set aside 5% of their SABG award for HIV early intervention services. This option does not apply to Hawaii since Hawaii was not "designated" within the last three years. However, ADAD will continue to allocate State general funds to provide HIV early intervention services at substance abuse treatment programs.

4. Although Native Hawaiians are not identified as a specific priority for Table 1, ADAD makes available a proportion of the SABG funds for substance abuse programs for Native Hawaiians, pursuant to Sec. 1953 of P.L. 102-321. The description of Block Grant expenditures and services for Native Hawaiians is included in Hawaii's SABG Report submitted annually to SAMHSA by December 1.

5. For Priority 9 (Recovery Support Services), ADAD selected "Other" but did not specify a subcategory of "Other" such as Adolescents or Homeless because ADAD intended to say that its recovery support contracts were also meant to serve "Other Adults" as well as PWWDC and PWIDs.

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023. ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) ^a	I. COVID-19 Relief Funds (SABG) ^a	J. ARP Funds (SABG) ^b
1. Substance Abuse Prevention ^c and Treatment	\$12,532,724.00		\$0.00	\$4,293,652.00	\$32,751,376.00	\$0.00	\$0.00		\$6,360,750.00	\$4,781,416.00
a. Pregnant Women and Women with Dependent Children ^c	\$3,600,000.00								\$2,751,500.00	\$1,719,039.00
b. All Other	\$8,932,724.00			\$4,293,652.00	\$32,751,376.00				\$3,609,250.00	\$3,062,377.00
2. Primary Prevention ^d	\$4,646,354.00		\$0.00	\$4,498,675.00	\$3,926,000.00	\$0.00	\$0.00		\$1,683,433.00	\$2,165,833.00
a. Substance Abuse Primary Prevention	\$4,646,354.00			\$4,498,675.00	\$3,926,000.00				\$1,683,433.00	\$2,165,833.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	\$150,000.00			\$1,122,461.00	\$3,966,680.00					
10. Crisis Services (5 percent set-aside)										
11. Total	\$17,329,078.00	\$0.00	\$0.00	\$9,914,788.00	\$40,644,056.00	\$0.00	\$0.00	\$0.00	\$8,044,183.00	\$6,947,249.00

^a The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

^b The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

^c Prevention other than primary prevention

^d The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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

Footnotes:

1. This Table 2 "State Agency Planned Expenditures [SA]" applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Table 2 "State Agency Planned Expenditures [SA]" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

2. Although no separate funds are shown for TB services, all ADAD-funded treatment programs are contractually required to comply with Sec. 1924(a) of P.L. 102-321, regarding availability of TB services.

3. According to CSAT's list of "designated states" for the FFY 2022 SABG, Hawaii is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000. (See 42 USC §300x-24(b) and 45 CFR §96.128). Thus, no SABG funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance abuse treatment programs.

4. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA updated this section.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023. Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) ^a	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG) ^b
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention ^e							\$0.00			\$0.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) ^d		\$725,000.00					\$570,000.00			\$320,416.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital					\$184,268,038.00					
7. Other 24-Hour Care		\$0.00	\$4,000,000.00		\$74,800,000.00		\$803,000.00			\$1,295,250.00
8. Ambulatory/Community Non-24 Hour Care		\$1,218,934.00	\$2,000,000.00	\$400,000.00	\$96,952,700.00		\$452,536.00			\$203,770.00
9. Administration (excluding program/provider level) ^f MHBG and SABG must be reported separately		\$187,934.00	\$5,000,000.00	\$4,000,000.00	\$39,341,526.00					
10. Crisis Services (5 percent set-aside) ^g		\$2,415,160.00			\$13,120,000.00		\$2,336,000.00			\$1,635,200.00
11. Total	\$0.00	\$4,547,028.00	\$11,000,000.00	\$4,400,000.00	\$408,482,264.00	\$0.00	\$0.00	\$4,161,536.00	\$0.00	\$3,454,636.00

^a The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

^b The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

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

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

^f Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

^g Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

MHBG Budget reflects planning period 10/01/2021-09/30/2023

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	0	0
2. Women with Dependent Children	0	0
3. Individuals with a co-occurring M/SUD	0	0
4. Persons who inject drugs	0	0
5. Persons experiencing homelessness	0	0

Please provide an explanation for any data cells for which the state does not have a data source.

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

Footnotes:

1. This Table 3 "SABG Persons in need/receipt of SUD treatment" applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Table 3 "SABG Persons in need/receipt of SUD treatment" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award ¹	ARP Award ²
1 . Substance Use Disorder Prevention and Treatment ³	\$6,178,035.00	\$6,360,750.00	\$4,781,416.00
2 . Primary Substance Use Disorder Prevention	\$2,330,000.00	\$1,683,433.00	\$2,165,833.00
3 . Early Intervention Services for HIV ⁴			
4 . Tuberculosis Services			
5 . Administration (SSA Level Only)	\$75,000.00		
6. Total	\$8,583,035.00	\$8,044,183.00	\$6,947,249.00

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

³Prevention other than Primary Prevention

⁴For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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

Footnotes:

1. Table 4 "SABG Planned Expenditures" applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Table 4 "SABG Planned Expenditures" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

2. Although no separate funds are shown for TB services, all ADAD-funded treatment programs are contractually required to comply with Sec. 1924(a) of P.L. 102-321, regarding availability of TB services.

3. According to CSAT's list of "designated states" for the FFY 2020 SABG, Hawaii is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000. (See 42 USC §300x-24(b) and 45 CFR §96.128). Thus, no SABG funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance abuse treatment programs.

4. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA updated this section.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Strategy	A	B		
	IOM Target	SA Block Grant Award	FFY 2022 COVID-19 ¹	ARP ²
1. Information Dissemination	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total		\$0	\$0
2. Education	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total		\$0	\$0
3. Alternatives	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total		\$0	\$0
4. Problem Identification and Referral	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total		\$0	\$0
	Universal			

5. Community-Based Process	Selective			
	Indicated			
	Unspecified			
	Total	\$0	\$0	\$0
6. Environmental	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	\$0	\$0	\$0
7. Section 1926 Tobacco	Universal	\$100,000		
	Selective			
	Indicated			
	Unspecified			
	Total	\$100,000	\$0	\$0
8. Other	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	\$0	\$0	\$0
Total Prevention Expenditures		\$100,000	\$0	\$0
Total SABG Award³		\$8,583,035	\$8,044,183	\$6,947,249
Planned Primary Prevention Percentage		1.17 %	1.24 %	1.44 %

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

³Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

1. Table 5a "SABG Primary Prevention Planned Expenditures" applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Table 5a "SABG Primary Prevention Planned Expenditures" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

2. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA updated this section.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award ¹	ARP Award ²
Universal Direct	\$1,290,600		
Universal Indirect	\$979,900		
Selective	\$95,600		
Indicated	\$23,900		
Column Total	\$2,390,000	\$0	\$0
Total SABG Award³	\$8,583,035	\$8,044,183	\$6,947,249
Planned Primary Prevention Percentage	27.85 %	0.00 %	0.00 %

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

³Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

1. Table 5b "SABG Primary Prevention Planned Expenditures by IOM Category" applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application

deadline, and states its commitment to update Table 5b "SABG Primary Prevention Planned Expenditures by IOM Category" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

2. Amount of primary prevention funds reported on Table 4, row 2, that are planned to be expended on Non-Direct-Services/System Development for SABG Prevention (Table 6): \$465,000.

3. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA updated this section.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award ¹	ARP Award ²
Targeted Substances			
Alcohol	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bath salts, Spice, K2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Targeted Populations			
Students in College	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LGBTQ	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
American Indians/Alaska Natives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
African American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeless	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rural	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Footnotes:

1. Table 5c "SABG Planned Primary Prevention Targeted Priorities" applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Table 5c "SABG Planned Primary Prevention Targeted Priorities" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

2. Aside from the Native Hawaiian target population, please note that ADAD does not track prevention funds allocated to or expected for specific substances or populations.

3. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA updated this section.

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated ¹	D. COVID-19 ²	E. ARP ³
1. Information Systems	\$465,000.00	\$465,000.00		\$134,000.00	\$1,131,145.00
2. Infrastructure Support				\$180,000.00	
3. Partnerships, community outreach, and needs assessment					
4. Planning Council Activities (MHBG required, SABG optional)					
5. Quality Assurance and Improvement	\$2,500.00				
6. Research and Evaluation					
7. Training and Education	\$1,022,900.00			\$1,201,250.00	\$355,229.00
8. Total	\$1,490,400.00	\$465,000.00	\$0.00	\$1,515,250.00	\$1,486,374.00

¹Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

²The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

³The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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

Footnotes:

1. Table 6 "Non-Direct Services/System Development [SA]" applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Table 6 "Non-Direct Services/System Development [SA]" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

2. Amount of SABG Primary Prevention funds (from Table 4, Row 2) to be used for Non-Direct-Services/System Development Activities for SABG

Prevention, Column B = \$ 465,000.

3. Amount of SABG Administration funds (from Table 4, Row 5) to be used for Non-Direct-Services/System Development Activities for SABG Combined, Column C = \$0.

4. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA updated this section.

Planning Tables

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

MHBG Planning Period Start Date:

MHBG Planning Period End Date:

Activity	FFY 2022 Block Grant	FFY 2022 ¹ COVID Funds	FFY 2022 ² ARP Funds	FFY 2023 Block Grant	FFY 2023 ¹ COVID Funds	FFY 2023 ² ARP Funds
1. Information Systems						
2. Infrastructure Support						
3. Partnerships, community outreach, and needs assessment						
4. Planning Council Activities (MHBG required, SABG optional)						
5. Quality Assurance and Improvement						
6. Research and Evaluation						
7. Training and Education						
8. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

¹ The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

² The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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

Footnotes:

Planning 6 Non-Direct- Services/System Development (MH)		
MHBG Planning Period Start Date: 07/01/2021		MHBG Planning Period End Date: 6/30/2023
Activity	FFY 2022 Block Grant	FFY 2023 Block Grant Funds
Information Systems	\$ 417,179.00	\$ 417,179.00
Infrastructure Support	\$ 512,000.00	\$ 512,000.00
Partnerships, community outreach, and needs assessment	\$ 135,948.00	\$ 135,948.00
Planning Council Activities	\$ 15,000.00	\$ 15,000.00
Quality Assurance and Improvement	\$ 100,000.00	\$ 100,000.00
Research and Evaluation	\$ 100,000.00	\$ 100,000.00
Training and Education	\$ 67,768.00	\$ 67,768.00
Total	\$ 1,347,895.00	\$ 1,347,895.00

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.²² Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth 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.²³ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁴

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.²⁵ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁶ 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.²⁷

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.²⁸

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.²⁹ 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.³⁰ 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 homes³¹ and ACOs³² 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.³³ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁴

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁵ 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.³⁶ 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.³⁷ 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.³⁸ 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.³⁹ 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.⁴⁰

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.⁴¹ 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.

²² BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

²³ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/million-hearts-initiative>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁴ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <https://www.samhsa.gov/find-help/disorders>

²⁵ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

²⁶ <https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development>

²⁷ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

²⁸ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

²⁹ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁰ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <https://www.cchpca.org/topic/overview/>;

³¹ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³² New financing models, <https://www.integration.samhsa.gov/financing>

³³ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

³⁴ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁵ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

³⁶ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

³⁷ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

³⁸ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

³⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

⁴⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>;

⁴¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

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 healthcare services from the West Honolulu Treatment Services Section and the Leeward-Central 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 provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and 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).

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? Yes No

b) and Medicaid? Yes No

4. Who is responsible for monitoring access to M/SUD services provided 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

ii) heart disease Yes No

iii) hypertension Yes No

iv) high cholesterol Yes No

v) 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.

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Footnotes:

1. This Environmental Factor 1. "The Health Care System, Parity and Integration" applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Environmental Factor 1. "The Health Care System, Parity and Integration" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴², [Healthy People, 2020](#)⁴³, [National Stakeholder Strategy for Achieving Health Equity](#)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)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."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 status⁴⁷. 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 populations⁴⁸. 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.

⁴² http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴³ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁴ https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

⁴⁵ <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?

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:

1. This Environmental Factor 2. "Health Disparities" also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Environmental Factor 2. "Health Disparities" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

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:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

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**)⁵⁵ 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.

⁴⁹ United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

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.

⁵¹ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵² National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵³ <http://psychiatryonline.org/>

⁵⁴ <http://store.samhsa.gov>

⁵⁵ https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf

Please respond to the following items:

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 focused on consumer outcomes rather than care processes.
 - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, 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?
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:

1. The Hawaii SSA provided no response because the Innovation in Purchasing Decisions section is not required for SABG per the FFY22-23 SABG Application instructions.

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.

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 2022 and FFY 2023 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.

Technical assistance is not needed at this time.

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Footnotes:

Environmental Factors and Plan

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.

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, a personal Safety Plan is developed in collaboration with the youth and their families. The plan details the youth and families preferences for handling potential crises. The Safety 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 Safety Plan builds on available information about the youth.

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 fewer 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.

Child & Adolescent Mental Health Division (CAMHD) clients and families are scheduled to meet with a Clinical Lead (Psychologist or Psychiatrist) within five days of eligibility determination. The goals of the meeting are to provide psychoeducation and foster "voice and choice" and consider the youth and families' input to be critical to the client's treatment. The client and families identify goals and expectations of their mental health treatment and clinically appropriate treatment options and strategies are presented for the client and family to decide which service would be best. Barriers to accessing service (e.g., transportation) are identified and discharge criteria is discussed so that the family is aware of possible treatment outcomes and the length of treatment they may expect. A coordinated service plan is developed based on interactions with the youth and their family and this plan is

continuously updated as the youth receives services with CAMHD till discharge.

Youth that are referred to the CAMHD from the Hawaii State Department of Education (DOE), have an existing ISP and both CAMHD and DOE continue to collaborate on the youth while receiving CAMHD until the youth is ready to be discharged from CAMHD.

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

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 receipts 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.

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Footnotes:

1. This Environmental Factor 6. "Program Integrity" also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Environmental Factor 6. "Program Integrity" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

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](#)⁵⁶ 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?
The State of Hawaii does not currently have any federally recognized tribes.
2. What specific concerns were raised during the consultation session(s) noted above?
N/A
3. Does the state have any activities related to this section that you would like to highlight?
N/A
Please indicate areas of technical assistance needed related to this section.
N/A

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Footnotes:

1. No federally recognized tribes or tribal lands exist within Hawaii's borders.

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? Yes No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) Yes No
 - a) Data on consequences of substance-using behaviors
 - b) Substance-using behaviors
 - c) Intervening variables (including risk and protective factors)
 - d) Other (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - Children (under age 12)
 - Youth (ages 12-17)
 - Young adults/college age (ages 18-26)
 - Adults (ages 27-54)
 - Older adults (age 55 and above)
 - Cultural/ethnic minorities
 - Sexual/gender minorities
 - Rural communities
 - Others (please list)
4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- Archival indicators (Please list)
- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

Uniform Crime Reporting (UCR)

Fatality Analysis Reporting System (FARS)

Pregnancy Risk Assessment Monitoring System (PRAMS)

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds? Yes No

If yes, (please explain)

Based on the analysis of needs assessment data and community profiles developed by the State Epidemiological Outcomes Workgroup (SEOW), priority populations and communities are identified for prevention services. Comments and feedback regarding the data and priorities is provided by the community-based service providers and stakeholders to also inform decisions regarding allocation of SABG primary prevention funds.

If no, (please explain) how SABG funds are allocated:

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? Yes No

If yes, please describe

Pursuant to State law (HRS §321-193(10) and regulations (Hawaii Administrative Rules, Title 11, Dept. of Health, Chapter 177 .1), ADAD approves credentials for Certified Prevention Specialist (CPS). Applicants complete the International Certification and Reciprocity Consortium (IC & RC) International Written Prevention Specialist Examination and submit an application including documentation of hours and signed code of ethics for review. Information on the certification process and requirements is available at <http://health.hawaii.gov/substance-abuse/counselorcertainment/>

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? Yes No

If yes, please describe mechanism used

Existing service contracts and collaborative partnerships facilitate the logistics of utilizing consultants, trainers, and venues to conduct relevant training workshops and courses approved for continuing education/contact hours (CEs) that may be applied toward meeting the education requirements for certification and/or renewal of certification. Additionally, ADAD continues to allocate SABG funds to maintain the Hawaii Prevention Resource Center to ensure prevention practitioners and the general public have access to up-to-date research, substance use disorder treatment and prevention resources, and evidence-based curriculum models. The <https://www.drugfreehawaii.org/hawaii-prevention-resource-center> links to a lending library, resource clearinghouse, and technical assistance services. A website specific to the Strategic Prevention Framework and prevention efforts is available for the workforce and prevention system at <https://www.spfhawaii.org/>.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? Yes No

If yes, please describe mechanism used

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) Yes No N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - b) Timelines
 - c) Roles and responsibilities
 - d) Process indicators
 - e) Outcome indicators
 - f) Cultural competence component
 - g) Sustainability component
 - h) Other (please list):
 - i) Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? Yes No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? Yes No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The EBW has established criteria and is consulted for implementation of programs and policies but not specific to SABG funds. The intent is to utilize the EBW for assistance in evaluating locally developed, culturally appropriate programs and innovative interventions to determine effectiveness.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
 - a) SSA staff directly implements primary prevention programs and strategies.
 - b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
 - c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
 - d) The SSA funds regional entities that provide training and technical assistance.
 - e) The SSA funds regional entities to provide prevention services.
 - f) The SSA funds county, city, or tribal governments to provide prevention services.
 - g) The SSA funds community coalitions to provide prevention services.
 - h) The SSA funds individual programs that are not part of a larger community effort.
 - i) The SSA directly funds other state agency prevention programs.
 - j) Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) Information Dissemination:
 - Health Fairs
 - Media Ready
 - Drug-free Awareness Community Events
 - School Presentations
 - b) Education:
 - LifeSkills Training
 - Positive Action Curriculum
 - Project Alert Curriculum
 - STARS for Families
 - Project Venture Curriculum
 - Second Step Curriculum
 - c) Alternatives:
 - Project Venture Camps
 - Family Strengthening Activities

Positive Action Alternative Activities
Project Alert Alternative Activities
Parenting and Family Management
Media Ready
Drug-Free Alternative Activities/Events

d) Problem Identification and Referral:

STARS for Families- psychoeducation

e) Community-Based Processes:

Prevention Resource Center
Coalition and interagency collaboration
Prevention Workforce Training

f) Environmental:

Synar Activities
Coalition involvement and interagency collaboration to address local conditions, attitudes and policies

- 3.** Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? Yes No

If yes, please describe

Applicants for funding provide information related to agency-wide budget and sources of funds, planned expenditures and actual expenditures for program services. Budgets and expenditures are approved and tracked by State fiscal and program staff.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) Includes evaluation information from sub-recipients
- c) Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) Establishes a process for providing timely evaluation information to stakeholders
- e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f) Other (please list:)
- g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a) Numbers served
- b) Implementation fidelity
- c) Participant satisfaction
- d) Number of evidence based programs/practices/policies implemented
- e) Attendance
- f) Demographic information
- g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a) 30-day use of alcohol, tobacco, prescription drugs, etc
- b) Heavy use
- Binge use
- Perception of harm
- c) Disapproval of use

- d) Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e) Other (please describe):

ADAD intends to track the select indicators from SAMHSA's NOMs related to youth such as 30-day marijuana and alcohol use; age of first use; perceived harm of use; lifetime prescription drug use without doctor's prescription; 30-day binge drinking; and family communication around substance use.

Further outcomes and impact of funded services will be determined by the SEOW, PFS evaluator, and the analysis and comparison of the Hawaii Youth Risk Behavior Survey results from 2013, 2015, 2017 and 2019. ADAD intends to work with an evaluator to enhance our ability to collect and report on outcome data from ADAD-funded providers as well as evaluate the prevention system as a whole.

Footnotes:

1. Environmental Factor 8. "Primary Prevention" also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Environmental Factor 8. "Primary Prevention" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

2. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA updated this section.

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
- Multi Systemic 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 | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) Mental Health | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) Rehabilitation services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) Employment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) Housing services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) Educational Services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| g) Substance misuse prevention and SUD treatment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| h) Medical and dental services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| i) Support services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| k) Services for persons with co-occurring M/SUDs | <input checked="" type="radio"/> Yes <input type="radio"/> No |

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.
- Normalized and incorporate natural supports, where services are offered in the least restrictive, most natural setting possible. Consumers are encouraged to use the natural supports in the community and should be integrated into the normal living, working, learning and leisure time activities of the community.

- Adapted to meet the needs of the subgroups of severely mentally ill individuals, such as, the elderly; young adults and youth in transition to adulthood; individuals with mental illness and substance use problems, medical co-morbidities, and/or individuals with mental illness who are homeless.
- Accountable to the users of the services and monitored by the State to assure quality of care and continued relevance to consumer needs. Consumers and their supports where applicable, are involved in the planning and implementation of services.
- Coordinated through mandates or written agreements that requires ongoing communication, collaboration, and linkages between multiple agencies, when needed, to ensure continuity of care.

Children's Mental Health

The state operated Family Guidance Center system for children with serious emotional disturbance (SED) includes intensive case management services. Case management services are provided in an individualized, strengths-based, youth-guided and family/guardian-centered manner. Every youth registered in the children's mental health system has an assigned care coordinator who will ensure timely, appropriate and coordinated service delivery.

Key functions of the Care Coordinators are to: A. Develop collaborative working relationships with other child serving agencies; B. Monitor all services; and C. Participate, with the family, in the development of the Mental Health Treatment Plan (MHTP) and quarterly MHTP reviews.

The Mental Health Care Coordinator (MHCC) 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. MHCCs are responsible for referring the youth for appropriate state mental health 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 youth's MHCC is responsible for convening an initial Coordinated Service Plan (CSP) meeting within thirty (30) days of eligibility determination or immediately if the youth has immediate needs and assuring service delivery within thirty (30) days of identification for routine services. The MHCC coordinates regular home visits, school visits, and community contacts as indicated in the CSP. When appropriate, responsibilities also include coordination of care with Family Court, and Department of Human Services 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 for communicating important clinical developments to the Branch Utilization Review Team.

The MHCC is responsible for ensuring that needed services, interventions and strategies are identified and delivered in a coordinated manner and in partnership with families. This includes the following activities:

- Ensuring that a sound clinical assessment is conducted that identifies the strengths and needs of the youth and family;
- Convening team meetings to conduct strength-based planning via the Coordinated Service Plan process;
- Responsible for the written Coordinated Service Plan as discussed and for obtaining the signatures of all participants attesting agreement.

- Implementation of the Coordinated Service Plan which includes linkages to other services or programs, referrals to natural community supports, advocacy and coordination with outside agencies and individuals;

- Performing ongoing monitoring and evaluation of the effectiveness of the Coordinated Service Plan and services;

- Through team participation, revising/adapting the plan as needs change;

- Ensuring that the Child and Adolescent Service System Program (CASSP) Principles always guide planning for all services; and

Upon first contact, and in addition to the prescribed intake procedure, provide the client/parent/legal guardian with a copy of the CAMHD flyer entitled "Notice of Privacy Practice" and the CAMHD client/family rights handbook entitled "Consumer Handbook."

Provide explanation, ensure that the family understands these rights, and obtain parental signature that attests to same.

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 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.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	44,000	n/a
2. Children with SED	11,726	n/a

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.

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 Yes No
- b) Educational services, including services provided under IDE Yes No
- c) Juvenile justice services Yes No
- d) Substance misuse prevention and SUD treatment services Yes No
- e) Health and mental health services Yes No
- f) Establishes defined geographic area for the provision of services of such system Yes No

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.

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.

The State of Hawaii's Homeless Initiative program annually conducts a point-in-time (PIT) count of homelessness individuals on the street and in shelters on a designated date. No unsheltered PIT count was conducted in 2021 due to the COVID-19 pandemic. However, in 2020, the statewide PIT count was 6,458 people experiencing homelessness of which 57% of those individuals were unsheltered and the remainder were in homeless shelters. The most common self-reported primary causes of homelessness by surveyed adults were inability to pay rent, job loss, and alcohol/drug use.^{1, 2} According to Hawaii's Lieutenant Governor press release on homelessness "A large portion of Hawaii's homeless population suffers from schizophrenia, severe substance abuse, or other incapacitating mental illnesses. The sad reality is that most of these people will continue to suffer for years while their mental and physical health deteriorates."³

The children's division plans to use block grant funding to provide targeted services to a rural, homeless population on the Waianae Coast on the island of Oahu. The Waianae Coast is a rural community of predominantly Native Hawaiians. 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 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: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

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 (QMHP) and paraprofessional staff by a QMHP or a Mental Health Professional (MHP) who is supervised by a QMHP. The Contractor is responsible for maintaining and tracking supervision records.

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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. 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.

Footnotes:

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.

According to the SAMHSA Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019, approximately 44,000 individuals 18+ years of age in Hawaii had a serious mental illness in the past year. With the adult population estimate shown in Table 1, this results in a 3.9% SMI prevalence rate (shown in Table 1).

Table 1
Estimate of Statewide Prevalence for Adults with SMI
FY 2020

County	Estimated 2020 Adult Population ¹	Estimated Adult SMI Prevalence (3.9%) ³	Estimated Number of those with SMI Served by the AMHD in FY 2020 ²	Estimated Percent SMI Prevalence Served
Statewide Total	1,119,689	43,668	7,762	17.8%

Application of the 3.9 percent prevalence rate of Hawaii's SMI adult population by County, utilizing the latest available population figures by County and Age (2020) is shown in Table 2.

According to the U.S. Census Bureau⁴, the estimated 2020 state population has increased 7% in the past decade, but detailed county level estimates are not yet available. Using 2019 census one-year estimates, Oahu is home of over two thirds (69.3%, n=775,598) of the state's adult (18+) population (1,119,689 residents), while 14.1% live on the Hawaii Island (Big Island) (158,129 adult residents), 11.6% in Maui County (129,561 adult residents including Molokai, and Lanai), and 5.0% or 56,041 residents

¹ Annual estimated resident population ages 18 years and older for the State of Hawaii in 2020. Source: U.S. Census Bureau, Population Division. Calculations and table creation by the Hawaii State Data Center, published through the Hawaii State Department of Business, Economic Development and Tourism, Research and Economic Analysis, Economic Data Warehouse. Obtained: August 2021. <https://dbedt.hawaii.gov/economic/datawarehouse/>

² Hawaii State Department of Health, Adult Mental Health Division, statewide unduplicated count – consumers served by county, age and ethnicity. Note: County data is unduplicated but is not additive to state total since some consumers move to a different county periodically. Obtained: August 2021. MS Excel file.

³ SAMHSA Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019, Table 33, Hawaii. Obtained: August 2021. <https://www.samhsa.gov/data/report/2018-2019-nsduh-state-specific-tables>

⁴ County population estimates from: United States Census Bureau. American Community Survey 1-Year Estimates Data Profiles. Downloaded 8/2021 from: https://data.census.gov/cedsci/table?tid=ACSDP1Y2019.DP05&g=0400000US15_0500000US15001

reside on Kauai. The prevalence rate shows that Hawaii County has the highest percent of estimated residents with SMI served by AMHD at 30.4%, followed Kauai County (27.6%), Oahu (15.2%) and with Maui County having the lowest percent of consumers served (7.4%). It should be noted these services include all AMHD services, including crisis response.

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.

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.

Treated Prevalence by Geographic Location and Race/Ethnicity

The number of individuals who received AMHD services in FY 2020 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**

County	Adult Population 2020		Estimated Adults SMI Statewide Prevalence (3.9%)	Estimated Number SMI Served in FY 2020	Percent SMI Served by County
	Number	Percent			
Oahu	775,958	69.3	30,262	4,363	14.4
Hawaii	158,129	14.1	6,167	1,779	28.8
Maui	129,561	11.6	5,053	956	18.9

Kauai	56,041	5.0	2,185	573	26.2
County Not Specified	--	--	--	91	--
Statewide Total	1,119,689	100.0	43,668	7,762	17.8

Table 3
Adults Served by County/State and Race, United States Census Population Estimates, July 1, 2019

Race/Ethnicity	State	Oahu	Hawaii	Maui	Kauai
	% of Population	% of Population	% of Population	% of Population	% of Population
American Indian / Native Alaskan	0.4	0.3	0.6	0.6	0.5
Asian	37.6	42.9	21.2	29.0	31.0
Black / African American	2.2	2.8	0.8	0.8	0.7
Native Hawaiian / Other Pacific Islander	10.1	9.6	12.8	10.6	9.1
White	25.5	21.6	34.0	34.9	33.0
More than One Race	24.2	22.8	30.5	24.2	25.7

Table 3 shows the estimate of the state and each county's population by race. The percent of the population for each race was then multiplied by the adult population to estimate the number of that race for adults from United States Census, QuickFacts for July 1, 2019 population estimates (<https://www.census.gov/quickfacts/fact/table/hi,mauicountyhawaii,hawaiicountyhawaii,honolulucountyhawaii,kauaicountyhawaii/PST045219>). The most common single race was Asian for Oahu (42.9%) and White for Hawaii County (34.0%), Maui (34.9%) and Kauai (33.3%). Native Hawaii/Other Pacific Islander single race ranged from 9.6% on Oahu to 12.8% in Hawaii County.

Table 4
Number and Percent of Total Served by AMHD by Race and County, 2020

Race/Ethnicity	Oahu		Hawaii		Maui		Kauai	
	#	%	#	%	#	%	#	%
American Indian / Native Alaskan	26	0.5	36	2.0	14	1.5	1	0.2
Asian	1017	23.3	161	9.1	122	12.8	112	19.5
Black / African American	170	3.9	39	2.2	18	1.9	5	0.9
Native Hawaiian / Other Pacific Islander	720	16.5	383	21.5	147	15.4	88	13.5
White	912	20.9	653	36.7	354	37.0	179	31.2
Race Not Available	1,518	34.8	507	28.5	301	31.5	188	32.8
Total	4,363	100	1779	100	956	100	573	100

Table 4 shows the numbers served in AMHD by Race and County. It should be noted that unknown race ranged from 28.5% in Hawaii County to 34.8% in Oahu. Compared to the percent of the total county populations' by race, Asian race is under-represented while Black and Native Hawaiian/Other Pacific Islanders are over-represented. This suggests the need for more services targeted at these vulnerable populations.

Criterion 5: MANAGEMENT SYSTEMS

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

In FY 2022, the total AMHD State and Federal planned are expenditures for community-based, inpatient, and administrative services are \$178,403,821 (Table 1). The AMHD State are expenditures for administrative, community-based and inpatient services are \$148,450,699 for General Funds and Special Funds for a total of \$166,241,132. The FY 2022 AMHD amount of Federal Funds are \$11,318,098 for community-based services and \$2,760,558 for administrative services for a total of \$14,078,656.

**Table 1
FY 2022 AMHD Expenditures**

	TOTAL	GENERAL FUNDS	SPECIAL FUNDS	FEDERAL FUNDS
Oahu CMHC Branch	9,416,602	8,941,537	475,065	0
Hawaii County CMHC Branch	3,454,946	3,332,446	122,500	0
Kauai CMHC Branch	2,187,658	2,600,958	126,700	0
Maui CMHC Branch	1,730,788	1,629,988	100,800	0
Subtotal - CMHC	16,789,994	15,964,929	825,065	0
POS & Other Community Services	62,042,140	3,939,107	10,784,935	11,318,098
Subtotal – Community Services	78,832,134	55,904,036	11,610,000	11,318,098
Court Evaluation Branch	922,314	922,314	0	0
Subtotal Community Services	79,754,448	56,826,350	11,610,000	11,318,098
Hawaii State Hospital	92,134,019	85,953,586	6,180,433	0
Subtotal – Direct Services	171,888,467	142,779,936	17,790,433	11,318,098
Administration	8,431,321	5,670,763	0	2,760,558
TOTAL	180,319,788	148,450,699	17,790,433	14,078,656

In FY 2023, the total AMHD State and Federal planned are expenditures for community-based, inpatient, and administrative services was \$181,372,835 (Table 2). The AMHD State expenditures for administrative, community-based, and inpatient services are \$151,419,713 for General Funds and \$17,790,433 for Special Funds.

General funds are expected to remain stable for FY 2022 to FY 2023; however, special funds are expected to increase. 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 2023 AMHD Expenditures

	TOTAL	GENERAL FUNDS	SPECIAL FUNDS	FEDERAL FUNDS
Oahu CMHC Branch	9,595,433	9,120,368	475,065	0
Hawaii County CMHC Branch	3,521,595	3,399,095	122,500	0
Kauai CMHC Branch	2,228,876	2,102,177	126,700	0
Maui CMHC Branch	1,763,388	1,662,588	100,800	0
Subtotal - CMHC	17,109,293	16,284,228	825,065	0
POS & Other Community Services	60,924,955	40,737,889	10,784,935	9,402,131
Subtotal – Community Support	78,034,248	57,022,117	11,610,000	9,402,131
Court Evaluation Branch	940,760	940,760	0	0
Subtotal Community Services	78,975,008	57,962,877	11,610,000	9,402,131
Hawaii State Hospital	93,853,091	87,672,658	6,180,433	0
Subtotal – Direct Services	172,828,099	145,635,535	17,790,433	9,402,131
Administration	8,544,736	5,784,178	0	2,760,558
TOTAL	181,372,835	151,419,713	17,790,433	12,162,689

Table 3 shows the plan for FY 2022-2023 AMHD Mental Health Block Grant Funds expenditures.

Table 3
FY 2022-2023 AMHD Planned Expenditures

Activity	Description	Mental Health Block Grant
Other 24 Hour Care	Mental Health Kokua	\$600,000.00
Ambulatory/Community Non-24-Hour Care	Day Treatment Program	\$269,379.00
Administration	Staff Development	\$50,000.00
TOTAL		\$919,379.00
Table 6b: Non-Direct Service Activities	State Council on Mental Health	\$40,000.00
	Management Information	\$100,000.00

	Systems	
	Infrastructure Supports	\$30,000.00
	Partnerships, Community Outreach, Needs Assessment	\$650,000.00
	Quality Assurance & Improvement	\$50,000.00
	Research & Evaluation	\$40,000.00
	Training & Education	\$40,000.00
		\$950,000.00

AMHD Allocation GRAND TOTAL

\$1,869,379.00

STAFFING

As of July 2021, 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. Nursing and psychiatric shortages continue, especially in rural areas.

TRAINING

Planned Trainings for Mental Health Service Providers for FY 2022-2023 are:

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

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening Yes No
- ii) Education Yes No
- iii) Brief Intervention Yes No
- iv) Assessment Yes No
- v) Detox (inpatient/social) Yes No
- vi) Outpatient Yes No
- vii) Intensive Outpatient Yes No
- viii) Inpatient/Residential Yes No
- ix) Aftercare; Recovery support Yes No

b) Services for special populations:

- Targeted services for veterans? Yes No
- Adolescents? Yes No
- Other Adults? Yes No
- Medication-Assisted Treatment (MAT)? Yes No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? Yes No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? Yes No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? Yes No
4. Does your state have an arrangement for ensuring the provision of required supportive services? Yes No
5. Has your state identified a need for any of the following:
 - a) Open assessment and intake scheduling Yes No
 - b) Establishment of an electronic system to identify available treatment slots Yes No
 - c) Expanded community network for supportive services and healthcare Yes No
 - d) Inclusion of recovery support services Yes No
 - e) Health navigators to assist clients with community linkages Yes No
 - f) Expanded capability for family services, relationship restoration, and custody issues? Yes No
 - g) Providing employment assistance Yes No
 - h) Providing transportation to and from services Yes No
 - i) Educational assistance Yes No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

In general, ADAD identifies compliance issues and corrective actions through contract monitoring and also through corrective action plans. The wait-list is also generated weekly via web-based infrastructure (WITS) for Treatment Services.

Award identification

The sub-recipient (in this case the PWWDC Provider) is informed of their initial contract award by the Competitive Purchases of Services Statement of Findings and Decision which informs the sub-recipient of the amount awarded, identifies other applicants who were selected for this RFP, and the technical review committee comments, which includes general comments and conditions of acceptance for proposals that are recommended for funding. The reviews of proposals are conducted by the Treatment and Recovery Branch (TRB) for substance abuse treatment programs. Once the Statement of Findings and Decision are completed, the contracts for each award are completed by the TRB Program Specialists.

During-the-Award Monitoring

After the contract is awarded, the accountants and Administrative Officer (AO) III in ADAD will monitor the agencies reported use of funds for the contracts on an annual basis. When the contract is finalized and executed at the Administrative Services Office (ASO), a copy of the contract is forwarded to ADAD. ADAD will create and send a purchase order (PO) to ASO to encumber funds for the contract. The pink copy of the PO is sent back to ADAD once the fund is encumbered and it is kept in the fiscal contract folder with the accountant or AO III. If the contract is a multiple year contract, ADAD will create and send a PO to ASO to encumbered funds accordingly for the contracted amount at the beginning of each subsequent year.

On Site Monitoring/Desktop Review (Treatment)

In the first year of a new contract, ADAD conducts on-site contract orientations. During this visit, ADAD requests a tour of the facility in order to understand and visualize how services will be implemented. An orientation of the contract is conducted with key staff. This orientation reviews the scope and terms of the contract, policy and procedure monitoring process, funding, WITS (the management information system utilized by ADAD), clinical requirements and any questions that the provider may have.

A desk top review of the providers Policies and Procedure is also scheduled within the first year of the contract. During the desk top review, the Contract Manager will complete the Treatment and Recovery Branch (TRB) Contract Compliance Monitoring Protocol to evaluate compliance with policies and procedures in the following areas: general, personnel, other administrative personnel files, and other administrative wait list capacity management. After the protocol is completed, it is sent to the provider, along with a cover letter, signed TRB Chief, informing them of the results of the desk top review. If the report has findings, ADAD will indicate that a Plan of Correction (POC) will need to be submitted within 30 days. After the POC is submitted, the TRB monitor

will then evaluate the POC for effectiveness of the corrective action measures. Once the POC is deemed acceptable, a final letter of acceptance will be sent to the provider.

In the second year of the contract, desk top reviews are completed at ADAD by either Contract Managers and or Clinical Psychologist. The Program Specialist protocols evaluate administrative requirements and scope of work requirements. The Clinical Psychologist protocols evaluate clinical services, treatment curriculum review, and facility standards which include interviews of staff and consumers. Random test sampling is performed to ensure compliance with the scope of the contract and work requirements. The desk top review consists of reviewing programs and clinical notes and billing information that are submitted by the providers. Prior to viewing the client information, which is considered to be protected Health Information (PHI), the TRB staff must obtain approval to view the information, and request proper log-on authorization in order to review WITS data, for the safe of monitoring. A follow-up site visit may or may not be scheduled depending on the additional information that would need to be verified. The site visit for these monitoring years, would be to verify client sign-in sheets, interview with staff, and interviews with client to verify services satisfaction and appropriateness of treatment services, as well as to follow up on any previous POCs for quality control.

Treatment Contract Managers are assigned a number of contracts, which are tracked on the "Contract Caseload" schedule. They are responsible for conducting the reviews for their assigned contracts each quarter, of each year. The contracts are constantly being reviewed and monitored, in conjunction with Fiscal section, for optimal utilization review, in order to minimize lapsing funds. Increasing or decreasing contract amounts require a contract modification. The Clinical Psychologist, is responsible for monitoring all clinical aspects of all the contracts.

On-site monitoring for the fourth year is mainly for those contracts with previous findings which required a POC. The priority for selection of on-site monitoring for the fourth year depends on the severity of the findings or correction action plan in the previous year.

Criterion 4,5&6**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
 - a) 90 percent capacity reporting requirement Yes No
 - b) 14-120 day performance requirement with provision of interim services Yes No
 - c) Outreach activities Yes No
 - d) Syringe services programs, if applicable Yes No
 - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation Yes No
2. Has your state identified a need for any of the following:
 - a) Electronic system with alert when 90 percent capacity is reached Yes No
 - b) Automatic reminder system associated with 14-120 day performance requirement Yes No
 - c) Use of peer recovery supports to maintain contact and support Yes No
 - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? Yes No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
 ADAD identifies compliance issues and corrective actions through contract monitoring and the use of corrective action plans. ADAD utilizes the same procedures and strategies to monitor program compliance for PWID activities and services. Please see response to Criterion 3, item 6.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? Yes No
2. Has your state identified a need for any of the following:
 - a) Business agreement/MOU with primary healthcare providers Yes No
 - b) Cooperative agreement/MOU with public health entity for testing and treatment Yes No
 - c) Established co-located SUD professionals within FQHCs Yes No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
 Additional response to 1.
 The RFP requires all providers to adopt a policy which states that it provides for TB and Hepatitis C screening, referral, and education as appropriate.
 Monitoring program compliance
 ADAD does annual monitoring of SSA-contracted providers for TB screening and when appropriate, referral for TB services. ADAD utilizes the same procedures and strategies to monitor program compliance for SUD activities and services. Please see response to Criterion 3, item 6.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? Yes No
2. Has your state identified a need for any of the following:
 - a) Establishment of EIS-HIV service hubs in rural areas Yes No

- b) Establishment or expansion of tele-health and social media support services Yes No
- c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS Yes No

Syringe Service Programs

- 1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)? Yes No
- 2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? Yes No
- 3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? Yes No
If yes, please provide a brief description of the elements and the arrangement

Criterion 8,9&10**Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement Yes No
2. Has your state identified a need for any of the following:
 - a) Workforce development efforts to expand service access Yes No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services Yes No
 - c) Establish a peer recovery support network to assist in filling the gaps Yes No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) Yes No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations Yes No
 - f) Explore expansion of services for:
 - i) MAT Yes No
 - ii) Tele-Health Yes No
 - iii) Social Media Outreach Yes No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? Yes No
2. Has your state identified a need for any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services Yes No
 - b) Establish a program to provide trauma-informed care Yes No
 - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education Yes No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? Yes No
2. Does your state provide any of the following:
 - a) Notice to Program Beneficiaries Yes No
 - b) An organized referral system to identify alternative providers? Yes No
 - c) A system to maintain a list of referrals made by religious organizations? Yes No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? Yes No
2. Has your state identified a need for any of the following:
 - a) Review and update of screening and assessment instruments Yes No
 - b) Review of current levels of care to determine changes or additions Yes No
 - c) Identify workforce needs to expand service capabilities Yes No

- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background Yes No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? Yes No
2. Has your state identified a need for any of the following:
- a) Training staff and community partners on confidentiality requirements Yes No
 - b) Training on responding to requests asking for acknowledgement of the presence of clients Yes No
 - c) Updating written procedures which regulate and control access to records Yes No
 - d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: Yes No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? Yes No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Two sub-recipients were identified during the fiscal years involved.

3. Has your state identified a need for any of the following:
- a) Development of a quality improvement plan Yes No
 - b) Establishment of policies and procedures related to independent peer review Yes No
 - c) Development of long-term planning for service revision and expansion to meet the needs of specific populations Yes No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? Yes No

If Yes, please identify the accreditation organization(s)

- i) Commission on the Accreditation of Rehabilitation Facilities
- ii) The Joint Commission
- iii) Other (please specify)

Criterion 7&11**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? Yes No
2. Has your state identified a need for any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state Yes No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No
 - c) Performance-based accountability: Yes No
 - d) Data collection and reporting requirements Yes No
2. Has your state identified a need for any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs Yes No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services Yes No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services Yes No
 - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort Yes No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
 - a) Prevention TTC? Yes No
 - b) Mental Health TTC? Yes No
 - c) Addiction TTC? Yes No
 - d) State Targeted Response TTC? Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women Yes No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis Yes No
 - b) Early Intervention Services Regarding HIV Yes No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment Yes No
 - b) Professional Development Yes No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Hawaii State administrative regulations which govern Mental Health are not covered here because such regulations apply only to the MHBG application. SAMHSA's MHBG provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. Please refer to their 2020-2021 MHBG Application Plan for information on this section.

For the SABG Application Plan, current state administrative regulations administered by ADAD are contained in Hawaii Administrative Rules (HAR) Chapter 177.1, "Certification Standards for Substance Abuse Counselors, Program Administrators, Prevention Specialists, Clinical Supervisors, Criminal Justice Addictions Professionals, and Co-Occurring Disorders Professional Diplomat." <http://health.hawaii.gov/opppd/files/2015/06/11-177.1.pdf>.

Hawaii Revised Statutes, Sections 321-191 to 198:

- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0191.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0192.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0192_0005.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193_0005.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193_0007.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0194.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0195.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0196.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0197.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0198.htm

Hawaii Revised Statutes, Sections 329-1 to 4:

- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0001.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0002.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0003.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0004.htm

Footnotes:

1. Environmental Factor 10. "Substance Use Disorder Treatment" also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Environmental Factor 10. "Substance Use Disorder Treatment" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

2. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA updated this section.

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 2020-FFY 2021? Yes No

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:

1. Environmental Factor 11. "Quality Improvement Plan" also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

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The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Environmental Factor 11. "Quality Improvement Plan" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma⁵⁷ 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 Trauma⁵⁸ 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? Yes No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? Yes No
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? Yes No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? Yes No
5. 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:

1. Environmental Factor 12. "Trauma" also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

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The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Environmental Factor 12. "Trauma" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

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.

⁵⁹ Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

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

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?

Act 26 Program to Increase Timeliness and Access to Behavioral Health Services for those in Criminal Justice System

AMHD worked with the judiciary to enact a new law, known as Act 26, in 2020. This law allows those charged with a non-violent petty misdemeanor with fitness/competency issues to be able to get an expedited fitness evaluation in two days and then if fitness is found to be an outstanding issue, the person can be evaluated in the custody of the Director of Health (at Hawaii State Hospital for Oahu residents for instance) and at the end of the seven days, if the person is still unfit to proceed with court activities, the person can be linked to behavioral health services or civilly committed. This has ended the previous wait time of 55 days for a traditional fitness evaluation before the person can even be considered for behavioral health services. This is leading to increased service use among these individuals as well. AMHD is using a forensic peer to help with motivation for entry into continued community care and this has been very promising. Also, recidivism has been low for those going through this program.

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

Technical assistance is not needed at this time.

Footnotes:

1. Environmental Factor 13. "Criminal and Juvenile Justice" also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

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Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - <https://www.ncbi.nlm.nih.gov/books/NBK64245/> [ncbi.nlm.nih.gov]

TIP 43 - <https://www.ncbi.nlm.nih.gov/books/NBK64164/> [ncbi.nlm.nih.gov]

TIP 45 - <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf> [store.samhsa.gov]

TIP 49 - <https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf> [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? Yes No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? Yes No
3. Does the state purchase any of the following medication with block grant funds? Yes No
 - a) Methadone
 - b) Buprenorphine, Buprenorphine/naloxone
 - c) Disulfiram
 - d) Acamprosate
 - e) Naltrexone (oral, IM)
 - f) Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? Yes No
5. Does the state have any activities related to this section that you would like to highlight?

ADAD has co-sponsored conferences and educational workshops which provide sessions on medication-assisted treatment for substance use disorders. ADAD has collaborative partnerships with other Department of Health programs and other State agencies such as the departments of Human Services, Attorney General, Public Safety, First Responders, Pharmacy, Primary Care providers, and the University of Hawaii, as well as community-based organizations like the Hawaii Health & Harm Reduction Center to sponsor and promote training sessions in evidence-based practices, naloxone, and overdose prevention. substance use disorders. ADAD has collaborative partnerships with other Department of Health programs and other State

agencies such as the departments of Human Services, Attorney General, Public Safety, First Responders, Pharmacy, Primary Care providers, and the University of Hawaii, the Hawaii Opioid Initiative, as well as community-based organizations like the Hawaii Health & Harm Reduction Center to sponsor and promote training sessions in evidence-based practices, naloxone, and overdose prevention.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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

Footnotes:

1. Environmental Factor 14. "Medication Assisted Treatment" applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

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2. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA updated this section.

Environmental Factors and Plan

15. Crisis Services - Required for MHBG

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.⁶¹ 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](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)⁶²,

"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."

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.

⁶¹<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶²Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

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

f) Recovery community coaches/peer recovery coaches

g) Recovery community organization

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

Intensive Case Management Plus – High Utilizer (ICM Plus – High Utilizer)

This service includes intensive and highly integrated services provided to consumers who have experienced recurring crises, who are frequently hospitalized or incarcerated within a six (6) month period, and who require a higher level of service coordination to become or remain stable in their residential housing placement. ICM Plus – High Utilizer services allows the case manager to increase their support time and the option to add contingency management incentives.

Island served: Oahu

Intensive Case Management Plus – Homeless (Homeless ICM Plus)

This service includes rapid linkage with continuing support services and is provided to consumers who are houseless, frequently arrested, are the subject of frequent calls for an MH-1, and have frequent emergency department visits.

Island served: Oahu

Short term stabilization beds (also known as Stabilization Bed Units or SBU) provide a sub-acute level of care for individuals whose behavioral health issues do not meet medically necessary criteria for acute hospitalization but whose presentation and current mental status are not conducive or appropriate for community-based services such as low intensity residential or outpatient services. Stabilization beds are designed to (1) stabilize the individual's mental health and substance use conditions and (2) assess then triage the individual to a clinically appropriate level of care through Hawaii CARES. SBU components include care coordination, peer support, treatment, supervision and nursing services, including 23/59 observation. 23/59 observation may be an appropriate crisis services intervention when an individual is in crisis, does not meet criteria for hospital admission, is in a condition whereby there is concern that being left alone or unmonitored may result in further decompensation or increased risk of harm, and when the assessment can be resolved in less than twenty-four (24) hours. 23/59 observation is not a substitute for detox and should not be used solely for detox purposes.

Island served: Oahu

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

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 Co-occurring and Serious Mental Illness (SMI) throughout the system;

Provide services that facilitate recovery;

Encourage connection between 'ohana (family) and 'aina (land) through the fostering of healthy relationships, social networks, and cultural and spiritual institutions;

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 clinical excellence and evidence-based practices that are adapted to account for linguistic, ethnic, rural, and urban differences across the state of Hawaii;

The recovery planning process, conducted collaboratively with consumer input begins within seventy-two (72) hours of admission 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 in the consumer's own voice, 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, friends and concerned parties to participate in trainings on self-determination, self-advocacy, and peer provided services. Services that support consumers in their recovery include: Recovery (Treatment) planning; Case Management; Group Homes; Specialized Residential Treatment; Therapeutic Living Program; Intensive Outpatient Hospital; Extended Adult Residential Care Home; Representative Payee; 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 Co-Occurring disorder of serious mental illness and substance use disorder in its programs and services. This is carried out by contract specific requirements for AMHD funded providers that include: integrated care, staff training in co-occurring disorder, use of best practices modalities, and well as mental health and substance use assessments as part of intake. The AMHD also provides robust outreach services to individuals who may only have a substance use disorder who are chronically homeless or are who are experiencing an episode of emotional, behavioral or psychological crisis.

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

The AMHD has developed a new community based program that provides long term residential treatment for co-occurring disorders though a combination of Intensive Case Management, Housing, and Programming these programs are being called Palekana which in Hawaiian means to be safe and protected. AMHD has three Palekana facilities on Oahu and Hawaii Island with a total of 50 beds. Elements of the Palekana program include:

On-site structured Intensive Case Management and Nursing services.

Psychosocial rehabilitations programming, including evenings and weekends hours.

Housing in shared or individual units monitored by staff seven days a week 24 hours a day.

AMHD has also partnered with the Big Island Substance Abuse Council (BISAC) as well as CARE Hawaii to provide short term community-based outreach, and psychoeducational services in response to COVID-19.

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

Technical assistance is not needed at this time.

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Footnotes:

1. Environmental Factor 16. "Recovery" also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

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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

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

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.⁶³ 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 24.⁶⁴ 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.⁶⁵

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 21.⁶⁶ 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.⁶⁷

According to data from the 2015 Report to Congress⁶⁸ 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).

⁶³Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁴Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁵Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁶The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁶⁷Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

⁶⁸http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? Yes No
 - The recovery and resilience of children and youth with SUD? Yes No
- 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:
 - Child welfare? Yes No
 - Juvenile justice? Yes No
 - Education? Yes No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? Yes No
 - Costs? Yes No
 - Outcomes for children and youth services? Yes No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - Mental health treatment and recovery services for children/adolescents and their families? Yes No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult M/SUD system? Yes No
 - 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 Med-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 to support the development of infant and toddlers with special needs from birth to three years of age. 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).

Alcohol and Drug Abuse Division (ADAD).

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.

Developmental Disabilities Division (DDD)

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.

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 public education; 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 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 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

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 Child & Adolescent Service System Principles (CASSP)

CAMHD is committed to the following 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 Service
- 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.

6. 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 or 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 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

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

Public schools provide assessment and diagnostic services whenever concerns arise over that children or youth who have a disability that might affect their education. If indicated, the school provides classroom strategies and specific mental health services. If more students need intensive mental health services that exceeds than what is 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
- serve as a direct link to the Departments of Education and Health and other child serving agencies regarding consumer and community satisfaction

There are 17 CCCs in Hawaii (8 on Oahu, 4 on Maui, 4 on Hawaii Island, 1 on Kauai) who usually meet once a month. Parent support groups, workshops, and informational meetings on pertinent subjects are common local activities. Conferences and special events are offered throughout the year.

IDEA is a federal law that ensures that students who require specially designed instruction to meet their unique learning needs due to a qualifying disability (e.g., Specific Learning Disability, Emotional Disability, etc.) are given an Individualized Education Program (IEP) and related service, if needed, to benefit from special education as appropriate. SBBH counseling can be considered one of those related services. During 2014-15, a total of 4,962 students identified as IDEA received Counseling or other SBBH services within the DOE.

Section 504 of the Rehabilitation act of 1973 is a federal civil rights law that protects students with a disability from discrimination, as well as ensures the same equal opportunity and access to educational opportunities to qualified students as are provided to students without disabilities; identified needs must substantially limit a major life activity and impact a student's education. Section 504 requires that students with disabilities are provided appropriate educational services designed to meet the individual needs of such students to the same extent as the needs of students without disabilities are met; SBBH counseling could be considered a supplementary service and may be listed on their Modification Plan (MP). During 2014-15, a total of 1,223 students identified as IDEA received Counseling or other SBBH services within the DOE.

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 Hawaii'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 Hawaii 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 Hawaii 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.

HAWAII'S INTEGRATED SERVICE SYSTEM

The Hawaii Early Intervention Coordinating Council (HEICC) is an advisory body that advises the Director of Health on issues related to the planning, implementation, evaluation, and monitoring of the statewide system of early intervention services, and assists the DOH in achieving the full participation, coordination, and cooperation of all appropriate public agencies in the state. Members are appointed by the Governor and include parents of children with special needs, early intervention providers, state legislators, and representatives for personnel preparation, special education preschool services, Medicaid program, Office of the Governor, provision/payment of early intervention services, Head Start/Early Head Start, child care, foster care, regulation of health insurance, education of homeless children, children's mental health, family advocacy, military, and community preschools.

In 1987, the Hawaii State Legislature passed a law that requires the establishment of an Interdepartmental Cluster for services to children in the Department of Health. The Cluster was to be comprised of representatives of all the major child-serving agencies with statewide authority and responsibility. Named in the law were the department of education, department of health, department of human services, the judiciary, the office of the governor and the office of youth services. The Cluster was tasked with coordinating services at the local level for the multisystem children with severe emotional and developmental problems. The Cluster later became known as the State Interagency Quality Assurance Committee. In 2015, the Committee was renamed the Hawaii Interagency State Youth Network of Care (HI-SYNC) to reflect the focus on youth outcomes. A few of the outcomes of the collaborative include a formal Memorandum of Agreement describing how the agencies will work together, an Interagency Consent Form, a Multidisciplinary Evaluation Team, and braided funding for a facilitator position. Additionally, HI-SYNC produces an annual report on performance outcomes for youth by the Developmental Disabilities Division, Family Health Services Division-Early Intervention Section, and Child & Adolescent Mental Health Division of the Department of Health; Special Education and School-Based Behavioral Health of the Department of Education; Child Welfare Services of the Department of Human Services; and Family Court of the Hawaii State Judiciary. The Hawaii Youth Interagency Performance Report (HYIPR) highlights each agency's population characteristics, service utilization, cost of services and performance outcome measures.

In 2014, the Hawaii juvenile justice system went through a major reformation. With the impetus of a report by the Pew Charitable Trusts that identified that too many youth were being held in confinement, the costs of confinement was steep and the results were poor, a working group was convened to make recommendations to address the issues.

The working group discovered that many areas of the state lacked effective community-based alternatives, leaving judges with few options to hold youth accountable and provide them with necessary services. Stakeholders highlighted the need for better access to mental health and substance abuse treatment, especially early in a youth's interaction with the juvenile justice system, and indicated that eligibility criteria—the standards used by an agency to guide service approval or denial decisions—made it difficult for youth to get treatment even where programs were available.

After five months of analysis, the working group produced a set of research-based, fiscally sound policy proposals. It recommended limiting placement in Hawaii's secure facility to more serious offenders; reinvesting the resulting savings in effective community-based options, specifically mental health treatment services; strengthening local supervision; and enhancing accountability in the juvenile justice system.

House Bill 2490, which contained the Working Group's recommendations was passed unanimously by the Legislature and signed into law in 2014. The law is projected to reduce the population in HYCF by 60 percent, enable the closure of two facilities on the HYCF campus, and produce savings of \$11 million in the facility's budget by 2019. It redirects the savings into effective community-based alternatives, and it also provides an upfront investment of \$1.26 million for mental health and substance abuse treatment, delinquency interventions, and implementation of the reforms.

With the passage of the law, the children's mental health division has been collaborating with the Judiciary and the Office of Human Services to streamline the referral process to enhance access to mental health services. The funding allows the children's division to provide needed services to those youth who would not otherwise be able to qualify for services based on their adjudicated standing.

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 service 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 discussion at HISYNC, and to attend their local HILYNC (Hawaii Interagency Local Youth Network of Care) meetings.

Overall, as a state system, Hawaii is not incarcerating as many youth as before. 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 concordant with this change. Nevertheless, Hawaii is heading in the right direction.

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?

The 2021 Hawaii State Legislature passed HB1322, SLH 2021, " Relating to Trauma Informed Care" Link: https://www.capitol.hawaii.gov/measure_indiv.aspx?billtype=HB&billnumber=1322&year=2021. CAMHD was designated to lead multi-state and private sector agencies to "create, develop and adopt a statewide framework for trauma informed practice.

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

CAMHD requested SAMHSA assistance to advise CAMHD and the Trauma Informed Task Force.

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:

1. Environmental Factor 18. "Children and Adolescents M/SUD Services" also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Environmental Factor 18. "Children and Adolescents M/SUD Services" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

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.

According to the Hawaii State Department of Health (2019), suicide is the leading cause of injury related deaths in Hawaii with one person dying by suicide in Hawaii every two days (2017, Prevent Suicide Hawaii Task Force Report to the Hawaii State Legislature). Conversations that raise awareness about suicide and training that provides clear guidelines for intervention are important for everyone to be knowledgeable about.

The Hawaii State Department of Health, Emergency Medical Services and Injury Prevention System Branch, Injury Prevention and Control Section collaborates with agency partners to address suicide prevention. Information about suicide prevention is shared on their website: <https://health.hawaii.gov/injuryprevention/home/suicide-prevention/information/>

Initially formed in 2001 after the Surgeon General's 1999 report focusing on suicide prevention, the Prevent Suicide Hawaii Task Force (PSHTF) is the major statewide, community-driven suicide prevention and mental health collaborative in the state involving over 100 different public and private organizations and island-specific task forces. The PSHTF is attached to the Hawaii State Department of Health and has a dedicated full-time Suicide Prevention Coordinator who oversees state general funds of approximately \$100,000 annual to support suicide prevention trainings, activities, technical assistance and meeting support, conferences and other statewide and county based activities.

In 2016, the Hawaii State Legislature passed a House Concurrent Resolution (HCR66: https://www.capitol.hawaii.gov/Archives/measure_indiv_Archives.aspx?billtype=HCR&billnumber=66&year=2016) which required the existing PSHTF Force to form a temporary subcommittee to assist in the development of its recommendation to improve education, awareness, support services and outreach to best prevent suicides in Hawaii.

The resulting Report to the Legislature generated by the task force and its subcommittee recommended five strategies including: (1) "Hope" (primary prevention, awareness, knowledge); (2) "Help" (services and prevention); (3) "Heal" (healing, support, and postvention); (4) Research and evaluation; and (5) Policy and advocacy.

<https://health.hawaii.gov/injuryprevention/files/2019/02/Prevent-Suicide-Hawaii-Taskforce-Strategic-Plan-by-2025.pdf>. In addition to outline seven goals related to the five strategies, the report summarized trends and data related to suicide deaths and suicide attempts and highlighted feedback from members of the Youth Leadership Council for Suicide Prevention (2017 Youth Summit).

The American Foundation for Suicide Prevention (AFSP) Hawaii Chapter is active in promoting prevention programs and actively engaging with the members of the community to education about risk factor and warning signs. <https://afsp.org/chapter/hawaii>

The Adult Mental Health Division and the Child and Adolescent Mental Health Division are agency partners who are actively working to address suicide prevention within the mental health population through participation in existing state suicide prevention taskforce, workgroup and intra-agency meetings, staff development and provider training opportunities. Hawaii CARES remains Hawaii's local crisis call center responding to suicide calls routed through the National Suicide Prevention Lifeline phone number 1-800-273-TALK (8255). <https://hicares.hawaii.gov/>

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 2020-FFY 2021 plan was submitted? Yes No

If so, please describe the population targeted.

The Hawaii Injury Prevention Plan (HIPP) for 2018-2023 identifies suicide prevention as one of its plan goals to create a healthy, safe and empowered community by reducing suicide attempts and deaths.

<https://health.hawaii.gov/hipp/files/2020/01/Hawaii-Injury-Prevention-Plan-HIPP-2018-2023.pdf>

Suicides were the leading cause of fatal injuries among Hawaii residents, accounting for 25% of the total. (Drug poisonings would be the leading mechanism, if intent was not taken into account.) The number of fatalities varied inconsistently over the 5-year period, although the 219 deaths in 2019 was the highest total to date. A commensurate decrease in the number of deaths coded as "undetermined intent" (i.e. generally possible suicides) has also complicated the assessment of trends. Residents of Oahu had significantly lower mortality or morbidity rates than residents of any other county. Fatality rates among all Neighbor Islands were not significantly different. These findings are consistent with national reports of higher rates, or risk, of suicide among more rural populations. Fatality rates peaked among 20 to 29 year-old Hawaii residents, and progressively decreased over the age span. Males comprised 80% of the victims, and had significantly higher rates than female residents of nearly every age group. Related autopsy records documented a history of mental illness for at least two-thirds (68%) of suicide victims, most commonly a "depressed mood" (54%); 24% had a diagnosis of depression. However, only 31% of decedents with a mental health problem were receiving treatment, and this proportion was much lower for residents of Neighbor Islands (8%), compared to those living on Oahu (40%). The most common "life stressors" were "problems" or "crisis" with their intimate partner (17%) or health (17%), with the former more prevalent among younger victims (29%) and the latter more prevalent (43%) among victims 65 years of age and older.

Suicide attempts, as inferred by self-inflicted injuries treated at hospitals, present a different epidemiology than deaths by suicide. The patients are majority (58%) female, 20% are under 18 years of age and 15 to 19 year-olds have the highest rates, and nearly two-thirds (63%) of the attempts are drug overdoses. By the most conservative method, there are an estimated 912 nonfatal attempts that require treatment in Hawaii hospitals each year; inclusion of injuries of undetermined intent or self-inflicted injuries with other principal diagnoses (e.g. mental illness) would more than double that estimate. The Hawaii Poison Center annually receives 865 calls that are related to intentional drug exposures.

Long-term indicators include morbidity and mortality rates for Hawaii residents and the rates by County per 100,000.

Mortality SMART Objective: Decrease the 5-year Suicide related mortality rate among Hawaii Residents from 63.51/100,000 in 2013-2017 to 57.159/100,000 by 2018-2022

County Count	Rate
Hawaii 187	97.19
Honolulu 541	52.04
Kauai 74	97.14
Maui 143	83.23
Total 945	63.51

Morbidity SMART Objective: Decrease the 5-year Suicide attempt morbidity rate among Hawaii Residents from 344.05/100,000 in 2013-2017 to 309.64/100,000 by 2018-2022

County Count	Rate
Hawaii 965	566.35
Honolulu 2,758	293.88
Kauai 329	518.07
Maui 488	330.30
Total 4,541	344.05

HIPP recommended the following strategies: The Hawaii State Department of Health, Emergency Medical Service and Injury Prevention System Branch (EMSIPSB) places a priority on having injury prevention strategies recommended by a community-driven action plan or informed by key implementing partners. Because a multitude of factors influence individual behavior, the strategies target risk and protective factors, framed across the individual, relationship, community, and policy levels.
<https://health.hawaii.gov/hipp/how-hipp-can-be-used/>

Level of SEM / Strategy / Risk Factors Reduced / Protective Factors Increased
Societal

Strategy: Promoted suicide prevention as a core component of Hawaii's overall system of care Ensure policies and protocols set the proper foundation for suicide prevention initiatives.

Risk Factor Reduced: Unsafe media portrayals of suicide Stigma associated with mental health and help-seeking behaviors.

Protective Factors Increased: Safe reporting and messaging about suicide. Supportive community environments for marginalized people.

Relationship

Strategy: Increase statewide capacity for training across multiple levels and disciplines, including a focus on cultural humility with diverse populations

Risk Factors Reduced: Violent relationships and financial/work stress.

Protective Factors Increased: Connectedness with caregivers and social institutions

Individual

Strategy: Increase State and community capacity to effectively and efficiently respond to those touched by suicide and those with mental health challenges

Risk Factors Reduced: History of mental health issues, substance abuse and prior suicide attempts.

Protective Factors Increased: Effective and available mental health care, substance abuse treatment services.

Community

Strategy: Increase community awareness and communication around suicide prevention as a public health problem.

Risk factors Reduced: Lack of access to providers, medication.

Protective Factors Increased: Availability of medical and behavioral health services and other healthcare providers.

Additional References:

Hawaii Health Data Warehouse (2021). Health reports and data: Mental health and mental disorders. <http://hhdw.org/health-reports-data/hp2020/mental-health-and-mental-disorders/>

HealthyPeople.gov Mental health and mental disorders (2021). <https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders?topicid=28>

Hawaii Health Matters (2021). Hawaii Suicide Death Rate 2015 (most current). <http://www.hawaiihealthmatters.org/index.php?module=indicators&controller=index&action=view&indicatorId=1308&localeId=14>

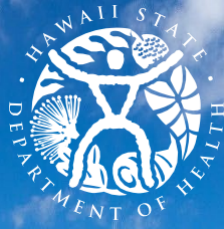
SAMHSA (2020). Behavioral Health Barometer, Hawaii Volume 6 – Adult mental health and service use, serious thoughts of suicide 2008-2010 and 2017-2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt32828/Hawaii-BH-Barometer_Volume6.pdf

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:



Hawaii Injury Prevention Plan 2018-2023

Injury Prevention Advisory Committee
Injury Prevention Control Section



Hawaii State Department of Health
Emergency Medical Services and Injury Prevention System Branch

Dear Community Colleagues,

We are pleased to present you with the *web-based* Hawaii Injury Prevention Plan (HIPP) 2018-2023, that serves as a guide for reducing the eight leading causes of injury in Hawaii. This HIPP builds on the previous Hawaii Injury Prevention Plan 2012-2017 and is the result of a collaborative effort between the Hawaii State Department of Health (DOH), Emergency Medical Services and Injury Prevention System Branch (EMSIPSB); the Injury Prevention Advisory Committee (IPAC); and other community partners. In the gap period between the end of the previous plan and inception of the new plan, the initial plan continued to guide the work of the DOH Injury Prevention and Control Section (IPCS) and community partners.

Here in Hawaii, we have made great strides in preventing injuries through the cooperative efforts of government agencies, voluntary and professional organizations, and numerous other community partners. There is much more we must do, however, to further reduce the burden of injury. Injury prevention remains an under-recognized and under-funded area of public health. Now more than ever, we must leverage our resources to join the best knowledge and practices with strong partnerships to effectively prevent injuries, thereby reducing pain and suffering, and saving Hawaii millions of dollars each year. We must work together to raise public awareness, build community capacity for injury prevention efforts, make changes to the physical environment, and implement policy and organizational practices that prevent injuries.

On behalf of the Injury Prevention Advisory Committee and the Hawaii State Department of Health, we invite you to join us in achieving the recommendations set forth in this plan. Please contact us through: <https://health.hawaii.gov/hipp/>

Working together, we can accomplish what none of us can do alone.

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Injury Prevention is a Public Health Priority in Hawaii

Injuries in Hawaii are responsible for more deaths from the first year of life through age 40 than all other causes combined, including heart disease, stroke, and cancer. Among residents of all ages, injury is the fourth leading cause of death and disability. The vast majority of injuries, however, are non-fatal and can lead to a range of outcomes, including temporary pain and inconvenience, disability, chronic pain, or a complete change in lifestyle.

During an average week in Hawaii:

- 15 residents die from an injury
- 103 are hospitalized
- Nearly 1,640 are treated in emergency departments

While the greatest impact of injury is in human suffering, the financial cost is staggering. In Hawaii, medical treatment for injuries generated nearly \$455 million in hospital charges.

Ten leading causes of death among Hawaii residents, by age group, 2014-2018

	<1	1-14y	15-24y	25-34y	35-44y	45-54y	55-64y	65+y
1	Perinatal conditions 268	Unintentional injuries 43	Unintentional injuries 162	Unintentional injuries 273	Unintentional injuries 266	Malignant neoplasm 723	Malignant neoplasm 2,178	Heart disease 9,961
2	Congenital anomalies 70	Malignant neoplasm 28	Suicide 143	Suicide 188	Malignant neoplasm 220	Heart disease 698	Heart disease 1,520	Malignant neoplasm 8,716
3	Sudden infant death synd. 23	Congenital anomalies 12	Malignant neoplasm 32	Heart disease 83	Heart disease 218	Unintentional injuries 430	Unintentional injuries 460	CVD 3,012
4	Unintentional injuries 17	Homicide 8	Heart disease 22	Malignant neoplasm 71	Suicide 147	CVD 155	CVD 316	Influenza and pneumonia 2,390
5	Heart disease 12	Heart disease 7	Homicide 17	Homicide 24	CVD 53	Suicide 147	Diabetes mellitus 224	Alzheimer's disease 2,109
6	Other resp. diseases 10	Oth. infectious diseases 7	Influenza and pneumonia 7	Injuries of unk. intent 19	Homicide 44	Liver disease and cirrhosis 113	Liver disease and cirrhosis 196	Chronic lower resp. diseases 1,494
7	Septicemia 8	Suicide 5	Congenital anomalies 7	CVD 18	Liver disease and cirrhosis 33	Diabetes mellitus 87	Chronic lower resp. diseases 188	Unintentional injuries 1,077
8	Infectious diseases 5	Oth. Intestine. Infections <5	CVD 6	Liver disease and cirrhosis 15	Diabetes mellitus 30	Influenza and pneumonia 59	Influenza and pneumonia 171	Diabetes mellitus 1,061
9	Homicide <5	Perinatal conditions <5	Diabetes mellitus 5	Diabetes mellitus 13	Injuries of unk. intent 19	Septicemia 47	Suicide 161	Nephritis, nephrotic synd 852
10	CVD <5	CVD <5	Injuries of unk. intent <5	Influenza and pneumonia 11	Influenza and pneumonia 17	Nephritis, nephrotic synd 40	Nephritis, nephrotic synd 104	Parkinson's disease 691

Deaths grouped as recommended by National Center for Health Statistics (http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_15.pdf).

Injury Prevention is a Public Health Priority in Hawaii

Leading Causes of Injury Mortality and Morbidity among Hawaii Residents¹

	Death Certificates (fatal)			Hospital Admission Records (non-fatal)			Emergency Department Records (non-fatal)		
	Cause ²	# ³	%	Cause	# ⁴	%	Cause	# ⁵	%
1	Suicide	185	25%	Falls	2,592	53%	Falls	24,789	31%
2	Falls	142	19%	Suicide	343	7%	Striking ⁶	13,414	17%
3	Poisoning	136	18%	Car occupant	314	6%	Cut/pierce	7,548	9%
4	Car occupant	49	7%	Assault	258	5%	Overexertion ⁷	5,485	7%
5	Drowning	39	5%	Motorcyclist	249	5%	Natural/ environmental ⁸	4,248	5%
6	Pedestrian	31	4%	Poisoning	221	5%	Assault	3,951	5%
7	Homicide	30	4%	Striking ⁶	161	3%	Car occupant	3,778	5%
8	Suffocation	27	4%	Pedestrian	115	2%	Fire/burn	1,096	1%
9	Motorcyclist	24	3%	Fire/burn	66	2%	Motorcyclist	1,037	1%
10	Injuries of undet. Intent	23	3%	Bicyclist	61	1%	Poisoning	1,005	1%
	<i>all other</i>	56	8%	<i>all other</i>	127	3%	<i>all other</i>	9,983	12%
	Annual total	741		Annual total	4,961		Annual total	82,392	

1 Non-residents comprised 10% of the victims killed by injuries in the state, 9% of those hospitalized, and 9% of those treated in emergency departments.

2 All injury causes are unintentional or “accidental” in intent, except for those labelled suicide, assault, and undetermined intent.

3 Average annual number of deaths, from 2013-2017 death certificates. For underlying cause of death in the ICD-10 code series: V01-Y36, Y85-Y87, Y89, and U01-U03.

4 Average annual number of injury-related hospitalizations, from 2013-9/2017 records. For principle diagnosis in ICD-9CM code series of 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, 995.80-995.85, and ICD-10CM series S through T78 (with some exceptions). Annual total includes 7% of records that did not have external cause of injury codes.

5 Average annual number of injury-related emergency department visits, from 2013-9/2017 records. For principle diagnosis in ICD-9CM code series of 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, 995.80-995.85, and ICD-10CM series S through T78 (with some exceptions). Annual total includes 8% of records that did not have external cause of injury codes.

6 Most of these patients were “struck accidentally by objects or persons”, or less commonly “struck accidentally by falling object”.

7 Most of these injuries were related to “Overexertion...from sudden strenuous movements”.

8 Nearly all of these visits were related to the bites or venom of animals, most specifically (in order): dog bites, centipedes, bee and wasp stings, and venomous marine animals.

Injury Prevention and Control Section



The Injury Prevention and Control Section (IPCS) is part of the Emergency Medical Services and Injury Prevention System Branch (ESMIPSB) at the Hawaii State Department of Health. IPCS is the focal point in the Department of Health for injury prevention throughout the state for all age groups.

IPCS is responsible for coordinating, planning, conducting, and evaluating injury prevention programs; developing policy and coordinating advocacy; collecting, analyzing and disseminating injury data; and providing technical support and training. Much of the work is achieved through community coalitions and partnerships in order to increase and focus community resources, minimize duplication of effort, and support the injury prevention activities of local agencies and community organizations. IPCS also provides staff support to IPAC.

Mission

- To provide statewide leadership in preventing death and disability associated with injuries in Hawaii by educating, supporting and mobilizing individuals and organizations to incorporate comprehensive injury prevention strategies in their daily activities.

Vision

- A safe Hawaii from the mountains to the sea.

Injury Prevention Advisory Committee



Mission: A safe Hawaii from the mountains to the sea.

The Injury Prevention Advisory Committee is a volunteer network of professionals and community members committed to working together to prevent injuries in Hawaii.

IPAC Members:

- Advise the Injury Prevention and Control Section
- Educate the public about injury prevention
- Advocate for injury prevention policies and legislation
- Serve as a liaison between IPAC and individual organizations
- Help identify and secure resources to support injury prevention

Focus Areas

Analyzing the burden of injury and violence in Hawaii is the first step used to determine focus areas for Hawaii. Having high, moderate or low capacity and infrastructure within the EMSIPSB for engagement are also factored into prioritizing injury prevention focus areas.

Core focus areas are identified with having high capacity and infrastructure for engagement by EMSIPSB. Core areas include five web-based components 1) the goal 2) problem statement, 3) long-term indicators, 4) SMART objectives, and 5) recommended strategies. **Special and emerging focus areas** are identified with having moderate to low capacity and infrastructure for engagement by EMSIPSB. While the EMSIPB is the lead for core areas, the Maternal and Child Health Branch (MCHB), Alcohol and Drug Abuse Division (ADAD), and Hawaii Concussion Awareness Management Program (HCAMP) are the lead agencies and community partners for special and emerging areas. For this reason, special and emerging focus area will only show a brief magnitude of the problem, and recommended strategies.

The Social Ecological Model is used as a guiding approach for EMSIPSB's work to prevent injuries in Hawaii. To frame our impact, strategies are aligned with risk and protective factors within each focus area, and across the individual, relationship, community, and societal levels of influence. This strategic plan establishes the foundation for Hawaii to later acknowledge and adopt the implementation of strategies utilizing a shared risk and protective factor framework.

<https://health.hawaii.gov/hipp/>

Core Focus Areas

- Drowning prevention
- Fall prevention
- Suicide prevention
- Traffic safety

Special and Emerging Focus Areas

- Poisoning prevention (substance abuse prevention)
- Violence and Abuse (Intimate partner/ sexual violence prevention)
- Child injury prevention
- Sports traumatic brain injury prevention

How the Hawaii Injury Prevention Plan Can Be Used

This Hawaii Injury Prevention Plan (HIPP) 2018-2023 reflects the current thinking of public health professionals and community partners. Developed in collaboration with injury prevention partners and EMSIPSB staff, the HIPP will be maintained as a “web-based strategic plan” that evolves with state of Hawaii. This web-based strategic plan, aligned with [Governor David Ige’s priorities](#) to convert to paperless systems, is beyond a static report, interactive, dynamic and will be regularly updated.

The HIPP can be used in a variety of ways by local agencies, businesses, community organizations, advocacy groups, planners, decision-makers, researchers, and others interested in preventing injuries. Examples include:

- **Collaboration:** Groups and individuals interested in addressing a particular injury area can use HIPP to assess the current thinking, get an understanding of the key players involved, and build consensus for implementing priority activities.
- **Policy making:** Advocacy groups working in injury prevention can use HIPP to support and act on prioritized areas of concern and identify key partners to collaborate with.
- **Program planning:** Organizations and individuals interested in addressing an injury area can use HIPP for priority setting and action planning.
- **Research:** Researchers, including graduate and medical students, can use HIPP to develop studies to adapt and evaluate evidence-based practices for Hawaii.

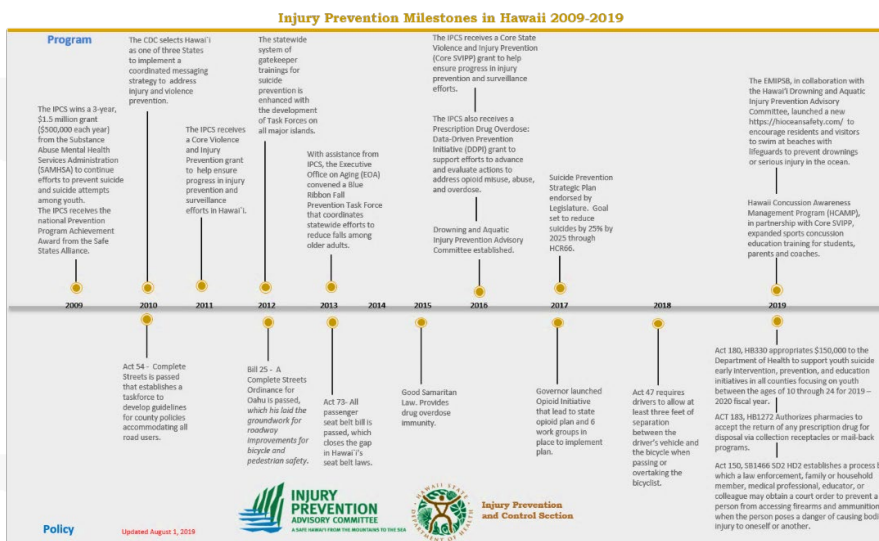
Core Capacity to Sustain Injury Prevention

Background

Since the release of the 2005-2010 and 2012-2017 Hawaii Injury Prevention Plans (HIPP), the Hawaii State Department of Health, Emergency Medical Services & Injury Prevention System Branch (EMSIPSB) has continued to work closely with partners in the community to build and strengthen the infrastructure to support injury prevention policy, research, surveillance and programs in Hawaii.

While EMSIPSB and IPAC have made tremendous strides, the priorities for injury prevention in Hawaii evolved. Based on the views and values captured from the Spring 2018 IPAC membership survey, accomplishments in injury prevention, and core capacity recommendations are refreshed in this section. The EMSIPSB and IPAC welcome all partners ready to engage in these critical public health recommendations to improve the lives of individuals and the overall health and well-being of our community. With the exception of Recommendation 3 which has been revised for improved clarity, the HIPP Core Capacity Recommendations remain constant and new priorities have been established for each of the six Core Capacities, extending the Plan through 2023.

Accomplishments



Program and policy accomplishments from every area of injury prevention is highlighted in the [timeline below](#). Notable successes include 1) the all passenger seat belt bill was passed by Act 73 in 2013, 2) the 2015 Good Samaritan Law

was passed to provide drug overdose immunity and set the stage for future drug overdose prevention efforts, 3) the 2017 Legislative endorsed the Suicide Prevention Strategic Plan to reduce suicides by 25% by 2025 through HCR66, and 4) first statewide Drowning and Aquatic Injury Prevention Advisory Committee established in 2017.

Core Capacity to Sustain Injury Prevention

Recommendation 1: Build and sustain infrastructure to provide leadership, data, technical assistance, and to support policy and evaluation for advancing injury prevention.

In the years since 2012 when the current HIPP was established, the role of injury prevention as a leading force for collaboration in support of public health initiatives has grown, particularly in response to emerging health issues such as trauma, technology impact on drowning prevention and impaired driving, opioid and substance abuse prevention, fall prevention as part of healthy aging, and the cross-cutting areas related to traumatic brain injury prevention.

This recommendation is central to the success of all the other Core Capacity Recommendations because its focus is on assuring sufficient infrastructure and resources exist to fulfill the mission of injury prevention. The expanding leadership role of injury prevention requires continued focus on sustaining and growing the infrastructure underpinning IPSC's ability to respond efficiently and effectively statewide to an increasingly engaged community.

Areas requiring particular attention include: maintaining and growing the data capacity to respond to the growing demand for data to support evidence-based decision making and well-informed policy initiatives; securing and coordinating the training and technical assistance in injury prevention among the IPAC membership and broader community; and continued leadership development and support to sustain and expand collaborative engagement among all concerned constituents.

Recommended Next Steps

Building on work completed for the *Hawaii Injury Prevention Plan 2005-2010*, IPSC and the IPAC steering committee developed the following recommendations. They are based on the core components of a state injury prevention program as identified by the Safe States Alliance (2003):

- Reorganize the Injury Prevention System Branch to better fulfill its mission in alignment with injury needs, including the addition of key positions where the needs are not adequately met.
- Engage in leadership development for IPAC and other injury prevention coalitions through collaboration and mentoring.
- Regularly update the cost/benefit analysis of the burden of injury.
- Secure sufficient staffing to meet the epidemiological and statistical needs of EMSPSB.

Core Capacity to Sustain Injury Prevention

Recommendation 2: Serve as a clearinghouse for data and incorporate other injury data sources to strengthen analyses and further injury prevention efforts.

Timely, high quality data is vital in targeting limited resources – monetary, policy, collaboration, staff, community engagement – for the greatest value and impact. EMSIPSB has developed a reputation for providing robust data and the demand is beginning to outstrip the capacity to respond. In addition, IPAC sees opportunities to expand the reach of this quality information through enhanced distribution through consumer-friendly communications.

Recommended Next Steps

- Maintain and expand EMSIPSB access to data.
- Promote the value and use of performance indicators to measure outcomes.
- Establish and maintain consumer-friendly communications on injury prevention.
- Establish and maintain online HIPP and a system for regularly updating data and other reports.

Recommendation 3: Provide training and technical assistance to increase injury prevention knowledge and skills among health care professionals and interprofessional education partners.

A robust training and technical assistance program that reflects the diverse areas of injury prevention must rely on the collaborative efforts of EMSIPSB, IPAC and other community organizations to identify, share and deliver quality services. EMSIPSB and IPAC will lead the identification, coordination, and promotion of injury prevention-related core competency-based training opportunities in collaboration with the Hawaii Public Health Institute and continue delivering technical assistance on an as needed basis.

Recommended Next Steps

- Assess the training and technical assistance needs in injury prevention among partners, practitioners and organizations working in related fields, and interested community members.
- Based on the results of the needs assessment, allocate resources towards relevant injury prevention and public health core competency-based training for existing and new workforce members.
- Offer Injury Prevention 101 training and refreshers at least annually that include the latest advancements in the field for health care practitioners.
- Develop injury prevention training through the University of Hawaii system that meets the Interprofessional Education (IPE) requirement of the University of Hawaii at Manoa Schools of Nursing, Medicine, Social Work, and Pharmacy, and the Office of Public Health Studies.

Core Capacity to Sustain Injury Prevention

Recommendation 4: Cultivate awareness among decision makers and the public to elevate injury and violence as a major public health problem in Hawaii.

While injury prevention has seen significant strides in policy and program initiatives in recent years, there is still a lack of public knowledge about injury and violence and the impact of preventing injuries on overall health and well-being. It remains imperative to effectively communicate the personal and financial costs of injury, as well as the potential solutions, in order to change behavior and ultimately prevent needless death and disability. EMSIPSB and IPAC are focused on developing accessible messages about injury prevention and evaluating the impact of increased awareness on safety practices.

Recommended Next Steps

- Develop, test and disseminate Hawaii-specific, consumer-friendly, targeted injury prevention messages covering all major injury areas.
- Inform partners about effective communication of injury prevention messages.
- Develop and disseminate data-informed policy papers for decision makers focused on legislative opportunities to advance injury prevention initiatives.

Recommendation 5: Inform injury prevention policy at all levels.

Establishing sound policy requires both good information and engaged champions who are prepared to show up and articulate the case effectively and passionately. EMSIPSB and IPAC are focused on ensuring the case for injury prevention is brought to the forefront by partners who are well-informed, supported in coordinating their efforts, and successful in building strong policies.

Recommended Next Steps

- Pursue a proactive legislative agenda in support of IPAC's annual priorities for action.
- Identify and support champions at the county, state and federal levels to advance injury prevention policy initiatives.
- Generate regular status updates on injury-related bills, e.g. through IPAC meetings and communications, and on the HIPP website.

Core Capacity to Sustain Injury Prevention

Recommendation 6: Increase opportunities for collaborative injury prevention efforts in all injury prevention areas.

Injury prevention is at its core a collaborative endeavor across diverse areas of public health, government, nonprofit sector, and interested community members. An ongoing priority for EMSIPSB and IPAC is reaching out to individuals and organizations to identify and cultivate new and emerging leaders, educating them on the leading areas of injury prevention, and inviting them to engage in collaborative efforts to affect change in the burden of injury and enhance the health and wellness of the people of Hawaii.

Recommended Next Steps

- Build a broader base of support for advancing and sustaining injury prevention efforts by identifying and engaging injury prevention partners who are currently missing from IPAC and related coalitions staffed by EMSIPSB.
- Convene multi-sector groups to increase collaborative efforts across injury areas.

Drowning Prevention

Goal

Decrease the incidence of fatal and non fatal drowning in Hawaii.

Magnitude of the Problem

Drownings are the 5th leading cause of fatal injuries among Hawaii residents, with an average of nearly 40 deaths a year. Drowning is the only injury cause for which non-residents comprise a majority of victims (53%), and their inclusion increases the average annual number of deaths to 83. Hawaii had the 2nd highest resident drowning fatality rate among all 50 States from 2013 to 2017, behind only Alaska. Within the state, residents of Hawaii County had the highest mortality rates, significantly higher than the rate for residents of Oahu. There was a slight increasing trend in the annual number of deaths; the change from ICD9-CM coding to ICD10-CM coding in October 2015 makes the assessment of trends in nonfatal drownings difficult. Most (84%) of the fatal drownings in Hawaii were in the ocean. Snorkeling was the most common activity, associated with 27% of all ocean drownings and 42% of those among non-residents. A review of EMS records of hospital patients indicated a very similar distribution of activity among victims of nonfatal ocean drownings. Children under 5 years of age comprised 30% (6) of the 20 victims of fatal swimming pool drownings, making this the leading cause of injury mortality among 1 to 4-years-old.

Drowning Prevention

Long – Term Indicators

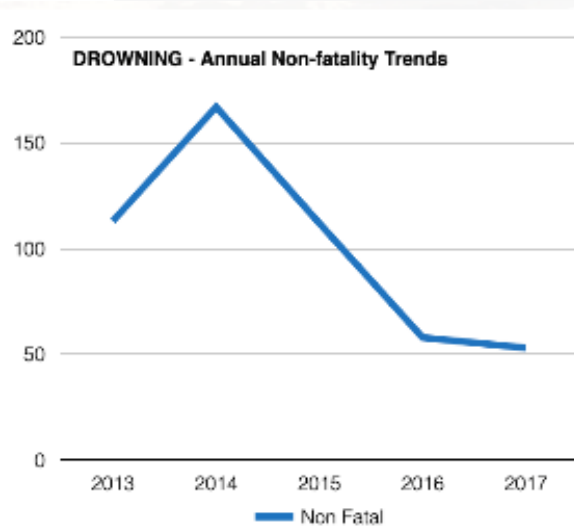
Mortality of Hawaii residents only: County & Total, 5-year number and rate (/100,000)

County	Number	Rate
Hawaii	38	18.72
Honolulu	124	11.78
Kauai	9	11.29
Maui	25	14.86
Total	196	13.02

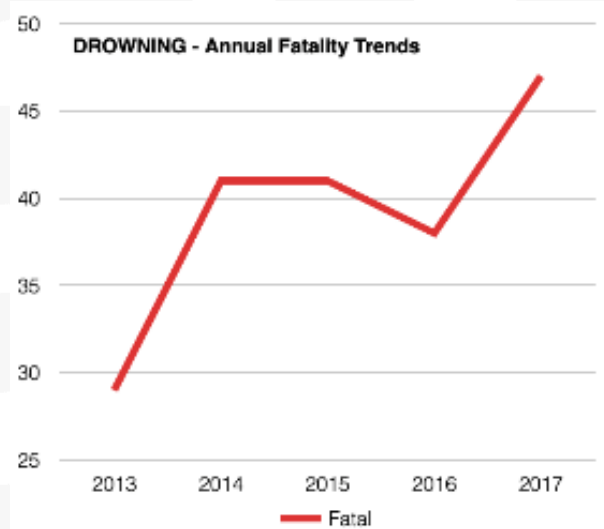
Morbidity of Hawaii residents only: County & Totals, 5-year number and rate (/100,000)

County	Number	Rate
Hawaii	60	32.35
Honolulu	395	43.24
Kauai	31	45.12
Maui	38	24.80
Total	523	40.02

Annual Nonfatal Trends



Annual Fatal Trends



SMART Objectives

- Decrease the 5-year drowning related mortality rate among Hawaii Residents from 13.02/100,000 in 2013-2017 to 11.72/100,000 by 2018-2022
- Decrease the 5-year drowning related morbidity rate among Hawaii Residents from 40.02/100,000 in 2013-2017 to 36.02/100,000 by 2018-2022

Drowning Prevention

Recommended Strategies

The EMSIPSB places a priority on having injury prevention strategies recommended by a community-driven action plan or informed by key implementing partners. Because a multitude of factors influence individual behavior, the strategies in the below table target risk and protective factors, framed across the individual, relationship, community, and policy levels.

Level	Strategy	Risk factors	Protective factors
Policy	Promote policies which support a foundation of drowning and aquatic injury prevention statewide	Lack of funds for first responder/ lifeguard services, support and equipment, absence of or poor aquatic health code, liability exposure to lifeguards, no state policy supporting child water safety.	Cohesive aquatic health codes Financial/ legal/community support of first responder/ lifeguard services
Community	Ensure representation from all organizations across the state that may influence the Advisory's mission of drowning and aquatic injury prevention. Support awareness regarding drowning as a major public health issue in Hawaii	Absence of lifeguards at pools, beaches, and other water environments, large visitor population. Promotion of snorkeling as a primary visitor activity, no state policy supporting child water safety.	Collaboration within counties and between counties and communities Access to swim lessons for adults and children Pervasive lifeguard water patrol Presence of public rescue tubes
Relationship	Establish a statewide culture that supports and promotes child water safety and water respect	Limited CPR ability of social network	Knowledge of and access to safety information
Individual	Develop, disseminate and sustain data driven drowning and spinal cord injury prevention messages applicable to risk and protective factors of target populations, and behavioral change prospect	No or poor swimming ability, Intrinsic medical condition, particularly circulatory, Going near or into the water alone, Positive blood level of alcohol or drugs	Experience in and around Hawaii ocean over time Ability to assess and respond to environmental conditions
Key Partner			
Drowning and Aquatic Injury Prevention Advisory https://hioceansafety.com/about-us/			

Fall Prevention Among Older Adults

Goal

Decrease the number of fatal and non-fatal falls statewide in Hawaii by implementing evidenced based programs.

Magnitude of the Problem

Unintentional falls were by far the leading cause of injury-related mortality among senior-aged (65 years and older) residents of Hawaii, accounting for nearly half (49%) of all such deaths. There was an average of 114 fatal falls among senior residents from 2013-2017, but there was a 48% increase over that 5-year period, from 88 to 130. Nonfatal injuries treated in hospitals also increased consistently, reaching a projected 10,000 in 2017. Falls were also the leading cause of nonfatal injuries among senior residents, accounting for 61% of those treated in emergency departments (ED) and 83% of those requiring hospitalization. Most (81%) of the deaths occurred among Oahu seniors, who also had the highest age-adjusted fatality rates, significantly higher than the rates for residents of Hawaii or Kauai counties. Senior residents of Kauai had the highest rates for nonfatal injuries treated in hospitals. Each ED visit resulted in an average of \$3,230 in hospital charges, and each hospitalization \$42,750, resulting in over \$100 million in combined hospital charges each year.

Fall Prevention Among Older Adults

Long – Term Indicators

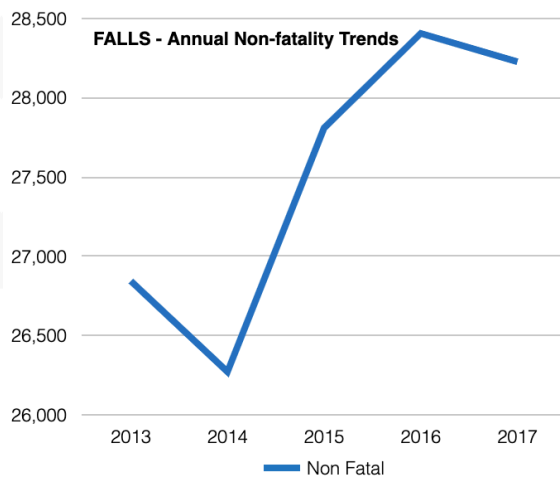
Mortality of Hawaii residents only: County & Total, 5-year number and rate (/100,000)

County	Number	Rate
Hawaii	36	105.20
Honolulu	464	249.00
Kauai	19	136.90
Maui	51	195.50
Total	570	219.00

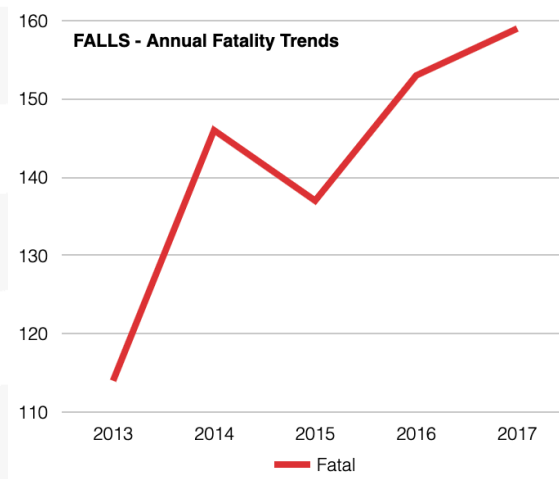
Morbidity of Hawaii residents only: County & Totals, 5-year number and rate (/100,000)

County	Number	Rate
Hawaii	22,722	11,121.96
Honolulu	92,654	8,779.58
Kauai	8,545	11,427.55
Maui	13,447	7,942.64
Total	137,368	9,119.40

Annual Nonfatal Trends



Annual Fatal Trends



SMART Objectives

- Decrease the 5-year Falls related mortality rate among Hawaii Residents from 36.45/100,000 in 2013-2017 to 32.80/100,000 by 2018-2023
- Decrease the 5-year Falls related morbidity rate among Hawaii Residents from 9119.40/100,000 in 2013-2017 to 8,207.46/100,000 by 2018-2023

Fall Prevention Among Older Adults

Recommended Strategies

The EMSIPSB places a priority on having injury prevention strategies recommended by a community-driven action plan or informed by key implementing partners. Because a multitude of factors influence individual behavior, the strategies in the below table target risk and protective factors, framed across the individual, relationship, community, and policy levels.

Level	Strategy	Risk factors	Protective factors
Societal	Institute fall screenings conducted by healthcare providers.	Limited laws encouraging fall prevention in the home and use of environment and services.	Laws and policy that require fall prevention be considered in the home, as programs and environmental design.
Community	Increase home modification services to community-dwellings. Institute effective fall prevention programs available to older adults and families. Increase free or affordable vision screening and vision improvement services. Increase free or affordable medication management services to older adults.	No established funding, capacity or infrastructure	Fostering partnerships, funding, contracts, agreements for building capacity community-based interventions, home modification services, screening, MOB classes, Tai Chi, etc.
Relationship		No Social Capital	Engagement of families; caregivers; fall prevention consortium members being aware and having access to and sharing fall prevention knowledge and programs.
Individual	Continue to increase fall prevention awareness among older adults, service providers, and family members.	No interest or awareness of intrinsic physical condition. Poor or lack of awareness of physical surroundings.	Self-efficacy; enhanced balance, mobility, vision, presence of home hazards, perceived risk, medication usage, awareness.
Key Partner			
Hawaii State Fall Prevention Consortium			

Suicide Prevention

Goal

To create a healthy, safe, and empowered community by reducing suicide attempts and deaths.

Magnitude of the Problem

Suicides were the leading cause of fatal injuries among Hawaii residents, accounting for 25% of the total. (Drug poisonings would be the leading mechanism, if intent was not considered.) The number of fatalities varied inconsistently over the 5-year period, although the 219 deaths in 2019 was the highest total to date. A commensurate decrease in the number of deaths coded as “undetermined intent” (i.e. generally, suicides) has also complicated the assessment of trends. Residents of Oahu had significantly lower mortality or morbidity rates than residents of any other county. Fatality rates among all Neighbor Islands were not significantly different. These findings are consistent with national reports of higher rates, or risk, of suicide among more rural populations. Fatality rates peaked among 20 to 29-year-old Hawaii residents, and progressively decreased over the age span. Males comprised 80% of the victims and had significantly higher rates than female residents of nearly every age group. Related autopsy records documented a history of mental illness for at least two-thirds (68%) of suicide victims, most commonly a “depressed mood” (54%); 24% had a diagnosis of depression. However, only 31% of decedents with a mental health problem were receiving treatment, and this proportion was much lower for residents of Neighbor Islands (8%), compared to those living on Oahu (40%). The most common “life stressors” were “problems” or “crisis” with their intimate partner (17%) or health (17%), with the former more prevalent among younger victims (29%) and the latter more prevalent (43%) among victims 65 years of age and older.

Suicide attempts, as inferred by self-inflicted injuries treated at hospitals, present a different epidemiology than deaths by suicide. The patients are majority (58%) female, 20% are under 18 years of age and 15 to 19-year-olds have the highest rates, and nearly two-thirds (63%) of the attempts are drug overdoses. By the most conservative method, there are an estimated 912 nonfatal attempts that require treatment in Hawaii hospitals each year; inclusion of injuries of undetermined intent or self-inflicted injuries with other principal diagnoses (e.g. mental illness) would more than double that estimate. The Hawaii Poison Center annually receives 865 calls that are related to intentional drug exposures.

Suicide Prevention

Long – Term Indicators

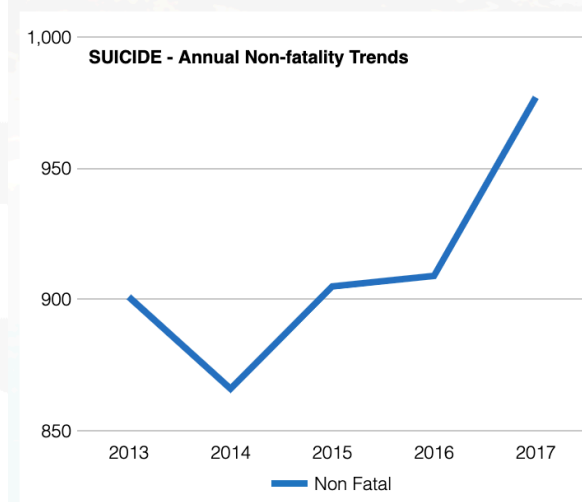
Mortality of Hawaii residents only: County & Total, 5-year number and rate (/100,000)

County	Number	Rate
Hawaii	187	97.19
Honolulu	541	52.04
Kauai	74	97.14
Maui	143	83.23
Total	945	63.51

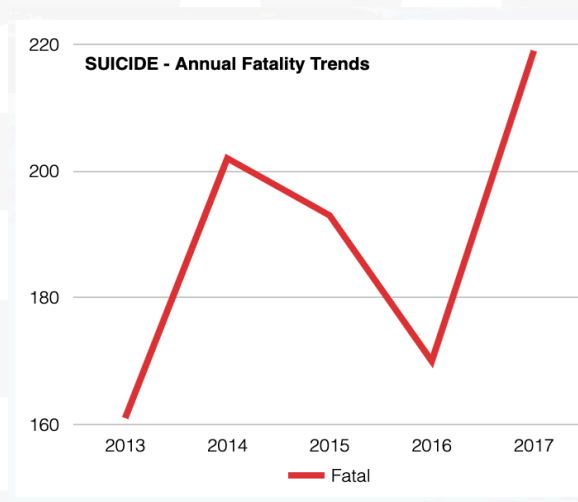
Morbidity of Hawaii residents only: County & Totals, 5-year number and rate (/100,000)

County	Number	Rate
Hawaii	965	566.35
Honolulu	2,758	293.88
Kauai	329	518.07
Maui	488	330.30
Total	4,541	344.05

Annual Nonfatal Trends



Annual Fatal Trends



SMART Objectives

- Decrease the 5-year Suicide related mortality rate among Hawaii Residents from 63.51/100,000 in 2013-2017 to 57.159/100,000 by 2018-2023
- Decrease the 5-year Suicide attempt morbidity rate among Hawaii Residents from 344.05/100,000 in 2013-2017 to 309.64/100,000 by 2018-2023

Suicide Prevention

Recommended Strategies

The EMSIPSB places a priority on having injury prevention strategies recommended by a community-driven action plan or informed by key implementing partners. Because a multitude of factors influence individual behavior, the strategies in the below table target risk and protective factors, framed across the individual, relationship, community, and policy levels.

Level	Strategy	Risk factors	Protective factors
Societal	Promoted suicide prevention as a core component of Hawaii's overall system of care Ensure policies and protocols set the proper foundation for suicide prevention initiatives	Unsafe media portrayals of suicide Stigma associated with mental health and help-seeking behaviors	Safe reporting and messaging about suicide. Supportive community environments for marginalized people
Community	Increase community awareness and communication around suicide prevention as a public health problem	Lack of access to providers, medication	Availability of medical and behavioral health services and other healthcare providers
Relationship	Increase statewide capacity for training across multiple levels and disciplines, including a focus on cultural humility with diverse populations	Violent relationships and financial/work stress	Connectedness with caregivers and social institutions
Individual	Increase State and community capacity to effectively and efficiently respond to those touched by suicide and those with mental health challenges	History of mental health issues, substance abuse and prior suicide attempts	Effective and available mental health care, substance abuse treatment services

Key Partner

- Statewide Prevent Suicide Hawaii Taskforce
- UH Department of Psychiatry – Deb Goebert - <https://jabsom.hawaii.edu/departments/psych/>
- American Foundation for Suicide Prevention, Hawaii Chapter <https://afsp.org/chapter/afsp-hawaii/>
- Mental Health America of Hawaii <http://mentalhealthhawaii.org/>
- Liliuokalani Trust <https://onipaa.org/>
- Adult Mental Health Division <http://health.hawaii.gov/amhd/>
- Child and Adolescent Mental Health Division <http://health.hawaii.gov/camhd/>
- US Military <http://www.garrison.hawaii.army.mil/asap/default.htm?tab=5>
- US VA <https://www.hawaii.va.gov/>
- Pacific Region Behavioral Health Alliance - Mary Burgess or David Brown www.pacificregionresources.org

Traffic Safety

Goal

To provide a transportation system where everyone arrives to their destinations free from injury.

Magnitude of the Problem

Traffic crashes are a significant source of injury-related mortality in Hawaii, accounting for over 100 deaths each year (about 14% of the total). About half (48%) of the decedents were occupants of cars or trucks, 22% were motorcyclists or moped riders, 28% pedestrians, and the remaining 2% were bicyclists. There were no consistent trends in the annual number of deaths for any of the modes over the 2013 to 2017 period. More detailed information was available for the 90% of decedents who were linked to FARS data from NHTSA. Impaired driving was a major factor, as 30% of the deaths were associated with alcohol-impaired driving, 29% with drug-impaired driving, and nearly half (47%) with either type of impairment. The latter proportion varied annually only between 41% and 53%, demonstrating the persistence of impaired driving. Lack of use of safety equipment was also prevalent, as nearly half (44%) of the car/truck occupants were not using seat belts at the time of the crash, and more than one-third (35%) of the motorcycle/moped riders were not wearing a helmet. (These proportions exclude 33% of decedents with no data on safety equipment.) There were strong associations between use of substances (alcohol or drugs) and non-use of safety equipment. Similar to suicides, residents of Oahu had significantly lower traffic-related mortality or morbidity rates than residents of any of the other 3, more rural, counties in Hawaii. Traffic crashes also cause nearly 6,000 nonfatal injuries which require treatment in Hawaii hospitals each year, including about 670 (11%) that result in hospital admissions. About two-thirds (64%) of these are injuries to car and truck occupants. However, more vulnerable road users (motorcycle and moped riders, pedestrians and bicyclists) constitute 54% of the admitted patients. There were decreasing trends in nonfatal injuries to motorcycle and moped riders and pedestrians, and an increasing trend in bicyclists injured in traffic crashes.

Traffic Safety

Long – Term Indicators

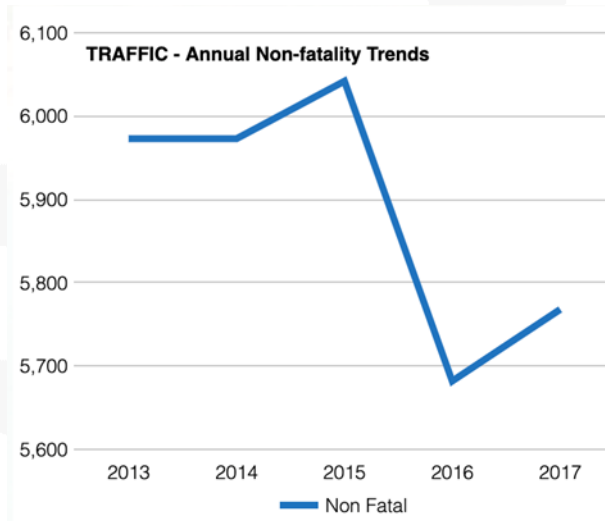
Mortality of Hawaii residents only: County & Total, 5-year number and rate (/100,000)

County	Number	Rate
Hawaii	120	64.97
Honolulu	269	25.69
Kauai	30	43.05
Maui	94	57.83
Total	513	34.93

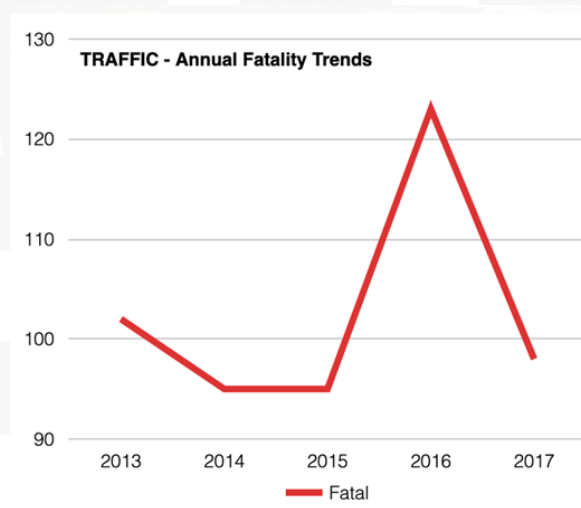
Morbidity of Hawaii residents only: County & Totals, 5-year number and rate (/100,000)

County	Number	Rate
Hawaii	6,077	3,310.82
Honolulu	18,299	1,832.57
Kauai	1,620	2,439.48
Maui	3,474	2,211.08
Total	29,469	2,087.74

Annual Nonfatal Trends



Annual Fatal Trends



SMART Objectives

- Decrease the 5-year motor vehicle mortality rate among Hawaii Residents from 34.93/100,000 in 2013-2017 to 31.437/100,000 by 2018-2023
- Decrease the 5-year motor vehicle related morbidity rate among Hawaii Residents from 2087.74/100,000 in 2013-2017 to 1,878.96/100,000 by 2018-2023

Recommended Strategies

The EMSIPSB places a priority on having injury prevention strategies recommended by a community-driven action plan or informed by key implementing partners. Because a multitude of factors influence individual behavior, the strategies in the below table target risk and protective factors, framed across the individual, relationship, community, and policy levels.

Traffic Safety

Level	Strategy	Risk factors	Protective factors
Societal	Promote policies that support safe driving, walking and riding behaviors Promote policies that encourage use of protective devices (helmets and seat belts) Support implementation of safe and connected roadway infrastructure for all road users	Objection to change in traffic safety laws	Policies and laws that encourage protective devices and safe driving behaviors
Community	Support community coalitions and partnerships to advance safe policies and protective street designs for all road users	Cultural norm of unsafe driving or occupant behavior Substance misuse Lack of safe connected facilities for vulnerable road users (walking, biking, disabled)	Enforcement and encouragement of protective polices and roadway design Environmental changes to promote safe alternatives to substance mis use and impaired driving
Relationship	Increase statewide capacity to use best available data to prioritize policy, enforcement and design.	Disconnected prevention efforts	Taskforces, coalitions and partnerships
Individual	Increase public and private partners to support traffic safety messages through their respective channels of influence	Negative social media messages. Addiction. Driving without training, license or insurance	Culturally based social media messaging Peer to peer influence Positive change challenges
Key Partners			
<ul style="list-style-type: none"> • Hawaii Strategic Highway Safety Plan • Hawaii State Highway Safety Council • Oahu Metropolitan Planning Organization • Hawaii Mothers Against Drunk Driving • Hawaii Trauma Advisory Council • Hawaii Department of Transportation • Kauai Path • Peoples Advocacy for Trails Hawaii • Hawaii Bicycling League • Hawaii Traffic Commanders 			

Poison Prevention

Magnitude of the Problem

If intent is not considered (i.e. suicides), drug poisonings is the leading mechanism of fatal injuries among Hawaii residents, surpassing deaths falls and motor vehicle crashes as of 2007. There was an average of 171 fatal drug poisonings among residents each year, with consistent increases from 148 in 2013 to 200 in 2017. At least 36% of these deaths were related to opioid overdoses, mostly prescription pain relievers. Poisonings involving methamphetamine are also thought to be common, although these are difficult to detect through death certificate coding. Relative to the U.S. as a whole, however, drug poisoning fatality rates are significantly lower for Hawaii residents, and not increasing at the same alarming rate. These generalizations are specifically true in the context of opioid overdoses, where Hawaii has yet to experience the dramatic spike in deaths involving heroin and synthetic opioids such as fentanyl. Linkage of autopsy data from Honolulu County and the Prescription Monitoring Program indicate that most (73%) of the opioid overdose victims had legally prescribed access to opioids, including about half (49%) with prescribed supply within 3 months of their death. For every fatal opioid overdose, there are nearly others nonfatal overdoses treated in Hawaii hospitals, and nearly 4 calls to the Hawaii Poison Hotline.

Recommended Strategies

The EMSIPSB places a priority on having injury prevention strategies recommended by a community-driven action plan or informed by key implementing partners. Because a multitude of factors influence individual behavior, the strategies in the below table are framed across the individual, relationship, community, and policy levels.

Poison Prevention

Level	Strategy
Societal	<p>Hawaii Poison Hotline</p> <p>*Focus Area #7: Integrate SUD screening in primary care settings and develop referral and entry system into a continuum of care.</p>
Community	<p>*Focus Area #6: Coordinate operations and services, support specialized training for first responders and assure effective laws and policies.</p> <p>*Focus Area #4: Improve community-based programs and public education to prevent substance misuse and related harms.</p>
Relationship	<p>*Focus Area #2: Improve opioid and related prescribing practices by working with healthcare providers.</p>
Individual	<p>*Focus Area #5: Increase consumer education and prescription harm management through pharmacy-based strategies.</p>
Key Partner	
<u>Hawaii Opioid Initiative - Alcohol and Drug Abuse Division (ADAD) *</u>	

Sport Traumatic Brain Injury Prevention

Magnitude of the Problem

There are 12650 traumatic brain injuries (TBI) that require hospital treatment among Hawaii residents each year, with a generally increasing trend. However, this total includes nearly 8,300 TBI defined by diagnoses of “unspecified head injury”. If case definition is limited to more specific coding (e.g. concussion, intracranial hemorrhage, etc.) there are 4360 TBI each year, with a decreasing trend over the 2013 to 2017 period. About one-third (32%) of these more specifically-coded TBI result in hospital admission, compared to only 3% of patients with “unspecified head injury”. Residents 75 years and older have the highest rates of any type of TBI, followed by those under the age of 5, and 15 to 18 year-olds. Hospital disposition generally worsened across the age range, reaching 4% mortality among patients 75 years and older. About three-fourths (73%) of the patients are residents of Oahu; standardized rate estimates are significantly higher for Oahu residents than for any other county. Unintentional falls caused over half (57%) of all TBI, including 41% among senior-aged (65 years and older) residents. Other common causes were car/truck crashes, assaults, and motorcycle/moped crashes. Data from the Hawaii Trauma Registry describes significant associations between non-use of seat belts and helmets and incidence of TBI among patients injured in motor vehicle crashes. It is difficult to say how many of these TBI were sustained while engaged in sports, as only 28% of the hospital records contained codes on patient activities. Among this subset of records, 21% had activity codes to indicate sports, most commonly tackle football (6%), basketball (3%) and soccer (3%). Most (62%) of the TBI among 10 to 17-year-old patients with requisite activity codes were sports-related.

Sport Traumatic Brain Injury Prevention

Recommended Strategies

The EMSIPSB places a priority on having injury prevention strategies recommended by a community-driven action plan or informed by key implementing partners. Because a multitude of factors influence individual behavior, the strategies in the below table are framed across the individual, relationship, community, and policy levels.

Level	Strategy
Societal	
Community	Increase availability of concussion education videos for high school coaches, parents and athletes. Content of video is based on needs assessment data, qualitative interviews, and peer reviewed literature, and CDC HeadsUp. Collaboration between Hawaii Concussion Awareness and Management Program (HCAMP) and the Core State Violence and Injury Prevention Program (Core SVIPP) .
Relationship	
Individual	<p>Increase availability on online educational resource that will educate school aged children and youth in the State of Hawaii on head, neck, and spinal cord related health and safety protocols. The educational resource will be a fun, engaging, and self-directed learning experience for youth that will test their knowledge and incorporate family members in the learning process.</p> <p>HCAMP Concussion Summit: DOH Neurotrauma sponsors the annual HCAMP Concussion Summit, which aims to provide concussion education and awareness for athletic trainers, parents, coaches, school administrators, and health care providers, including physicians, physical therapists, and speech pathologists.</p>
Key Partners	
Hawaii Concussion Awareness and Management Program (HCAMP)	
Hawaii State Department of Health – Neurotrauma Supports	

Child Injury Prevention

Magnitude of the Problem

Injuries were the 2nd leading cause of death among child (ages infant to 17 years) residents of Hawaii, accounting for about 17% of the total. More children died from injuries from 2014 through 2018 than from congenital anomalies, cancer, or other chronic diseases. If infants are excluded, injuries were by far the leading cause of death among 1 to 17-year-old residents, accounting for nearly (43%) as many deaths as all other causes combined. Most (66%) of the fatal injuries among Hawaii children were unintentional, 21% due to suicide and 11% from homicide. Fatal injury causes differ across the child age range, with suffocation (also including SIDS), homicide, and drowning more prevalent among children under 5, and suicide and motor vehicle crashes predominating among teenagers. An average of 24 children die from injuries each year in Hawaii, but fatalities represent only a small proportion. Each year, 373 resident children are hospitalized from injuries, and another 23,500 are treated in the emergency department. Nearly 2,800 injured children are transported by EMS ambulance to hospitals. If fatal injuries are considered together with those that require a hospitalization of 7 days or longer (46 each year), the age-related causes are largely the same: issues of safe sleep and assault for young children, and suicide and motor vehicle crashes for older children. Despite their prominence as a cause of mortality and morbidity, fatal injury rates for Hawaii's children (8.6 deaths /100,000) are significantly lower than those for the United States as a whole (12.2/100,000). Hawaii had the 8th lowest child injury fatality rate among the 50 States over the 2014 through 2017 period. Hawaii rates for fatal unintentional injuries, and violence-related (homicides and suicides) were also significantly lower, by 28% and 31%, respectively, compared to the nation.

Recommended Strategies

The EMSIPSB places a priority on having injury prevention strategies recommended by a community-driven action plan or informed by key implementing partners. Because a multitude of factors influence individual behavior, the strategies in the below table are framed across the individual, relationship, community, and policy levels.

Child Injury Prevention

Level	Strategy
Societal	<p>Safe Sleep Hawaii provides statewide leadership in preventing infant deaths through educating parents, caregivers, teachers and health care providers on the Safe Sleep.</p> <p>Institute statewide training for Hawaii Home Visitors/ Your Ohana to prevent child injury among enrolled families.</p>
Community	<p>Strategy: Creating Safe and Protective Environments</p> <p>Safe and Nurturing Family Framework – ECAS is a statewide public-private collaborative designed to improve the system of care for Hawaii’s youngest children and their families. Includes messaging, training, and resources for families and early childcare providers.</p>
Relationship	<p>Strategy: Community Cafés</p> <p>Implement the Community Café practice model. The model supports meaningful conversation to promote leadership skills and relationships based on the protective factors to address preventing child maltreatment in their community.</p>
Individual	<p>Strategy: Community Awareness</p> <p>Child Abuse Prevention Month activities; supporting year-round community-based family-child engagement activities designed around protective factors; showing the documentary “Resilience” with facilitated discussion; Safe Sleep Summit.</p>
Key Partners	
<p>Maternal and Child Health Branch Early Childhood Action Strategy (ECAS) Hawaii Public Housing Authority and Resident Advisory Boards Hawaii Children’s Trust Fund Hawaii Home Visiting Service Unit – Your ‘Ohana</p>	

Violence and Abuse (Intimate Partner/ Sexual)

Magnitude of the Problem

Intimate partner violence is well known to be under-reported (under-coded) in administrative medical records. The reliability of describing this issue through sources such as hospital billing data is therefore in question. Analysis of such data from 2015 through 2017 indicated an average of 125 hospital presentations of injuries from IPV against women each year. (This number could be increased to approximately 200 if records with no information on perpetrator are also included.) Most (92%) of these injuries were treated at the emergency department level. The proportion of patients residing in Oahu (54%) was lower than expected, given 69% of female residents 12 years and older reside there. Conversely, 28% of the patients were from Hawaii County, which accounts for only 14% of the female population.

To examine this issue in the pre-hospital setting, a random sample of 855 (18%) of the 4,777 Emergency Medical Services records for females (ages 12 to 50 years) who were injured by assaults from 2013 through 2015. Based on open text narrative from the EMS provider, IPV was identified as the “definite” cause of 38% of the injuries, and the “probable” or “possible” cause of 21%. These proportions result in annual estimates of 609 definite EMS encounters of IPV each year, and an additional 340 probable/possible incidents. Nearly two-thirds (65%) of the EMS patients refused transport to a hospital for further medical attention. Even so, the estimated average of 330 EMS transports of female victims of IPV exceeds that indicated from hospital billing data (125), confirming the under-coding of IPV in hospital records. Based on a study of Hawaii EMS records linked to hospital records, only 39% of female IPV hospital patients arrive by EMS. Combined with the 330 who are transported by EMS, the annual estimate of hospital presentations of IPV is 800 to 900.

The average age of the IPV victims was 31 years, and 75% were 20 to 40 years of age. Victim age distribution was similar across counties. Overall 66% of the patients refused hospital transport. This proportion was significantly lower for those treated in Hawaii County (23%) compared to other counties (71%). There was no association between victim age and transport status.

Violence and Abuse (Intimate Partner/ Sexual)

Recommended Strategies

The EMSIPSB places a priority on having injury prevention strategies recommended by a community-driven action plan or informed by key implementing partners. Because a multitude of factors influence individual behavior, the strategies in the below table are framed across the individual, relationship, community, and policy levels.

Level	Strategy
Societal	<p>Institute statewide standard for DV screening at medical and dental sites.</p> <p>Institute statewide training for Hawaii Home Visitors/ Your Ohana to enhance skills and confidence when screening families for IPV.</p>
Community	<p>Create Multidisciplinary Teams for DV</p> <p>Strategy: Social Norms Change/Engaging Men as Allies Na Leo Kane, Social Media and Website Project– Na Leo Kane is a statewide public-private collaborative of agencies, organizations and individuals engaging men as allies to prevent domestic and sexual violence.</p> <p>Strategy: Creating Safe, Protective Environments ECAS is a statewide public-private collaborative designed to improve the system of care for Hawaii’s youngest children and their families. Includes messaging, training and resources for early childhood providers and families. Middle and High School Campus Mapping Project, Kapiolani Medical Center, Sex Abuse Treatment Center</p> <p>Middle and High School Campus Mapping Project, Kapiolani Medical Center, Sex Abuse Treatment Center</p>
Relationship	<p>Strategy: Community Mobilization Sexual Violence Prevention (SVP) Community Action Teams (CAT), DOH MCHB Statewide – CATs include Alcohol Junction, Hawaii Partnership to Prevent Underage Drinking, Military, Engaging Men and Boys, Leeward Waianae, University/Higher Education, LGBTQ, Maui, Kauai, Kau, East Hawaii, and Molokai. SVP CATs attend annual SVP trainings and develop action plans to implement primary prevention strategies in their communities and/or communities of practice. CATs also participate in planned activities for Sexual Assault Awareness Month (SAAM) in April intended to raise awareness of the prevalence of sexual violence and opportunity to engage new community members to participate in SVP efforts throughout the year.</p>
Individual	<p>Strategy: Coaching Boys into Men</p> <p>Strategy: Bringing in the Bystander</p> <p>Strategy: Middle and High School Sexual Violence Prevention</p>
Key Partners	
<p>Maternal and Child Health Branch Sexual Violence Prevention (SVP) Community Action Teams Hawaii Early Childhood Action Strategy (ECAS) Hawaii Family Law Clinic dba Ala Kuola</p>	

University of Hawaii Prevention Awareness and Understanding (PAU) Violence Program
Kapiolani Medical Center, Sex Abuse Treatment Center
Hawaii Home Visiting Service Unit – Your ‘Ohana

Acknowledgements

The Hawaii State Department of Health, Emergency Medical Services & Injury Prevention System Branch extends our sincere appreciation for attending IPAC meetings and offering your expertise and feedback to help us development the 2018 – 2023 Hawaii Injury Prevention Plan, and for IPACs commitment to guide its ongoing implementation.

DOH EMSIPSB

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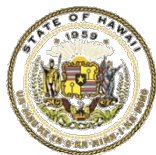
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Key partners are acknowledged in each injury areas.



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Supported by:

This publication was produced by the Injury Prevention and Control Section and supported by the U.S. Centers for Disease Control and Prevention (CDC) through the [Hawaii Core State Violence and Injury Prevention Program Grant](#) (Cooperative Agreement #NU17CE924848). The views expressed in this publication and do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Updated: January 2020

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) and Child Adolescent Mental Health Division (CAMHD) partners with state and county agencies, private and non-profit organizations, and individuals to address needed services and programs. Many times, opportunities to build and partner become evident when new services are created or when grant funding becomes available.

Within the last MHBG period, there have been many opportunities to work with partner agencies and organizations, some who may not be organically tied to mental health services but whose strengths collectively contributed to providing rapid response in a times of crisis and limited resources. For example, from the beginning of the COVID-19 pandemic, the Hawaii State Department of Health has been a critical resource for statewide guidance on COVID-19 response, procedures, guidelines and technical assistance for personal protective equipment (PPE), vaccination, and infection control. Within the Hawaii State Department of Health, Behavioral Health Administration (BHA), the AMHD, CAMHD, Developmental Disabilities Division (DDD) and Alcohol and Drug Abuse Division (ADAD) provided direct support to address COVID-19 response within our serious mental illness (SMI) populations, including homelessness, congregate housing, inpatient facilities and community-based clinics and offices. Utilizing available federal, state, and county resources, the BHA mobilized its response teams to assist with virtual webinars for information sharing, vaccination point-of-distribution (POD) clinic operation and support, PPE and logistics controls, assistance with homeless coordination efforts, and providing operational and day-to-day support for isolation and quarantine facilities.
<https://health.hawaii.gov/bhhsurg/>

Beyond COVID-19 response, some examples of how Hawaii has responded when a need to develop new partnerships was identified include:

- Expanding community-based case management to include additional providers for intensive case management services,

- Expanding stabilization bed units to include additional residential providers, and
- Expanding Mental Health Emergency Worker (MHEW) availability across multiple counties.

AMHD and CAMHD are in the process of procuring and re-procuring services and hope that with these Requests for Proposal (RFP) notices, we receive RFP responses from interested entities willing to partner to provide services to our SMI population groups - youth and adult.

Partnerships with the Hawaii Judiciary continue to be developed as additional opportunities to collaborate on improvements for streamlining referral and triage for justice involved individuals with a serious mental illness (SMI). Trainings on various mental health, forensic and court processes for fitness evaluation are periodically offered to staff from the Judiciary, prosecutor's office, and public defender's office through the AMHD Court Evaluation Branch and through the Forensic Coordination Section of the Community Mental Health Center Branch. In addition to drug court, mental health court and jail diversion, the AMHD and CAMHD partner with Judiciary court staff and involved entities (e.g. probation officers, public defenders) who are directly involved with assisting justice involved individuals with linkage to community supports including community-based case management, residential programming and outpatient treatment, and forensic coordination.

Partnerships with the Hawaii State Department of Education aim to provide assistance to students who may need emotional, behavioral and learning supports. The Child & Adolescent Mental Health Division (CAMHD) provides mental health services free of charge for eligible Hawaii children and youth who have severe emotional and/or behavioral challenges. Services include assessment, case management, and an array of therapeutic supports provided in the home and community, or temporary out-of-home placements. We make every effort to provide culturally-sensitive, child- and family-centered services, and include the youth and family in all aspects of the service planning and treatment decisions.

Partnerships with the Hawaii Department of Human Services, Child Welfare Services (CWS) are continuously evaluated for areas where new partnerships may be advantageous. For example the CAMHD may provide intervention and consultation for cases that are referred out of Family Drug Court. Recent action taken as a result of grant funding for Project Laulima has resulted in the CAMHD working towards the development and implementation of a two-tiered, state and local-level framework for a cross-system collaboration and coordination to better serve youth with co-occurring mental illness and developmental/intellectual disabilities and their families.

<https://nmcndn.io/e186d21f8c7946a19faed23c3da2f0da/5ef2e685c81348acbb22d12524a5a4be/files/usfconference30th/agenda/wednesday-march-8-2017/S83b-Musburger.pdf>

Partnerships with the Hawaii Public Housing Authority (HPHA) continue to be explored, especially in the areas of providing support to families who may not have access to technology or financial resources and who may be limited in their English proficiency. These individuals may be living in a subsidized or independent housing unit and may need to be outreached to through familiar contacts such as through their resident managers, HPHA facility and operations staff and through known contacts with health care providers.

<https://www.hphaishereforyou.org/resources-support>

In the most recently published triennial Community Health Needs Assessments for four of Hawaii's major 501(c)3 hospital organizations, all four organizations identified and prioritized mental health as an area of focus within their assessment findings. It is well documented that inpatient psychiatric hospitalization and emergency room services for individuals presenting with a mental health, psychiatric or co-occurring health situation may not always require hospital admission but do require a warm hand off to trained community-based providers who are able to meet the individual where they are located (e.g. sometimes in the hospital emergency department, sometimes accompanied by a police officer or another community health or crisis worker) and determine where they may be redirected to for appropriate outpatient and community-based care. Partnerships in these areas may make a difference in the lives of those who seek treatment voluntarily, but who may be appropriate for residential and community resources as alternatives to hospitalization.

Additional References:

Hawaii Pacific Health. 2019 Community Health Needs Assessment - Kapiolani Medical Center, Straub Medical Center and Hospital, Pali Momi Medical Center and Hospital, and Wilcox Medical Center. <https://www.hawaiipacifichealth.org/about-us/community/>

Kaiser Permanente. 2019 Community Health Needs Assessment - Moanalua Hospital, Honolulu, Hawaii Oahu. <https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2019/09/Honolulu-CHNA-2019.pdf>

The Queen's Medical Center. 2018 Community Health Needs Assessment. https://www.queens.org/media/file/2019_QMC_CHNA.pdf

Wahiawa General Hospital. FY2020-2022 Comprehensive Community Health Needs Assessment Implementation Plan. <https://www.wahiawageneral.org/wp-content/uploads/2021/06/CHNA-FY20-F22-Tracking-Documents-June-21-Updated.pdf>

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

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health 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.

⁶⁹<https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

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?

The Council seeks to be more involved in the development and review of Hawaii's state plan and report. For example, in past application years, the full application with the state plan and report was provided to the Council several weeks prior to the due date allowing for more dialogue with representatives from the state mental health authority and opportunities to discuss the application content with individuals within each Council members area of representation. This year, there have been challenges with receiving a copy of the application which has resulted in the Council being left with little time to review, discuss, advise and respond.

To accommodate the untimely sharing of the full application, Council members approved the convening of an Executive Council meeting on Sunday, August 29, 2021 from 6pm to 9pm HST specifically to review the application with the state plan and report, discuss the application with the AMHD Planner or designee, collated our questions and comments about application content, and finalize the Council's letter of support for the application. As of 8/24/21, Council members have not received a copy of the application, state plan and report.

Typically, Council members received a of the application section, "Environmental Factors Plan" where the State Planning/Advisory Council is included. This application year, with the help of S. Haitsuka, the Council received a copy of this section prior to the Council's August 10, 2021 meeting allowing the Council ample time to review previous Council responses and to discuss and draft this current response. As of 8/24/21, this is the only section of the full application Council members have reviewed.

Please see the attached supporting documentation: Meeting minutes, Council member attendance logs (FY2021 and FY2022), Strategic Plan and Action Plan, Annual Report to the Legislature, legislative testimony, and letter to the DD BHA regarding COVID-19 and mental health.

The Council identified three mechanisms used by the state to plan and implement substance misuse prevention and SUD treatment and recovery services.

First, the Council represents the voice of mental health service recipients, family members, providers, Service Area Boards on mental health and substance abuse, state agency partners and youth advocates and collectively seeks to advocate for the recognition of human rights for people with disabilities by (a) listening to feedback shared by community members and stakeholders through scheduled meeting presentations and community input and (b) engaging with representatives

from the state mental health authority and policymakers about community mental health and substance abuse issues and offering, for their consideration and inclusion in the state plan, recommendations for addressing service gaps.

For example, community members have shared about challenges with accessing care via hospital emergency departments when an individual presents with needing help with their alcohol intoxication, where detox services are needed but is not readily available in the emergency department.

Second, the Council extends its surveillance, advocacy, learning and outreach activities to other established meetings. For example, the Council receives and reviews the meeting minutes of the Hawaii Advisory Committee on Drug Abuse and Controlled Substances (HACDACS). A member of HACDACS is a dual member of the Council. This member shares updates about HACDACS activities and discussions, and vice versa. Council members regularly attend and vocally participate in Mental Health Task Force (MHTF) meetings which are hosted by the Chair of the House Health, Human Services and Homelessness Committee and co-facilitated by the Deputy Director, Hawaii Health and Harm Reduction Center and the Executive Director, Mental Health America Hawaii.

For example, topics such as the Hawaii CARES statewide 24/7 behavioral health crisis and suicide hotline, behavioral health legislative initiatives, and coordination/continuity of care between levels/types of services are discussed in these meetings.

Third, the Council prioritizes island/county-based feedback regarding substance misuse prevention and SUD treatment and recovery services.

For example, the Counties of Kauai and Maui noted a need for youth substance abuse services; the City and County of Honolulu has noted the need for expansion of the current Honolulu Police Department COVID Enforcement Teams to provide six shifts of 24/7 foot patrol enforcement beyond the Chinatown area to increase opportunities to engage with individuals who are homeless and divert them from the criminal justice system by connecting them to mental health and substance abuse services.

- 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)? Yes No
- 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 purpose of the Council is (1) to advise agencies and policy makers in their efforts to establish a comprehensive community-based mental health system, utilizing public and private resources that aim to prevent, reduce, and heal mental disorders and substance abuse among children and adults; (2) to advocate for the mental health needs of each County in partnership with the County Service Area Boards on Mental Health and Substance Abuse (SABs); and (3) to represent recipients of mental health services in our communities.

The Council's duties and responsibilities include:

1. The development and implementation of a strategic plan that incorporates data and input from the community, stakeholders, and consumers.
2. The approval to convene short-term Permitted Interaction Groups (PIGs) that complete activities related to:
 - a. Legislative information, advocacy and critical bills that affect 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 Hawaii State Department of Health (DOH), Adult Mental Health Division (AMHD) and Child Adolescent Mental Health Division (CAMHD)

During fiscal year 2021, the Council met monthly to identify its goals and objectives, address the Council's administrative and operational tasks, schedule and hear from community members and stakeholders about various mental health and substance abuse topics, and receive updates from Council members about their activities related to their area(s) of Council representation.

Council discussions around advocacy, legislation, and island/County-based issues has elevated awareness about ways in which the Council may expand its advisory responsibilities to positively affect Hawaii's mental health and substance abuse system. For example, by testifying on legislative bills, conversing with the Hawaii State Department of Health (DOH) Deputy Director of Behavioral Health Administration (DD BHA), responding to updates from the DOH Child Adolescent Mental Health Division (CAMHD) and Adult Mental Health Division (AMHD), and considering feedback about community issues related to mental health and substance abuse.

Overall, the Council's actions over the past 14-month period have been consistently focused on addressing areas of mental health and substance abuse from a statewide perspective but also acknowledging where there are systemic issues affecting one or more

islands/counties or areas within an island/county.

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

The Council requests technical assistance in the following areas related to this section:

1. AMHD policy and procedure 60.520 for state and county service plans - Planning Council recommends Hawaii DOH and AMHD update the policy and provide a copy to the Planning Council and to all four Service Area Boards on Mental Illness and Substance Abuse with timeline and due date changes, as applicable.
2. Budget for Council expenditures - what are examples of allowable/approved items that other Planning Councils have successfully expended funds for?

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.⁷⁰

⁷⁰There 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

Footnotes:

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
May 19, 2020
9:00 a.m. – 11:30 a.m.

Members Present: **Crum, Louise; Knightsbridge, Christopher; Lau-James, Eileen; Macias, Alexandra; Martinez, Kai; Matayoshi, Carol; Ries, Richard; Vorsino, Marie**

Members Absent: **Crozier, Charleen; Lino, Timothy; Pascual-Kestner, Rusnell; Shimabukuro, Scott**

Members Excused: **Dang, Cynthia; Jackson, Arwyn; Nagao, Lani; Souza, Chiree**

Guests Present: **Dau, Chelsea; Talisayan, Bryan**

Staff Present: **Clarke, Judith; Hiraga-Nuccio, Madeleine; Nazareno, Jocelyn; Pangburn, Teresa; Tom, Trina**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Marie Vorsino, 1st Vice Chair, called the meeting to order at 9:17 a.m. because Chair Ries was not present. Members and guests introduced themselves.</p> <ul style="list-style-type: none"> • Quorum was not established. • Agenda Item IV was tabled. • Agenda Item V was discussed. 	For information, only.	M. Vorsino, 1 st Vice Chair	5/19/20
V. Old Business <ul style="list-style-type: none"> • Focused Ideas for the Advocacy/Website/Social Media Permitted Interaction 	<p>C. Knightsbridge commented:</p> <ul style="list-style-type: none"> • The Council needs to come up with procedures or guidelines for the website, and on how information will be uploaded on it. • Maintenance of the website – will the Council do the maintenance themselves or will it be outsourced? The website has not currently been updated. 			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<p>Group (PIG)</p> <ul style="list-style-type: none"> Focused Ideas for the Legislative PIG 	<p>E. Lau-James commented that members of the Legislative PIG thought that the information given to the PIG was too vague. The PIG thought that it should be a committee rather than a PIG because the issues were too broad.</p> <p>C. Knightsbridge stated that given the pandemic and the closure of the Legislature, the Council needs more guidelines on how the PIG can be more useful. There is a need to have someone come and speak to the Council on what is going on with the Legislature during the pandemic.</p> <p>Council members' suggestions for the Legislative PIG:</p> <ul style="list-style-type: none"> Outline what the PIG can do. Need scope of what the PIG can do. Explore options for the PIG to move toward actions. Invite someone to give guidelines for the Legislative session. 			
	<p>M. Vorsino turned over the meeting to R. Ries, Chair.</p> <p>Quorum established at 9:34 a.m.</p> <p>Chair Ries called for roll call to confirm who was in attendance at the meeting at the time quorum was established.</p> <p>The following attendees re-introduced themselves.</p> <p>Members Present :</p> <p>E. Lau-James, L. Crum, K. Martinez, M. Vorsino, C. Matayoshi, C. Knightsbridge, A. Macias, R. Ries</p> <p>Guests Present: C. Dau, B. Talisayan</p>	<p>For information, only.</p>	<p>R. Ries, Chair</p>	<p>5/19/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>Staff Present: M. Hiraga-Nuccio, T. Tom, T. Pangburn, J. Clarke, J. Nazareno</p>			
<p>II. Consideration and Approval of Review Minutes</p>	<p>M. Vorsino commented that a recommendation from the Office of Information Practices when conducting virtual-type meetings is to have one person as a designee who would make motions to approve, and one person as a designee to second the motions to approve. This would make the meeting run more smoothly.</p> <p>The minutes for the January 14, 2020 draft minutes were reviewed. The minutes were amended as follows:</p> <ul style="list-style-type: none"> • Delete Greg Keane (staff) as present. • Page 1, Item II, first bullet, to read, “January 14, 2020 minutes were reviewed.” • Page 3, Item VIII, Hawaii Service Area Board (SAB) to read, “There will be a pilot project to train dogs for consumers with mental illness. The dog training program has not yet started. It is in the planning stages. The HSAB is working with the East Hawaii Dog Psychology Center to work on a grant with the County of Hawaii to develop a plan.” <p>E. Lau-James moved that the minutes for the January 14, 2020 be approved with amendments. M. Vorsino seconded the motion.</p> <p>Chair Ries took attendance again to see who was present at the meeting.</p>	<p>For information, only.</p> <p><u>Action:</u> The January 14, 2020 minutes with amendments were approved. Motion carried unanimously.</p>	<p>R. Ries, Chair</p>	<p>5/19/20</p>
<p>III. Community Input</p>	<p>No community input was received.</p> <p>Chair Ries stated that if any Council member was having problems with their connectivity to the meeting, they should call staff at (808) 478-6204.</p>	<p>For information, only.</p>	<p>R. Ries, Chair</p>	<p>5/19/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<p>IV. State Council Statement on Behavioral Health Considerations for Department of Health, the Governor, and the Lieutenant Governor, regarding COVID-19 and Public Health</p>	<p>Chair Ries asked Council members to share their thoughts, issues, concerns, or recommendations about the impact of COVID-19 on public health. This he opined the leadership of the Department of Health (DOH) should be more aware of.</p> <p>K. Martinez shared that the Hawaii Public Housing Authority (HPHA) used federal funds and monies from the Cares Act to order emergency supplies such as face masks, hand sanitizers, gloves, cleaning supplies, etc., and shared it with families and other state departments who did not have available funds to get emergency supplies for their essential workers. Funds were also used to provide information and interpretive services on social distancing in different languages. These were distributed to public housing residents and their families.</p> <p>M. Vorsino shared from a non-profit perspective that there was a tremendous outpouring of food drives, mental health services, in-person and telehealth services offered to the community. She continued that the Executive Director and the Chief Operating Officer of her organization are working with the heads of each department to communicate client needs across the State and are helping community members get through the unemployment system.</p> <p>E. Lau-James commented that perhaps the Council could draft a letter to the DOH, the Governor, and the Lt. Governor with specific recommendations for each of the role groups that the Council represents.</p> <p>C. Knightsbridge mentioned that the Council could meet twice a month during this pandemic so that the Council could get things done.</p>	<p>For information, only.</p>	<p>R. Ries, Chair</p>	<p>5/19/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>Chair Ries responded that it depends on how busy Council members' schedules were. He opined that the Council could meet if there is an urgent matter.</p> <p>E. Lau-James suggested that Council members bring to the next meeting, issues, ideas, solutions, and recommendations to include in the draft letter.</p> <p>A. Macias suggested that a Permitted Interaction Group (PIG) be developed and tasked with writing the draft letter.</p> <p>E. Lau-James motioned to create a COVID-19 PIG to draft a letter to the to the DOH, the Governor, and the Lt. Governor. C. Matayoshi, and C. Knightsbridge seconded the motion.</p> <p>Members of the COVID-19 PIG are: C. Matayoshi, E. Lau-James, C Knightsbridge, A. Macias, and R. Ries.</p> <p>COVID-19 PIG to meet on Thursday, May 28th at 10:00 a.m.</p> <p>At 10:52 a.m. M. Vorsino announced that she had to leave the meeting to attend to an emergency. Quorum was lost at 10:52 a.m.</p>	<p><u>Action:</u> Motion was approved by majority vote.</p>		
<p>V. Old Business</p> <ul style="list-style-type: none"> Discussion on Development of an Individual on the SCMH Responsible for Ensuring Sunshine Law and Robert's Rules of Order 	<p>Chair Ries commented that the Council could perhaps ask C. Dang if she would be interested in taking on this role for the Sunshine Law and Robert's Rules of Order to be followed at Council meetings.</p> <p>Chair Ries also suggested to change the agenda item to, "A Discussion of the Sunshine Law and Robert's Rules of Order" for the next meeting.</p>	<p>For information, only.</p> <p><u>Action:</u> Add to the next meeting agenda: A Discussion of the Sunshine Law and Robert's Rules of Order.</p>	<p>R. Ries, Chair</p>	<p>5/19/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
are Followed				
VI. New Business <ul style="list-style-type: none"> • Retreat Permitted Interaction Group (PIG) to Present Recommendations for Retreat Venue 	Retreat PIG presented two (2) quotes for the retreat venue. <ol style="list-style-type: none"> 1. Pomaka'i Ballroom (Dole Cannery) cost for venue including parking, food, audio/visual, and microphones is \$2,400. 2. Moana Grand Ballroom cost for venue is \$1,884.00 includes parking. \$200 fee for audio and microphones does not include assemble of equipment. E. Lau-James will send the price quotes for the venues to staff to send to Council members.	For information, only.	E. Lau-James	5/19/20
VII. Island Reports	Oahu, Maui and Kauai <ul style="list-style-type: none"> • No report. Hawaii Island <ul style="list-style-type: none"> • The Hawaii Service Area Board will be meeting next week (May 26, 2020). 	For information, only.		
VIII. Announcements	None.			
IX. Future Agenda Items	<ul style="list-style-type: none"> • C. Knightsbridge reported that he invited an individual to speak at a future Council meeting because the individual needs health care insurance and does not have a social security number, therefore; he is unable to get QUEST insurance. Further, this individual is of Native Hawaiian ancestry and has renounced his U.S. citizenship. • K. Martinez responded that if Native Hawaiians have renounced their U.S. citizenship, which they have a right to do, and are now seeking medical assistance from the U.S., she does not think the Council can assist them with this issue. • Chair Ries stated that this individual can attend a Council meeting and speak as a community member to address their concerns. 	For information, only.	R. Ries, Chair	5/19/20

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> Council members to bring their specific concerns or recommendations that they would like to include in the letter that the PIG is putting together. 			
X. Adjournment	The meeting was adjourned at 11:30 a.m.	For information, only.		
Electronic Mail Outs	<ul style="list-style-type: none"> State Council on Mental Health – May 19, 2020 Agenda State Council on Mental Health – March 10, 2020 Minutes (DRAFT) State Council Attendance Log 2020 	For information, only.		

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
June 9, 2020
9:00 a.m. – 11:30 a.m.

Members Present: **Crozier, Charleen “Naomi”; Crum, Louise; Knightsbridge, Christopher; Lau-James, Eileen; Lino, Timothy; Martinez, Beatrice “Kauai”; Matayoshi, Carol; Nagao, Lani; Reed, Tara; Ries, Richard; Vorsino, Marie**

Members Absent: **Macias, Alexandra**

Members Excused: **Dang, Cynthia “Cindi”; Jackson, Arwyn; Pascual-Kestner, Rusnell; Shimabukuro, Scott; Souza, Chiree**

Guests Present: **La’akea; Brian Talisayan; Steve Brittain**

Staff Present: **Clarke, Judith; Cooper, Rei; Haituka, Stacy; Hiraga-Nuccio, Madeleine; Keane, Gregory “Greg”; Nazareno, Jocelyn; Sutton; Yara; Tom, Kathleen “Trina”**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 9:00 a.m.</p> <p>Members and guests introduced themselves.</p> <p>Quorum was established.</p> <p>R. Ries welcomed T. Reed to the SCMH. T. Reed is the Maui Service Area Board representative on the Council.</p> <p>R. Ries acknowledged the following SCMH members whose terms will end on June 30, 2020:</p> <ul style="list-style-type: none"> • Louise Crum • Arwyn Jackson • Marie Vorsino 	For information only.	R. Ries, Chair	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	Council members shared their farewell messages to these members for their years of service on the Council.			
II. Consideration and Approval of Review Minutes <ul style="list-style-type: none"> • May 19, 2020 	The minutes for the May 19, 2020 draft minutes were reviewed. The minutes were amended as follows: <ul style="list-style-type: none"> • Change the title of the May meeting from “Kinau Hale Conference Room, 1st Floor” (on page 1) to “Virtual Meeting via Zoom” E. Lau-James made a motion for the minutes from the May 19, 2020 meeting be approved with amendments. C. Knightsbridge seconded the motion.	Amend the meeting minutes as noted. Ayes (9); Noes (0); Abstentions (1). Motion was passed.	S. Haituka	6/9/20
III. Community Input	No community input was received.			
IV. Old Business <ul style="list-style-type: none"> • Focused Ideas for the Advocacy/Website/Social Media Permitted Interaction Group (PIG) 	The following updates for the PIG on Advocacy/Website/Social Media was provided by C. Knightsbridge. <ul style="list-style-type: none"> • This PIG has questions about the website such as: <ul style="list-style-type: none"> ○ Website management for changes and updates ○ Consideration for outsourcing the maintenance of the website or having the website managed by Council members. • He would like this PIG to identify options for website improvements and to draft a procedure for website maintenance. The Council discussed priorities for the Council’s website maintenance and identified the following suggestions: <ul style="list-style-type: none"> • Add information about Council guidelines • State the goals for the website 	For information only. Members of this PIG will review suggestions and provide an update at the next meeting.	Members of this PIG	7/14/20

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> • Ask AMHD staff for assistance and clarification about website procedures • Include information about the Crisis Line of Hawaii on the website • Discuss a strategic plan for the next agenda item <p>S. Haituka stated that her role is to assist the Council with their activities. She will serve as a conduit for all PIGs including requests, follow up items, and activities. She suggested that Council members and the public view the Council website within the next two weeks and send suggestions or feedback about the website to her. She will collate the comments and will forward it to this PIG.</p> <p>M. Vorsino made a motion to have this PIG identify the strengths and weakness of the website using a Strengths, Opportunities, Weaknesses and Threats (SWOT) analysis and to share the results at a future meeting. C. Matayoshi seconded the motion.</p> <p>PIG membership was discussed. Members of this PIG as of the May 19, 2020 meeting are: C. Dang, C. Knightsbridge, and R. Ries.</p> <p>Other Council members were strongly encouraged to join this PIG if interested in website, social media and advocacy topics.</p> <p>T. Reed stated her interest in joining this PIG. C. Knightsbridge made a motion to have T. Reed added as a member of this PIG. C. Matayoshi seconded the motion.</p> <p>C. Matayoshi expressed her interest to join this PIG. N. Crozier made a motion to have C. Matayoshi added as a member of this PIG. M. Vorsino seconded the motion.</p>	<p>Any suggestions for website changes may be submitted to Stacy/AMHD.</p> <p>Motion passed unanimously.</p> <p>Motion passed unanimously.</p> <p>Motion passed unanimously.</p> <p>Members of this PIG as of today's meeting are: C. Knightsbridge, C. Dang,</p>	<p>S. Haituka</p> <p>Members of this PIG</p>	<p>7/7/20</p> <p>7/14/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> Sunshine Law and Robert's 	<p>Health Systems, HI Psychological Association.</p> <p>Based on the Council's discussion about HB2680, C. Matayoshi motioned for the Council to write a letter to E. Mersereau expressing the Council's support of HB2680. E. Lau-James seconded.</p> <p>C. Knightsbridge made a motion to have this PIG revisit this bill again after the Council has received adequate information on HB2680 and for Council to revote at the next meeting. M. Vorsino seconded.</p> <p>PIG membership was discussed. Members of this PIG as of the May 19, 2020 meeting are: C. Dang, A. Jackson, C. Knightsbridge, E. Lau-James, and R. Ries.</p> <p>C. Matayoshi made a motion to dissolve the current PIG on Legislation because several current members are leaving the Council due to their term ending. L. Nagao and M. Vorsino seconded the motion.</p> <p>Council members were strongly encouraged to join the new legislative PIG if interested in legislative topics.</p> <p>C. Knightsbridge made a motion to create a new PIG on Legislation. L. Nagao seconded.</p> <p>This agenda item was not discussed.</p>	<p>Ayes (5); Noes (4); Abstentions (2) Motion was not passed.</p> <p>Motion passed unanimously.</p> <p>Motion passed unanimously.</p> <p>Motion passed unanimously.</p> <p>Members of this PIG as of today's meeting are: C. Knightsbridge, E. Lau-James, T. Reed, and R. Ries</p> <p>Add to the July 2020 meeting agenda</p>	<p>S. Haituka</p>	<p>7/7/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<p>Rules of Order</p> <ul style="list-style-type: none"> Response from the PIG on the Letter to DOH Deputy Director of Behavioral Health Administration Regarding the Impact of COVID-19 on Recipients of Mental Health Services 	<p>The following updates for the PIG on the letter to the DOH Deputy Director of Behavioral Health Administration regarding the impact of COVID-19 on recipients of mental health services was provided by R. Ries.</p> <ul style="list-style-type: none"> Mental health screening in conjunction with the state's COVID-19 screening should be considered. <p>For example, the Hawaii Psychological Association is offering free psychotherapy for those who have lost health insurance due to COVID-19.</p> <p>Communicating this recommendation to the Behavioral Health Administration (BHA) is important.</p> <ul style="list-style-type: none"> The letter could include other mental health issues related to the COVID-19 pandemic. <p>The Council discussed priorities for the Council's letter to the Deputy Director of BHA regarding COVID-19 and mental health services and identified the following suggestions:</p> <ul style="list-style-type: none"> C. Knightsbridge suggested having information on financial services and resources translated and printed in different languages. <p>PIG membership was discussed. Members of this PIG as of the May 19, 2020 meeting are: C. Knightsbridge, E. Lau-James, A. Macias, C. Matayoshi, and R. Ries.</p>	<p>Members of this PIG will review suggestions and provide an update at the next meeting.</p> <p>Members of this PIG as of today's meeting have not changed.</p>	<p>Members of this PIG</p>	<p>7/14/20</p>
<p>V. New Business</p> <ul style="list-style-type: none"> PIG on the SCMH Retreat: Reconsideration of Plans for the 	<p>The following updates for the PIG on the SCMH Retreat was provided by E. Lau-James.</p> <ul style="list-style-type: none"> Quotes were requested from three vendors for a venue to host the State Council Retreat. One vendor responded. 			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	R. Ries stated if a member took a break, upon their return he would summarize discussion that occurred while they were on break.			
VI. New Business <ul style="list-style-type: none"> • Discuss the Differences Between PIGs and Committees 	This agenda item was not discussed.	Add to the July 2020 meeting agenda	S. Haituka	7/7/20
VII. Island Reports	<p>Maui Service Area Board (MSAB) report was provided by T. Reed.</p> <ul style="list-style-type: none"> • The MSAB filled their vacant positions and has been able to reach quorum at their meetings. • MSAB sent a letter to Maui Memorial regarding an Adult/Adolescent Center, but its been placed on hold due to COVID-19. • Two issues that MSAB is aware of involve the proper disposal of needles and the exchanging of dirty needles for clean needles. • An Adolescent Unit is not being re-established on Maui • Alternate Prom was cancelled. • Maui Community Health Center is doing telehealth and so far, it is going well. • Youth Suicide and Bullying training is being conducted through the DOE with staff and students receiving training. <p>Hawaii Island Service Area Board (HSAB) report was not provided.</p> <p>***NOTE: C. Matayoshi left the meeting at 11:30 a.m.***</p> <p>Kauai Service Area Board (KSAB) report was provided by L. Nagao.</p> <ul style="list-style-type: none"> • The KSAB discussed services and challenges in light of COVID-19. • Teleconferencing is available for clients receiving services 	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>from the Child Adolescent Mental Health Division (CAMHD) Family Guidance Center and through the Adult Mental Health Division (AMHD).</p> <ul style="list-style-type: none"> • Many agencies are providing mental health services but there has been a drop in services due to COVID-19. For example, it has been a challenge to provide outreach to clients who are houseless and don't have smart devices. • Agencies are looking for funding to provide smart devices. <p>Oahu Service Area Board (OSAB) report was not provided.</p>			
VIII. Announcements	<p>The following announcement was shared:</p> <ul style="list-style-type: none"> • L. Nagao announced that the Kauai Adolescent Treatment and Healing Center was repurposed for DOH COVID-19 response activities but will be redesigned in the future to be a teen court hub for services. • M. Hiraga-Nuccio confirmed there is no shortage of personal protective equipment (PPE) on Kauai. 			
IX. Future Agenda Items	<p>The following agenda items were identified as potential agenda items for the July 14, 2020 meeting:</p> <ul style="list-style-type: none"> • Sunshine Law and Robert's Rules of Order • Differences between PIGs and Committees • Behavioral Health and Homeless Statewide Unified Response Group (BHHSURG) and HI CARES Presentation 	For information, only.		
X. Adjournment	The meeting was adjourned at 11:45 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMh members and individuals on the SCMh e-mail distribution list:</p> <ul style="list-style-type: none"> • State Council on Mental Health – June 9, 2020 Agenda • State Council on Mental Health – May 19, 2020 Meeting Minutes (DRAFT) • State Council Attendance Log 2020 	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> Handout - Differences Between Permitted Interaction Group and Committees 			

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
July 14, 2020
9:00 a.m. – 11:30 a.m.

Members Present: **Dang, Cynthia “Cindi”; Fujii, John; Ilyavi, Heidi; Knightsbridge, Christopher; Lau-James, Eileen; Martinez, Beatrice “Kau’i”; Macias, Alexandra; Matayoshi, Carol; Pascual-Kestner, Rusnell; Reed, Tara; Ries, Richard; Shimabukuro, Scott**

Members Absent: **Crozier, Charleen “Naomi”;**

Members Excused: **Lino, Timothy; Nagao, Lani**

Guests Present: **Beninato, Antonino; Boyer, Katherine; Orimoto, Trina**

DOH Staff Present: **Cooper, Rei; Haitsuka, Stacy; Hiraga-Nuccio, Madeleine; Keane, Gregory “Greg”; Nazareno, Jocelyn**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 9:01 a.m.</p> <p>Members and guests introduced themselves.</p> <p>Quorum was not established at 9:05 a.m. Therefore, the meeting continued as an information only meeting.</p> <p>R. Ries welcomed two new SCMH members whose terms both started on July 1, 2020 and will end on June 30, 2023.</p> <ul style="list-style-type: none"> • John Fujii – Dually representing Medicaid and the Hawaii Advisory Committee on Drug Abuse and Controlled Substances (HACDACS). • Heidi Ilyavi – Representing parents of youths receiving (or previously received) support for emotional and behavioral development (SEBD). 	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>Quorum was not established at 9:11 a.m. Therefore, the meeting continued as an information only meeting.</p>			
<p>II. Meeting Announcements</p>	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally interject during the meeting to get his attention. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who need to take a break and step away from the meeting, please notify him before leaving as the Council needs to keep track of when Council members leave and return to verify quorum. • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. • If you are not speaking in the meeting, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear the person speaking. 	<p>For information only.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
III. Consideration and Approval of Review Minutes <ul style="list-style-type: none"> June 9, 2020 	<p>The draft minutes for the June 9, 2020 meeting were reviewed.</p> <p>The minutes were amended as follows:</p> <ul style="list-style-type: none"> Attendance: Move Scott Shimabukuro from Members Absent to Members Excused. Old Business, page 3: Spell out SWOT which stands for Strengths, Weaknesses, Opportunities, and Threats Old Business, page 5: Change “form” to from New Business, page 7: Change “form” to from Island Reports, page 8, MSAB: Change “Maui Community College (MCC)” to Maui Memorial Island Reports, page 9: MSAB: add “not” to adolescent unit and change “bulling” to bullying <p>Quorum was established at 9:14 a.m.</p> <p>T. Reed made a motion for the minutes from the June 9, 2020 meeting be approved with amendments. E. Lau-James seconded the motion.</p>	<p>Amend the meeting minutes as noted.</p> <p>Motion passed unanimously.</p>	S. Haitsuka	7/24/20
IV. Community Input	No community input was received.			
V. Permitted Interaction Group (PIG) Reports	<p>R. Ries explained that in this section of the agenda, PIG members may briefly summarize the PIG activities since the last Council meeting including discussion, actions and recommendations on topics approved by the Council.</p> <p>He asked that oral summaries be brief and if PIG members would like to share a longer report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p><u>PIG for the Letter to the DOH Deputy Director of Behavioral Health Administration (DD BHA) Regarding the Impact of COVID-19 on Recipients of Mental Health Services</u></p> <p>The following updates were provided by R. Ries.</p>	<p>Members of this PIG are: C. Knightsbridge, E. Lau-James, T. Reed, and R. Ries</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> • PIG members met via Zoom on June 25, 2020. • A letter is being drafted in Google Docs with recommended content including a broad response from the Council about COVID-19 and mental health related issues. • Suggested content includes the following topics: <ul style="list-style-type: none"> ○ Transmission of COVID-19; ○ Anxiety of public health providers; ○ Behavioral health leadership’s role and Council members as advocates; ○ Highlight the need to address substance abuse, multi-language services/communication, housing/homelessness, education/schools; and ○ COVID-19 screening questions with a mental health focus. • Council members who have additional suggestions for content may submit them to S. Haitsuka within the next week for PIG members to review. • A draft will be distributed for Council member feedback. • Goal for next meeting is to finalize the draft and send the final version to the DOH DD BHA. <p><u>PIG for Website, Social Media and Advocacy</u> The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> • PIG members met on June 16, 2020. Future meetings will be scheduled via Zoom with S. Haitsuka’s assistance. • An assessment of the Council website found that the website is not as bad as originally thought. • A few areas of the Council website were identified as potentially needing updates or being added as a Council website function; however, there are no recommended changes for the Council website as of right now: <ul style="list-style-type: none"> ○ Add a live link to HI CARES (formerly known as the Crisis Line of Hawaii); ○ Add section for resources; and 	<p>Submit suggested content for the letter.</p> <p>Send draft to S. Haitsuka.</p> <p>Members of this PIG are: C. Knightsbridge, C. Dang, R. Ries, T. Reed, and C. Matayoshi.</p>	<p>Council members</p> <p>Members of this PIG</p>	<p>7/21/20</p> <p>8/4/20</p>


AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> ○ Translate website content into other languages. ● Council members with additional suggestions for potential updates or additions to the Council website may submit them to S. Haitsuka within the next week for PIG members to review. ● Per eHawaii.gov, the Council website meets the accessibility criteria for the Americans with Disabilities Act (ADA) of 1990. <ul style="list-style-type: none"> ○ C. Knightsbridge commented that the Council website does not meet accessibility criteria according to a 508 accessibility test that he is familiar with. ● C. Knightsbridge likes the idea of having the Council website outsourced for maintenance. ● Please check that the “Contact Us” e-mail option is linked to the Council’s e-mail address, not a specific Council member. <p>** J. Fujii joined the meeting at approximately 9:55 a.m.**</p> <p><u>PIG for Legislation</u> The following updates were provided by E. Lau-James.</p> <ul style="list-style-type: none"> ● PIG members did not meet. ● HB2680 – Relating to Mental Health https://www.capitol.hawaii.gov/measure_indiv.aspx?billtype=HB&billnumber=2680&year=2020 <p>As currently drafted (HD2), this bill seeks to:</p> <ul style="list-style-type: none"> ● Amend the definition of “dangerous to self” and to define the terms “gravely disabled” and “psychiatric deterioration”; ● Broaden the terms of “imminently dangerous to self and others” to persons who will likely be dangerous within the next ninety days, rather than within the next forty-days; ● Increase the maximum period of emergency hospitalization from forty-eight hours to seventy-two hours. <p>The Legislative session ended on July 10, 2020.</p>	<p>Submit suggested updates or additions for the Council website.</p> <p>Verify the “Contact Us” e-mail option is linked to the Council’s e-mail address.</p> <p>Members of this PIG are: C. Knightsbridge, E. Lau-James, T. Reed, and R. Ries.</p>	<p>Council members</p> <p>S. Haitsuka</p>	<p>7/21/20</p> <p>8/5/20</p>

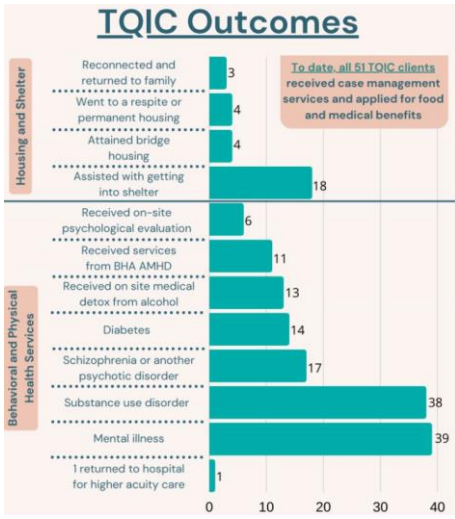
AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>This bill did not advance when the Legislature reconvened in July 2020. Therefore, there is no further PIG discussion on this bill.</p> <p><u>PIG for the SCMH Retreat</u> The following updates were provided by E. Lau-James.</p> <ul style="list-style-type: none"> • PIG members did not meet. • Likely to be a virtual retreat. • A draft agenda was previewed. • Karen Anderson Oliver, the facilitator for the previous SCMH Retreat, was contacted. She is available for the 2nd Tuesday in September pending her invoice/quote and preference for virtual meeting platform. <ul style="list-style-type: none"> ○ C. Knightsbridge suggested https://hopin.to/ as the virtual meeting platform. • PIG members will meet to discuss the virtual meeting platform, agenda and other details. <p>Council members shared the following feedback:</p> <ul style="list-style-type: none"> • C. Dang suggested a two-part retreat could be an alternative, such as a retreat held on two separate days. This may address concerns about a full 8-hour day which is a long time to sit in front of a computer. • E. Lau-James mentioned having one 8-hour retreat day followed by a second retreat day to follow up on the first day's discussion. She noted that the Council is using less money for the first day since the retreat will be virtual so there may be funds for a second retreat day. • C. Knightsbridge stated he prefers two shorter retreat days this term and an in-person retreat in the future. • S. Shimabukuro noted that his schedule and work obligations make it challenging to attend the retreat if it is scheduled for a full day. He offered that the Council may want to consider allowing members to attend parts that they are able to attend 	<p>Members of this PIG are: R. Ries, Eileen Lau-James, and C. Knightsbridge</p> <p>Members of this PIG will review suggestions and provide an update at the next meeting.</p>	<p>Members of this PIG</p>	<p>8/11/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>and not be present for other parts due to work conflicts. His preference is for 4-hour retreat which is more doable for him.</p> <ul style="list-style-type: none"> • J. Fujii expressed similar concerns about work obligations. • C. Dang suggested the Council could consider voting for either a one-day 8-hour retreat or two 4-hour retreat days. • C. Dang offered that the Council may need time to do some pre-work before the day of the retreat. • E. Lau-James noted that the facilitator will provide suggestions to the Council prior to the retreat. • R. Ries suggested if the Council agrees to have two 4-hour retreat days to consider scheduling the first day and assess the Council's needs after that first day and before scheduling the second day. • C. Dang asked for information about the facilitator's experience with virtual retreats and asked for the facilitator to provide input on how the Council might accomplish its goals in a 4-hour retreat. • E. Lau-James suggested the first 4-hour retreat day could be the 2nd Tuesday in September and the second 4-hour retreat day could be the 2nd Tuesday in October. • E. Lau-James suggested excluding a keynote speaker. <p>C. Dang made a motion to have this PIG schedule the retreat over two 4-hour days with the first day being the 2nd Tuesday in September and the second day being the 2nd Tuesday in October. E. Lau- James seconded.</p> <p>Council members with additional suggestions for the SCMH Retreat agenda or suggestions for speakers may submit them to S. Haitsuka within the next week for PIG members to review.</p>	<p>Motion passed unanimously.</p> <p>Submit suggested agenda items and speakers.</p>	<p>Council members</p>	<p>7/21/20</p>
<p>VI. Old Business</p> <ul style="list-style-type: none"> • Sunshine Law and Robert's Rules of Order 	<p>R. Ries referred Council members to the Office of Information Practice's presentation at the March 10, 2020 Council meeting. If Council members are interested in learning more about the Sunshine Law, they</p>	<p>Provide a copy of the OIP Sunshine Law presentation to Council</p>	<p>S. Haitsuka</p>	<p>8/5/20</p>


AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> Differences Between Permitted Interaction Groups (PIGs) and Committees 	<p>may do an Internet search on this subject.</p> <p>R. Ries asked that Robert’s Rules of Order be removed from the agenda. He acknowledged that in general, input shared at Council meetings are acknowledged by the Chair. If Council members are interested in learning more about Robert’s Rules, they may do an Internet search on this subject.</p> <p>R. Ries referred Council members to the meeting handout which explains the differences between PIGs and Committees.</p> <ul style="list-style-type: none"> One advantage of a standing committee is that Council members discuss items assigned to the committee in Council meetings. In contrast, an advantage of a PIG is that Council members are nominated to work between Council meetings on items assigned to the PIG and reporting their findings and recommendations at Council meetings. <p>C. Dang added that a committee’s meetings are always open to the public. Committees are part of regularly scheduled Council meetings and can stretch discussions about items assigned to the committee over a longer period of time because discussions only occur during regularly scheduled Council meetings. In comparison, PIG meetings are held outside of regularly scheduled Council meetings where PIG members conduct research and report their findings at regularly scheduled Council meetings. An advantage to PIGs is that more Council business can be worked out.</p> <p>R. Ries confirmed that, as of today’s meeting, the Council does not have any standing committees.</p>	<p>members.</p> <p>For information only.</p>		
BREAK	<p>A break was scheduled from 10:30 a.m. to 10:40 a.m.</p> <p>In lieu of a formal break, R. Ries stated at the beginning of the meeting that members who need to take a break during the meeting should</p>	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	notify him before leaving and when they return to assure Council meeting quorum is monitored.			
<p>VII. New Business</p> <ul style="list-style-type: none"> Preview of the Behavioral Health and Homelessness Statewide Unified Response Group (BHHSURG) Website with an Update on the HI CARES Program 	<p>R. Ries introduced the following presenters who shared information about the BHHSURG, the HI CARES Program, and the ways Council members can be active in BHHSURG activities.</p> <p>Trina Orimoto, Ph.D. is a licensed clinical psychologist. She works at the DOH Child Adolescent Mental Health Division (CAMHD) in the Program Improvement and Communications Office.</p> <p>Kathryn Boyer, MPA is the Project Director for the Hawaii Coordinated Access Resource Entry System (HI CARES) Program.</p> <div data-bbox="621 764 1056 1042" data-label="Image"> </div> <p>Slide 1</p> <p>Topics covered in their presentation about the BHHSURG included:</p> <ul style="list-style-type: none"> What is the BHHSURG? BHHSURG launched on March 21, 2002 as a synchronistic partnership between three state offices – DOH’s Behavioral Health Administration (DOH/BHA), Department of Human Services’ Homeless Programs Office (DHS/HPO), and the Governor’s Coordinator on Homelessness (GCH) – as well as the counties, the University of Hawaii, and other partners. <p>Unified together, they prioritized the control of the spread of the coronavirus disease (COVID-19) in within Hawaii’s behavioral</p>	For information only.		

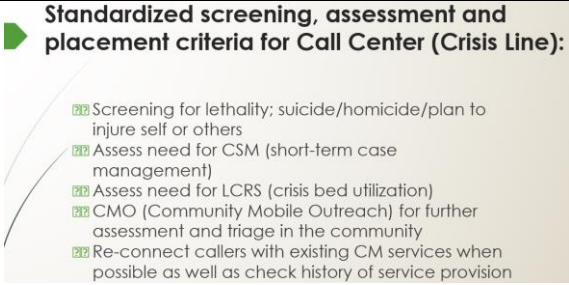
AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>health and homeless populations while ensuring continuity of coverage of essential services, including behavioral health and homeless services.</p> <ul style="list-style-type: none"> • What are the BHHSURG Subcommittees? Each committee includes subject matter experts from BHHSURG partner agencies who focus their efforts around specific committee activities. <ul style="list-style-type: none"> ○ Digital Media and Strategic Communications Coordinates press releases, social media, and internal and external communications of the BHHSURG ○ Contracts Generates and coordinates contracts specifically for BHHSURG services. ○ Analytics, Epidemiology and Evaluation Tracks and analyzed data and monitors trends to assist with oversight, evaluation and reporting of COVID-19 and BHHSURG committee related activities. ○ Logistics and Planning Oversees BHHSURG personal protective equipment (PPE) donations and distributions through public-private partnerships and Resilience Hubs. <div data-bbox="562 1052 1123 1339" style="text-align: center;"> <p>Public-Private Partnership to Secure PPE: Resilience Hubs</p>  <p>Donate Homemade & Un-Opened Store-Bought PPE at O'ahu Resilience Hubs</p> <p>MASKS FACE SHIELDS DISPOSABLE GLOVES GOGGLES</p> <p>KROC Center in Kapolei 44-1225 Kaulaia Parkway The Shops @ KROC Hours: Mon - Fri, 9:00 am - 11:00 am Phone: (808) 681-1005</p> <p>KEY Project 41-209 Waihihi Road Kalihi, HI 96744 Hours: Mon - Fri, 9:00 am - 12:00 pm Phone: (808) 235-5777</p> <p>Kalihi YMCA 1135 Kalia Street Honolulu, HI 96819 Hours: Mon - Fri, 9:00 am - 11:00 am Phone: (808) 846-2424</p> <p>• "Resilience Hubs" developed to receive PPE for essential behavioral health and homelessness service providers</p> <p>• Mahalo to: • Hawaii Community Foundation • KROC Center (Salvation Army) • KEY Project • Kalihi YMCA • BlackSand Capital</p> </div> <p>Slide 14</p> <ul style="list-style-type: none"> ○ Clinical and Operational Guidance Including oversight and coordination of the Temporary 			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>Quarantine and Isolation Center (TQIC) in Honolulu.</p> <p>The TQIC is a 26 unit facility overseen, coordinated and operated by the DOH, the HI CARES Program, previously with the Hawaii Homeless Healthcare Hui (H4) Local 5, and currently with the Hawaii Health and Harm Reduction Center (HHRC).</p> <p>Individual are referred for short-term stays at TQIC if there are awaiting the results of their COVID-19 test or if they tested positive and have no other place to stay where they can safely quarantine.</p> <p>Additional information about TQIC may be found on the BHHSURG website and by reviewing recently published information: https://health.hawaii.gov/bhhsurg/files/2020/06/TQIC-White-Paper-200528.pdf</p>  <p>The chart, titled 'TQIC Outcomes', displays two categories of results. The 'Housing and Shelter' category includes: Reconnected and returned to family (3), Went to a respite or permanent housing (4), Attained bridge housing (4), and Assisted with getting into shelter (18). The 'Behavioral and Physical Health Services' category includes: Received on-site psychological evaluation (6), Received services from BHA AMHD (11), Received on site medical detox from alcohol (13), Diabetes (14), Schizophrenia or another psychotic disorder (17), Substance use disorder (38), and Mental illness (39). A note states 'To date, all 51 TQIC clients received case management services and applied for food and medical benefits'. A final bar shows '1 returned to hospital for higher acuity care'.</p> <p>Slide 16</p>			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> • How May Council Members be Active in BHHSURG Activities? <ul style="list-style-type: none"> ○ Website http://bhhsurg.hawaii.gov/ Browse information including guidance on imporant topics for providers such as billing, administrative updates, personal protective equipment (PPE) decision tree, telehealth service decision tree and more! ○ Webinar https://health.hawaii.gov/bhhsurg/weekly-webinar/ Sign up for weekly webinars. No cost to attend! ○ Newsletter https://health.hawaii.gov/bhhsurg/news/ Subscribe to receive an electronic copy of the newsletter. ○ Ask a Question https://health.hawaii.gov/bhhsurg/submit-question/ If you don't find an answer to your question already posted to the BHHSURG website, you may submit your question (excluding protected health information (PHI) and excluding patient personnally identifiable information (PII)) and a member of the BHHSURG team will reply with a response. <p>Council members shared the following feedback:</p> <ul style="list-style-type: none"> • C. Knightsbridge asked if information on the BHHSURG website is offered in other languages? T. Orimoto stated that the BHHSURG website is currently available in English only but if there are particular resources that Council members would like to have translated, the BHHSURG Media and Strategic Communications Committee will look into translating the information. • A. Macias asked what types of housing were TQIC participants able to obtain? K. Boyer shared that some TQIC participants were referred to their existing case management agencies who assisted with housing referrals to foster homes and other appropriate residential housing options. 			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> A. Macias asked what was the average length of stay (LOS) for TQIC participants? K. Boyer shared that the average LOS for the first 51 TQIC participants was four days. A. Macias inquired about the reason for H4 not currently providing TQIC services. K. Boyer explained that H4 was an initial partner when TQIC first opened; however H4 was not contracted for TQIC services. They provided services during a limited time period and when a contract was available, H4 was not awarded. <p>The contract was awarded to HRRRC, with Heather Lusk and Dr. Christina Wang coordinating TQIC operations.</p> <div data-bbox="583 651 1050 933" style="text-align: center;">  <p>Hawai'i CARES: Implementing a Coordinated Behavioral Health Service System</p> <p>Kathryn Boyer, MPA – Director, Hawai'i CARES UH Mānoa – Myron B. Thompson School of Social Work</p> <p>Slide 1</p> </div> <p>Topics covered during their presentation about HI CARES included:</p> <ul style="list-style-type: none"> What is the HI CARES Program? The HI CARES Program is the entry point and the coordinating center for access to statewide behavioral health services for adults and adolescents. Through a universal intake process, the program offers an around-the-clock call and referral center. <p>The HI CARES Program is an initiative to help continue the continuum of care (CoC) for individuals seeking Hawaii-based behavioral health services.</p> <p>The CoC includes an array of treatment and recovery support services delivered on-demand to those who need it, when they</p>			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>need it, and where they need it. This method and approach to treatment ensures individuals continue to receive the appropriate care recommended in a coordinated, clinically appropriate and responsive manner.</p> <ul style="list-style-type: none"> • How is the HI CARES Program Funded? The HI CARES Program is a collaboration between the DOH BHA and the University of Hawaii at Manoa's Myron B. Thomson School of Social Work (UH MBTSSW). The UH MBTSSW was awarded a contract on October 1, 2019 from the DOH through the BHA Alcohol and Drug Abuse Division (ADAD) to develop, plan and implement the HI CARES Program. • Did the HI CARES Program Replace the Crisis Line of Hawaii? As of July 1, 2020, the HI CARES Program is the entity responsible for providing statewide clinical and telephonic assistance to individuals seeking Hawaii-based behavioral health services. <p>The HI CARES Clinical Team is composed of trained behavioral health staff who conduct screenings for behavioral health services, make referrals to behavioral health treatment providers, and provide clinical review and authorization for clinically appropriate care.</p> <p>The HI CARES Call Center Team is composed of trained behavioral health staff who address consumer and community needs by providing crisis support, conducting screenings for behavioral health and crisis services, making referrals to community-based mobile crisis services, and linking individuals to behavioral health case management services.</p>			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> Nomination for State Council 1st Vice Chair 	<p>  </p> <p>Slide 8</p> <ul style="list-style-type: none"> How May Council Members Contact the HI CARES Program? <ul style="list-style-type: none"> Website http://manoa.hawaii.edu/cares/ Browse information including data and reports, view job postings, and submit feedback. Telephone To reach the HI CARES Program by phone, 24 hours a day, 7 days a week, call 832-3100 on Oahu and toll free from Neighbor Islands 1 (800) 753-6879. <p>There was no Council member feedback; however, an attendee asked the following question:</p> <ul style="list-style-type: none"> M. Hiraga-Nuccio asked if the HI CARES Program provides the same services to Neighbor Islands? K. Boyer confirmed that the HI CARES Program is a statewide program and they offer clinical team and call center team services statewide. She shared that the HI CARES Program works with island-based providers to coordinate services. <p>**C. Matayoshi left the meeting around 11:15 a.m.**</p> <p>R. Ries explained that the Council currently has a vacancy for the 1st Vice Chair position. The previous 1st Vice Chair, Marie Vorsino, served in this position until her term ended on June 30, 2020.</p>			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>In general, the responsibilities of the 1st Vice Chair include, but are not limited to:</p> <ul style="list-style-type: none"> • Facilitating Council meetings in the absence of the Chair; • Performing other duties as requested by the Chair – these delegated tasks would be discussed and agreed to during Council meetings; and • Keeping time during Council meetings. <p>Nominations for State Council Vice Chair may be self-nominated or nominated by another Council member. If the Council member accepted the nomination, R. Ries asked that he/she share a brief statement about their leadership qualities and why he/she believes they would be a good Vice Chair for the Council.</p> <p>** J. Fujii left the meeting at approximately 11:19 a.m. **</p> <p>E. Lau-James nominated T. Lino. S. Shimabukuro seconded the nomination. T. Lino was not present; however, if elected, he would be asked at the next Council meeting whether he accepts the nomination and is willing to serve.</p> <p>C. Knightsbridge self-nominated but withdrew his nomination.</p> <p>A. Macias nominated C. Matayoshi. C. Knightsbridge and C. Dang seconded the nomination. C. Matayoshi was not present; however, if elected, she would be asked at the next Council meeting whether she accepts the nomination and is willing to serve.</p> <p>R. Ries nominated L. Nagao. C. Knightsbridge seconded the nomination. L. Nagao was not present; however, if elected, she would be asked at the next Council meeting whether she accepts the nomination and is willing to serve.</p>			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>C. Dang asked if the Council may vote to elect a Vice Chair today and if elected, but not present today, their election would be pending their acceptance of the nomination and confirmation of their willingness to serve.</p> <p>E. Lau-James made a motion to elect the 1st Vice Chair today and if elected, but not present today, their election would be pending their acceptance of the nomination and confirmation of their willingness to serve. C. Knightsbridge seconded the motion.</p> <p>**Quorum was verified at approximately 11:28 a.m. There were 10 Council members present.**</p> <p>The three nominees are and votes were cast as indicated:</p> <ul style="list-style-type: none"> • T. Lino Votes: None • C. Matayoshi Votes: C. Dang, C. Knightsbridge, A. Macias, K. Martinez, H. Ilyavi • L. Nagao Votes: E. Lau-James, S. Shimabukuro, R. Pascual-Kestner. R. Ries <p>Voting results indicate T. Lino (0 votes), C. Matayoshi (5 votes), and L. Nagao (4 votes). T. Reed abstained.</p> <p>R. Ries stated if C. Matayoshi declines the nomination and does not want to serve as the 1st Vice Chair, the Council will vote again at the next meeting.</p>	<p>C. Matayoshi voted as 1st Vice Chair pending her acceptance of the nomination and confirmation of her willingness to serve.</p>	<p>C. Matayoshi</p>	<p>8/11/20</p>
<p>VIII. Island Reports</p>	<p>Maui Service Area Board (MSAB) report was provided by T. Reed.</p> <ul style="list-style-type: none"> • There are technical difficulties being addressed with the telehealth kiosks in the clinics, including issues with the Internet connection. The kiosks will be in privacy cubicles. • The Suicide Task Force is losing their funding which may be redirected to COVID-19 activities. 	<p>For information only.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> • A pilot program is currently attempting to give cell phones to consumers; however, the biggest challenge is when consumers lose the phones and need funding to replace them. • The MSAB meets monthly on the 1st Monday from 2-3 p.m. <p>**K. Martinez left the meeting at approximately 11:37 a.m.**</p> <p>Hawaii Island Service Area Board (HSAB) report was not provided.</p> <p>Kauai Service Area Board (KSAB) report was not provided.</p> <p>Oahu Service Area Board (OSAB) report was provided by C. Dang.</p> <ul style="list-style-type: none"> • The OSAB meet in June with quorum. • Working on an integrated service plan with ideas generated through the development of an affinity map which will help the OSAB to focus on specific areas within behavioral health care needs in the state. • One emerging area is looking at improvements to the diversion program. • OSAB is exploring ways to have a student serve as a member of the OSAB. A youth and adolescent perspective and input about services provided by the Child and Adolescent Mental Health Division (CAMHD) from their perspective is why the OSAB is interested in strategies for recruiting a student. • The OSAB meets monthly on the 3rd Wednesday from 9-10 a.m. <p><u>Comprehensive Integrated Service Area Plans (CISAP)</u></p> <p>R. Ries expressed an interest in the Council reviewing the CISAPs which are island/County-based plans that includes information and data about current and future mental health services. With this CISAP information, the Council may then review and consider what is presented and use that information for Council discussions.</p> <p>R. Ries confirmed that the CISAP is a covered activity under the SAB</p>	For information only.	T. Reed	8/11/20

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>and State Council Bylaws. He asked each island SAB representative to obtain a copy of the most recently completed CISAP.</p> <p>**S. Shimabukuro left the meeting at approximately 11:41 a.m.** **The Council lost quorum; therefore, the meeting is now an informational meeting.**</p>	Inquire with island SAB for a copy of the most recently completed CISAP.	C. Matayoshi L. Nagao C. Dang	
VIII. Announcements	<p>The following announcement was shared:</p> <ul style="list-style-type: none"> • R. Ries mentioned that the Council is in the process of filling vacant positions for the human services and criminal justice specialty areas. If Council members are aware of any youth or parents/family members who may be interested in service as a member of the Council, please refer them to Stacy for details. <p>The next Council meeting is scheduled for Tuesday, August 11, 2020 via Zoom from 9-11:30 a.m.</p>	For information only.		
IX. Future Agenda Items	<p>The following agenda items were identified as potential agenda items for the August 11, 2020 meeting:</p> <ul style="list-style-type: none"> • 1st Vice Chair Acceptance of Nomination and Confirmation of Willingness to Serve • Comprehensive Integrated Service Area Plans (CISAP) from Island Service Area Board (SAB) Representatives 	For information, only.		
X. Adjournment	The meeting was adjourned at 11:46 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <ul style="list-style-type: none"> • State Council on Mental Health – July 14, 2020 Agenda • State Council on Mental Health – June 9, 2020 Meeting Minutes (DRAFT) • State Council Attendance Log 2020 • Handout - Differences Between Permitted Interaction Group and Committees 	For information only.		

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
August 11, 2020
9:00 a.m. – 11:30 a.m.

Members Present: **Crozier, Charleen “Naomi”;** **Dang, Cynthia “Cindi”;** **Ilyavi, Heidi;** **Lau-James, Eileen;** **Macias, Alexandra;** **Martinez, Beatrice “Kau’i”;** **Matayoshi, Carol;** **Nagao, Lan;** **Pascual-Kestner, Rusnell;** **Ries, Richard;** **Shimabukuro, Scott**

Members Absent: **Fujii, John**

Members Excused: **Knightsbridge, Christopher;** **Lino, Timothy;** **Reed, Tara**
Renee Rivera (Maui Svc Area Board); **Brian Talisayan (Mental Health America);** **and an unknown guest with the Zoom ID “Hawaii Public Policy Advocates” who did not respond to multiple chat prompts asking for the guest(s) name.**

DOH Staff Present: **Haitsuka, Stacy;** **Keane, Greg;** **Nazareno, Jocelyn;** **Tanaka, Jean**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	Chair R. Ries called the meeting to order at 9:06 a.m. Members and guests introduced themselves. Quorum was not established by 9:11 a.m. Therefore, the meeting continued as an information only meeting.	For information only.		
II. Meeting Announcements	R. Ries shared the following announcements: <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual 	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>Council meeting courtesies:</p> <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally interject during the meeting to get his attention. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. <ul style="list-style-type: none"> ● In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. ● For Council members who need to take a break and step away from the meeting, please notify him before leaving as the Council needs to keep track of when Council members leave and return to verify quorum. ● If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. ● If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear the person speaking. <p>Today’s agenda includes a format change with reports from Council members for their respective Council representation areas.</p>			
<p>III. Consideration and Approval of Review Minutes</p> <ul style="list-style-type: none"> ● July 14, 2020 	<p>The draft minutes for the July 14, 2020 meeting were reviewed.</p>			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>There were no amendments.</p> <p>Quorum was established at 9:15 a.m.</p> <p>E. Lau-James made a motion for the minutes from the August 11, 2020 meeting be approved. C. Matayoshi seconded the motion.</p>	<p>Finalize minutes as drafted.</p> <p>Motion passed unanimously.</p>	S. Haitzuka	8/31/20
IV. Community Input	[No community input was received.]			
<p>V. New Business</p> <ul style="list-style-type: none"> • 1st Vice Chair Acceptance of Nomination and Confirmation of Willingness to Serve • Letter of Support for the Mental Health Block Grant 	<p>R. Ries asked C. Matayoshi if she was willing to serve as the 1st Vice Chair of the Council. Official duties of the 1st Vice Chair are shared in the Council Bylaws.</p> <p>C. Matayoshi confirmed her willingness to serve as 1st Vice Chair.</p> <p>Council members support having Neighbor Island representation on the Council’s leadership team. Council members expressed their appreciation to C. Matayoshi, a Hawaii Island resident, for her willingness to serve as 1st Vice Chair.</p> <p>R. Ries referred members to the draft Council letter and related handouts. Each year, the Council reviews the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant information and writes a letter to SAMHSA acknowledging its review and sharing any comments.</p> <p>This year, the Council is being asked to review the proposed block grant spending for Fiscal Year (FY) 2021.</p> <p>One handout describes the direct and indirect services covered under the mental health block grant.</p>			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>The handout that did not have any green shading identifies the block grant categories, the Adult Mental Health Division (AMHD) contracted provider who provides the service, and how much funds are proposed. This handout only shows AMHD’s proposal for block grant funding.</p> <p>The third handout with the green shading identifies the total spending for both the AMHD and the Child and Adolescent Mental Health Division (CAMHD) by type of activity (direct or indirect service). Estimated combined funding from the Block Grant, Medicaid and other federal funds and state funds are noted on this handout.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • This is the second half of the Block Grant year. • Last year the Council sent a letter of support. • C. Dang noted in the past, Council members volunteered to read the Block Grant information and share feedback based on their areas of representation or knowledge. • H. Ilyavi stated she supports approving the draft letter now with the Council scheduling a future presentation about the mental health block grant. <p>J. Tanaka, AMHD Planning Specialist, joined today’s meeting to address any questions from Council members. She noted that the maintenance of effort process includes SAMHSA allowing Hawaii to request a waiver for funding. She can review the process more thoroughly when she returns to present about the Block Grant at a future Council meeting.</p> <p>C. Matayoshi made a motion to approve the letter with non-substantive technical edits. H. Ilyavi seconded the motion.</p>	<p>Ayes (9); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p>		

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	A. Macias left the meeting at approximately 9:36 a.m.			
<p>VI. Permitted Interaction Group (PIG) Reports</p> <ul style="list-style-type: none"> PIG for the Letter to the DOH Deputy Director of Behavioral Health Administration (DD BHA) Regarding the Impact of COVID-19 on Recipients of Mental Health Services 	<p>R. Ries explained that in this section of the agenda, PIG members may briefly summarize the PIG activities since the last Council meeting including meeting dates, discussions, and recommendations on topics approved at previous Council meetings.</p> <p>He asked that oral summaries be brief and if PIG members would like to share a longer report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by R. Ries.</p> <ul style="list-style-type: none"> This letter leverages the Council’s advisory capacity with interface with the DOH through our advocacy and recommending actions that strengthen our state’s mental health system. PIG members revised the previous draft letter with input from Council members at the last meeting. This letter also represents the “new” Council/new term and is our voice for stakeholders about the following topics related to the impact of COVID-19 on recipients of mental health services. <ul style="list-style-type: none"> Leadership Testing, Contact Tracing and Tracking Helping Residents in Crisis Caring for Residents with Substance Use Disorders and Populations without Housing Caring for Individuals Involved with Domestic Violence Accessibility, Language Barriers and Cultural Considerations <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> C. Dang suggested adding bullet points within each section and each PIG member could take a section to work on which is how the initial draft was done. 	<p>Members of this PIG are: A. Macias, C. Knightsbridge, E. Lau-James, R. Ries, C. Matayoshi</p>		

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<ul style="list-style-type: none"> • PIG for Website, Social Media, and Advocacy • PIG for Legislation 	<ul style="list-style-type: none"> • E. Lau-James suggested adding bullet points at the end of the letter. • C. Matayoshi offered to assist with drafting the bullet points and sending them to the other PIG members for review. <p>E. Lau-James made a motion to approve the letter with the addition of bullet points. H. Ilyavi seconded the motion.</p> <p>R. Ries noted that other members of this PIG were not present to provide an update. He shared that he would like to step down from this PIG at this time.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • C. Dang and C. Matayoshi expressed support for R. Ries stepping down. <p>E. Lau-James provided an update. She noted that this PIG has not met and noted that the regular 2020 Legislative Session has ended. She would like this PIG to be dissolved at the time to allow for a short break. Prior to the 2021 Legislative Session, a new PIG can be formed. Council members shared the following comments:</p> <ul style="list-style-type: none"> • C. Dang noted that DOH does its legislative planning now. • R. Ries suggested as an alternative to dissolving this PIG, to consider leaving the PIG active, but if no report, so state. • C. Dang stated she is interested in joining this PIG. • E. Lau-James stated she joined this PIG to learn more about the legislative process with the expertise of a previous Council member. • C. Dang stated she is willing to invite legislative staff to a future Council meeting to provide an overview of the legislative process. 	<p>Ayes (9); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p> <p>Members of this PIG are: C. Knightsbridge, C. Dang, R. Ries, T. Reed, and C. Matayoshi.</p> <p>Members of this PIG are as of today's meeting are: C. Knightsbridge, E. Lau-James, T. Reed, and C. Dang</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> • PIG for the SCMH Retreat 	<p>She is willing to contact legislators for their availability.</p> <p>S. Haituka shared, as the Legislative Liaison for the AMHD, the DOH will likely not be ramping up any legislative activities until later this year. The soonest the Council could expect to receive a DOH legislative update would be in December.</p> <p>E. Lau-James made a motion for C. Dang to join this PIG. N. Crozier and C. Matayoshi seconded the motion.</p> <p>The following updates were provided by E. Lau-James.</p> <ul style="list-style-type: none"> • There is a six (6) week paperwork processing time; therefore, the current Retreat dates are pushed to October/November. • Hopefully the paperwork will get processed in time for October. • The facilitator provided her background information with her experience as a virtual meeting facilitator as requested at last month's meeting. E. Lau-James read the facilitator's bio statement so all Council members could learn more about her. • Facilitator recommended that attendees complete pre-work ahead of Part I of the retreat and give more work that can be done between Part I and Part II. • A draft agenda was shared as a handout and reviewed. If the facilitator recommends changes to the agenda, she will let everyone know. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • C. Dang thanks E. Lau-James for sharing about the facilitator's background and experience with virtual meetings. • R. Ries suggested to save time, forego a guest speaker for Part I of the retreat but possibly consider a guest speaker for Part II of the 	<p>Ayes (9); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p> <p>Members of this PIG are: Eileen Lau-James and C. Knightsbridge</p>		

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	<p>retreat, such as Lt. Governor Josh Green.</p> <ul style="list-style-type: none"> • C. Dang thought that 30 minutes is a long time to speak. She suggested asking Lt. Governor Josh Green to speak for 15 minutes and asking Deputy Director Edward Mersereau to speak for 15 minutes. • E. Lau-James concurred that 15 minutes is a reasonable amount of time. • R. Ries asked for clarification on the times listed on the agenda. Usually, Council meetings start at 9:00 a.m. He is okay with a start time of either 9:00 a.m. or 10:00 a.m. • Majority of Council members requested that the agenda be revised to start at 9:00 a.m. which is their preferred start time. <p>N. Crozier made a motion to accept the retreat agenda with amendments to the time (change to 9:00 a.m.) and to add two (2) 15-minute speakers to Part II of the agenda. C. Matayoshi seconded the motion.</p>	<p>Ayes (9); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p>		
<p>VII. Island Reports</p> <ul style="list-style-type: none"> • Kauai Service Area Board (KSAB) 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective Service Area Board may briefly summarize their board meetings and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer Service Area Board report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by L. Nagao.</p> <ul style="list-style-type: none"> • There are three (3) KSAB members all of whom have ended their terms and are in the process of renewing. • There has been discussion about the absence of detox facilities on Kauai that are dedicated to substance use detox. 	<p>For information only.</p> <p>L. Nagao represents the KSAB on the SCM.</p>		

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<ul style="list-style-type: none"> • Maui Service Area Board (MSAB) • Oahu Service Area Board (OSAB) 	<ul style="list-style-type: none"> • She has over 11 years of experience working in addiction treatment with individuals who were diagnosed with a co-occurring disorders and She has learned a lot about all the systems including getting help for people who do not want help. • It's important to support families who want to get help for loved ones but also respect autonomy for individual choice. • A report provided by Wilcox hospital's Emergency Department showed an influx of young patients with alcohol poisoning and other substances over the past two (2) months. • Samuel Mahelona is looking at a future vision to implement a detox facility. • An adolescent center has been physically created on Kauai but it needs an operator. <p>No update was provided.</p> <p>The following updates were provided by C. Dang.</p> <ul style="list-style-type: none"> • The OSAB met in July with quorum. • They are working on the CISAP and have identified two emerging issues. • One emerging issue is access to mental health mobile kiosks especially in rural communities. The legislature talked about mobile vans during the 2020 Legislative Session and how these van can be used in the community on specific dates to increase access to services. • The second emerging issue is addressing mental health crises in the community. It's important to partner with the Honolulu Police Department (HPD) for officer training. 	<p>T. Reed represents the MSAB on the SCM.</p> <p>MSAB meets monthly on the 1st Monday from 2-3 p.m.</p> <p>C. Dang represents the OSAB on the SCM.</p> <p>OSAB meets monthly on the 3rd Wednesday from 9-10 a.m.</p>		

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<ul style="list-style-type: none"> Hawaii Service Area Board (HSAB) 	<ul style="list-style-type: none"> The OSAB is still looking for a school representative/youth to join the board. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> R. Ries noted that the OSAB may want to inquire with T. Lino and S. Shimabukuro regarding resources for board membership of a youth. S. Shimabukuro noted that the Crisis Intervention Team (CIT) contract was awarded. There were two CIT trainings so far. R. Ries mentioned that the Council could consider asking a representative from HPD to present at a future Council meeting. <p>The following updates were provided by C. Matayoshi.</p> <ul style="list-style-type: none"> H. Ilyavi will join the HSAB. CAMHD reported less missed appointments as a result of offering telehealth services. On August 3, 2020 Hawaii Island Clubhouses re-opened on a limited basis. The Hawaii Island District Health Office received a large shipment of personal protective equipment (PPE). The HSAB is working on the CISAP with input from stakeholders. They invited service providers, including Mental Health Kokua (MHK) and Big Island Substance Abuse Council (BISAC) to HSAB meetings to share information. <p><u>Comprehensive Integrated Service Area Plans (CISAP)</u> The Council will review CISAPs which are island/County-based plans that includes information and data about current and future mental health services. With this CISAP information, the Council may then review and consider what is presented and use that information for Council discussions.</p>	<p>C. Matayoshi represents the HSAB on the SCMH.</p> <p>HSAB meets monthly on the 4th Tuesday at 9:30 a.m.</p>		

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	<p>Reviewing the CISAP is a covered activity under the SAB and State Council Bylaws. Each island SAB representative is responsible for obtaining a copy of the most recently completed CISAP.</p>			
BREAK	<p>A break was scheduled from 10:15 a.m. to 10:25 a.m.</p> <p>However, in lieu of a formal break, R. Ries stated at the beginning of the meeting that members who need to take a break during the meeting should notify him before leaving and when they return to assure Council meeting quorum is monitored.</p>	For information only.		
<p>VIII. State Agency Representative Reports</p> <ul style="list-style-type: none"> • Department of Education (DOE) 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective state agency may briefly summarize agency data, agency information related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>T. Lino was not present to provide a report but shared information that describes ways the DOE provides behavioral health supports to students. On his behalf, S. Haitsuka shared the information.</p> <ul style="list-style-type: none"> • Speak Now HIDOE Anti-Bullying app allows reporting in real time about bullying incidents on campus. School officials receive tips (reports) which can be submitted anonymously. The app stores the user's prior tips and users can submit updates if available. • HIDOE Ho'oha'ahoe February 2020 Newsletter highlights the Office of Student Support Services (OSSS) where T. Lino works. His supervisor, Heidi Armstrong is featured in the newsletter and the OSSS services are described in the newsletter article. • HIDOE Office of Student Support Services (OSSS) informational handout provides a more comprehensive description of the OSSS 	<p>For information only.</p> <p>T. Lino represents the DOE on the SCM.</p>		

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<ul style="list-style-type: none"> Hawaii Public Housing Authority (HPHA) 	<p>including details about crisis and suicide prevention, support for students in unstable housing, social and emotional learning (SEL), positive behavior intervention support (PBIS), and more!</p> <ul style="list-style-type: none"> HIDOE Return to Learn website is the DOE’s official statewide school reopening plan website that includes guidance and updates and an archive of previous communication. <p>The following updates were provided by K. Martinez.</p> <ul style="list-style-type: none"> The Hawaii Public Housing Authority (HPHA) is committed to promoting adequate and affordable housing, economic opportunity, and a suitable living environment, for low-income families and individuals, free from discrimination. Of the 3,300 public housing authorities (PHAs) nationwide, the HPHA is one of the top 20 largest PHAs and one of only three PHAs statewide. Eligibility for federal public housing includes, in part: <ul style="list-style-type: none"> Meeting U.S. Citizenship or eligible immigrant status. Must be 18 years old or older, single, or a family of two or more individuals who intend to live together as a family unit and whose income and resources are available to meet their needs. Income is within limits set forth by the U.S. Housing and Urban Development (HUD) office. Yearly gross income means \$99K (median family income); \$96,400 (low income; 80% for a family of 4); or \$60,250 (very low income; 50% for a family of 4). Eligibility for state public housing, includes, in part: <ul style="list-style-type: none"> Meeting State of Hawaii residency criteria. Income limits of \$96,400 (low income; 70% for a family of 4); \$60,250 (very low-income; 50% for a family of 4); or \$36,150 (extremely low-income; 30% for a family of 4). Qualify as a family or elderly/disabled individual. Have no assets exceeding the applicable limit. 	<p>K. Martinez represents HPHA on the SCM.</p>		

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	<ul style="list-style-type: none"> • HPHA housing programs include: <ul style="list-style-type: none"> ○ Housing Choice Voucher Program (aka Section 8) ○ Federal and State Rental Subsidies ○ Section 8 Family Self-Sufficiency ○ State Rent Supplement Program <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • N. Crozier asked how long someone can get rent supplement? K. Martinez noted that rent supplement is only as long as state funds are available. • N. Crozier asked if the rent supplement includes Maui? K. Martinez confirmed that it is only available on Oahu. • K. Martinez added that while the public housing waitlist on Oahu is closed, the waitlist is open for all other islands. For example, there are a lot of openings on Molokai and Maui County is advertising within the County for these rent supplement funds. • N. Crozier asked where the application can be accessed. K. Martinez stated that the application is available through the HPHA website at www.hpha.hawaii.gov and if anyone has questions related to COVID-19, they can visit the HPHA COVID-19 website at www.hphaishereforyou.org. • K. Martinez shared that renters are able to pay online versus having to physically completing the transaction in person. • R. Ries asked if there is a similar housing authority within the city? K. Martinez confirmed that the city has affordable housing such as those offered through the Hawaii Housing Finance and Development Corporation (HHFDC). • K. Martinez emphasized that the foundation for eligibility is income after factors are reviewed, which then can determine the amount of rent and housing options that someone qualifies for. <p>**K. Martinez left the meeting around 10:54 a.m.** **The Council lost quorum; therefore, the meeting in now an</p>			

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<ul style="list-style-type: none"> Department of Health Child Adolescent Mental Health Division (DOH CAMHD) 	<p>informational meeting.**</p> <p>The following updates were provided by S. Shimabukuro.</p> <ul style="list-style-type: none"> CAMHD is the state’s largest Medicaid-service behavioral health agency. CAMHD provides mental health services statewide free of charge to eligible youth with severe emotional and/or behavioral challenges through an array of services including assessment, case management, and therapeutic supports in the home, community or in temporary out-of-home placements. CAMHD was recently awarded a four-year, \$11.8M system of care expansion grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The grant focuses on enhancing services to approximately 2,400 youth (ages 3-21) with serious emotional disturbance (SED) per year statewide. For example, by improving youth outcomes through strengthening the state’s data-driven decision making infrastructure; increasing coordination across child-serving agencies; improving adherence to CAMHD principles; and bolstering in-home treatments that strengthen families. <p>Grant partners include DHS Social Services and MQD Divisions, Office of Youth Services Network, EPIC Ohana, Inc., Child and Family Service, Kinai ‘Eha, UH Department of Psychology, University of Pennsylvania, Palo Alto Veterans Institute for Research, and PracticeWise, LLC.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> C. Dang asked if CAMHD has seen an increase or a decrease in the number of adolescents seeking services since March 2020. S. Shimabukuro shared that for new enrollments, CAMHD saw a large drop in April 2020 and a slow increase since then and through the summer. 	<p>S. Shimabukuro represents DOH CAMHD on the SCM.</p>		

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<ul style="list-style-type: none"> <li data-bbox="138 256 369 505">• Department of Human Services (DHS) MedQUEST (MQD) Division Medicaid Program <li data-bbox="138 548 369 797">• Department of Human Services (DHS) Division of Vocational Rehabilitation (DVR) 	<p data-bbox="405 256 699 282">No report was provided.</p> <p data-bbox="405 548 1136 574">The following updates were provided by R. Pascual-Kestner.</p> <ul style="list-style-type: none"> <li data-bbox="443 586 1241 686">• DVR provides services to persons with disabilities, whether physical or mental, deaf, or blind. DVR staff help individuals to prepare for, obtain, maintain and advance employment. <li data-bbox="443 698 1251 870">• DVR also helps students with disabilities. DVR sets aside 15% of their grant to help students prepare for pre-employment transition services which is a big national push for VR programs. While students are not VR participants, they are eligible participants and DVR recognizes them in their annual report. <li data-bbox="443 881 1272 943">• DVR is a program authorized under the Workforce Innovation and Opportunity Act (WIOA) which took effect in July of 2014. <li data-bbox="443 954 1272 1239">• DVR is one of four core (4) partners. The three (3) other core partners include: <ul style="list-style-type: none"> <li data-bbox="510 1029 1262 1091">○ Title I = WIOA; Adult, Dislocated Worker and Youth formula programs administered by the Department of Labor (DOL); <li data-bbox="510 1102 1182 1164">○ Title II = Adult Education and Literacy Act programs administered by the Department of Education (DOE) <li data-bbox="510 1175 1157 1237">○ Title III = Wagner-Peyser Act employment services administered by the DOL. <li data-bbox="443 1250 1272 1386">• Since COVID-19 stay-at-home orders began in March 2020, DVR staff have been teleworking and helping with unemployment claim filing as well as staying on top of workforce needs including watching labor market conditions. <li data-bbox="443 1398 1241 1459">• Staff received training on how to use secure and private virtual training platforms. 	<p data-bbox="1299 256 1587 354">J. Fujii represents DHS MQD Medicaid Program on the SCMH.</p> <p data-bbox="1299 548 1587 646">R. Pascual-Kestner represents DHS DVR on the SCMH.</p>		

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	<ul style="list-style-type: none"> There has been a noticeable decrease in applications compared to pre-COVID-19 applications and during COVID-19 started. DVR is lifting their waitlist of approximately 400 individuals and hopes to work with those individuals to provide DVR services. 			
<p>IX. Specialty Area Representative Reports</p> <ul style="list-style-type: none"> Hawaii Advisory Committee on Drug Abuse and Controlled Mental Health Providers 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective specialty area may briefly summarize specialty area activities related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>No report was provided.</p> <p>The following updates were provided by R. Ries.</p> <ul style="list-style-type: none"> He is a clinical psychologist. He participates with other organizations and interfaces about topics related to behavioral health. He is a member of the Hawaii Psychological Association (HPA) as a clinical representative. He is a founding member of the Hawaii Group Therapy Association (HGTA). HGTA members meet monthly. Just before COVID-19 began, he ended his last group for people who live with social anxiety. He is a member of the American Psychological Association. He is a member of the Hawaii Bereavement Network and has 	<p>For information only.</p> <p>J. Fujii represents HACDACS on the SCM.</p> <p>R. Ries represents mental health providers on the SCM.</p>		

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	<p>observed many members with behavioral health and mental health backgrounds in this network as well as therapists, psychologists, nurses and case managers as well as members who are associated with memorial arrangements and mortuary arrangements.</p> <ul style="list-style-type: none"> • He co-hosts a weekly radio show called Subliminal Peaks and he speaks live to community callers. • He is the Resiliency and Behavioral Health Subject Matter Expert on the City and Council of Honolulu’s Public Health and Medical Advisory Board. This board meets weekly to inform Mayor Caldwell about issues related to COVID-19 and public health at the city level. The group discusses ways to expand support and to preserve resources and serves as a thinktank around COVID-19 issues such as the opening and closing of parks and hiking trails and other city services. The board also shares input on contact tracing and talk about community related issues. Other group members have a background in or are working as epidemiologists, infectious disease doctors, emergency medical services, behavioral health, and other city agency representatives. • Regarding referrals during the COVID-19 pandemic, he is aware of many providers who are in private practice who have been inundated with referrals and have been overburdened. He has opened his services one hour earlier and closing an hour later to accommodate clients. He continues to get referrals weekly. • His observation is that some clients do not feel comfortable with telehealth just yet. Not providing services is not an option but at the same time telehealth is not optimal. Due to COVID-19 concerns and deciding that it is best not to provide in-person appointments to any client, he has taken on at least seven (7) clients pro bono because insurance policies and criteria for provider claims payment does not fit the client’s needs. Providing services pro bono has affected his ability to continue his 			

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<ul style="list-style-type: none"> Parents and Family Members of Mental Health Service Recipients 	<p>business.</p> <ul style="list-style-type: none"> Responding to crises has also affected his business. He has had to take emergency calls and provide crisis intervention more often after hours and during the day which sometimes requires emergent schedule changes. He assesses that there are not enough psychiatrists, advance practice nurses with prescriptive authority (APRN-Rx), and psychologists with prescriptive authority. Clients who need psychiatric services do not have many options. While he is not an advocate personally for psychologists with prescriptive authority, he does feel that more needs to be done to keep psychiatrists who want to live in Hawaii to stay in Hawaii. <p>The following updates were provided by H. Ilyavi.</p> <ul style="list-style-type: none"> She works with parents who have youth/adolescents who receive services from the CAMHD. They are very concerned about how COVID-19 is affecting their child's school situation. For example, a concern is how their child's Individual Service Plan (ISP), 504 plans, and special education (SPED) services will be accommodated by the schools. The schools are busy creating schedules to open the schools. Another big issue for parents is how do they get support for their child at home. For example, having enough devices, reliable Internet service, quiet space, keeping the child focused with learning on a computer when the child has behavioral issues or attention deficit issues. When parents go back to work, how will school at home get worked out. Parents are not particularly fond of being teachers in the home. Lots of uncertainty and fear about their jobs, sending their child to school and COVID-19 exposure risk. There are concerns about socialization and tactile exposure for children who need engagement in the school setting and need to be able to touch 	<p>H. Ilyavi, E. Lau-James and A. Macias represent parents and family members of mental health service recipients on the SCMH.</p>		

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	<p>and feel things to learn.</p> <ul style="list-style-type: none"> There is a lack of services right now. All services she knows about are currently wait listed including MST, in home therapy, TFH homes, and Just Coffee, and programs funded by CAMHD. Parents who were excited to hear from their child's care coordinator about new services were disappointed to learn that the services were cut are being shifted back to the former program. There seems to not be enough resources. Parents are struggling. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> S. Shimabukuro shared the website www.pandemic-parent.org as a resource. <p>The following updates were provided by E. Lau-James.</p> <ul style="list-style-type: none"> She is a wife of someone diagnosed with schizoaffective disorder. She is a veterinarian by trade and recently opened A Feline Experience in Kapahulu. She recently started a Facebook page and group called Hawaii Advocates for Serious Mental Illness (SMI). It's a group for family members of someone who lives with SMI because, even though you don't have the illness yourself, it's very difficult to find support in the community. It can be a very isolating experience to be a family member in this situation and the experience can be very similar to domestic violence situations. There is a lot of shame and stigma associated with both situations and guilt associated with seeking resources. Sometimes there are legal ramifications to consider. It can be very difficult to find resources on island for family members. When she needed help as a family member, she reached out to the crisis line but services for family members is limited. Family members are told to call 911. She had to call 911 twelve (12) times before she was able to get her husband into treatment. The only other resource she had was to press charges and/or get a 			

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<ul style="list-style-type: none"> Consumer Advocates 	<p>restraining order. Both options feel like you're giving up on your family member.</p> <ul style="list-style-type: none"> There are a lack of psychiatric inpatient beds. The wait time to get an appointment with a psychiatrist was three months out. Crisis situations are a main topic of concern for the public. With mass shootings, the Diamond Head shooting, there are limited options for family members to assist their loved one to get treatment. The law sets the bar so high for "imminent threat" that it is extremely difficult to get help for your loved one. Basically, someone must be actively murdering someone or actively committing suicide in order for the police to step in and help. Early treatment is key but when the laws are so prohibitive that it takes a crisis to get your loved one 48 hours of minimal treatment, obviously there's a lot of improvement that can happen. She is attempting to reach out to more local mental health groups to provide the Council with a broader perspective of the pulse of family members of consumers. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> R. Ries acknowledges that the Council may have a role in trying to get police officers better situated to address mental health crises. R. Ries agreed that having to wait three months to see a psychiatrist is definitely an issue that needs to be addressed. <p>A. Macias was not present to share an update.</p> <p>The following updates were provided by N. Crozier.</p> <ul style="list-style-type: none"> She has worked at Mental Health Kokua for 10 years. She is a Hawaii Certified Peer Specialist and a Hawaii Certified Benefits Planner. She uses her certifications, knowledge and skills to assist consumers with getting back to work and 	<p>N. Crozier, C. Knightsbridge and T. Reed are consumer advocates on the SCMH.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>obtaining benefits and entitlements.</p> <ul style="list-style-type: none"> • Her husband passed away at the age of 38 from Crones Disease. After he passed, she experienced addiction for about a year before seeking treatment for her addiction problem. • In her post-addiction recovery, she worked at Aloha House before joining Mental Health Kokua. • At Mental Health Kokua, she was previously a case manager working with consumers and landlords for housing referrals and placements. She provided support to consumers and helped them to understand how to live in a rental unit and how to be a good tenant. Her current position at Mental Health Kokua is Supported Housing Case Manager. • She observes that Maui has a lot of homeless individuals sheltering in place but public restrooms are closed. As a result, they are forced to defecate on sidewalks, plant/grass areas and trash cans. • COVID-19 has made it more challenging to interface with consumers. • Maui does need more behavioral health services. Housing is so important! There's not much inventory for individuals who can afford • She loves her work and loves helping consumers! Her way of working with consumers is to meet them where they are in their recovery. Fortunately, she has been able to get help from the community and the hospitality industry. Generous donations of towels, blankets, and toiletries have been greatly appreciated by everyone who receives them. <p>**N. Crozier left the meeting at approximately 11:27 a.m.**</p> <p>C. Knightsbridge and T. Reed were not present to share an update.</p>			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
X. Presentation/ Guest Speaker	There were no presentations or guest speakers scheduled.			
XI. Old Business	There were no old business agenda items.			
X. Closing Announcements/ Meeting Evaluation	<p>There were no closing announcements shared.</p> <p>R. Ries invited members to share their feedback about today’s meeting including what they felt was good about the meeting, constructive criticism about what could be improved, and offer suggestions for improvements.</p> <ul style="list-style-type: none"> • C. Dang shared that she felt that today’s meeting agenda format was great! She felt this meeting agenda was comprehensive and informative. She felt the meeting was like attending a team building session as far as learning and understanding better how Council members are contributing. • E. Lau-James shared that she felt the meeting format was fantastic and was so informative. She felt this was the best meeting to date. <p>The next SCMH meeting is scheduled for Tuesday, September 8, 2020 via Zoom from 9-11:30 a.m.</p>	For information only.		
IX. Future Agenda Items	R. Ries encouraged Council members to share any future presenters or new agenda items if they think of any.	For information, only.		
X. Adjournment	The meeting was adjourned at 11:31 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <p>E-mail with Handout Set 1 of 3 (total of 7 handouts)</p> <ol style="list-style-type: none"> 1. SCMH Agenda – August 11, 2020 Meeting 2. SCMH Minutes – July 11, 2020 Meeting (DRAFT) 	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> 3. SCMH Attendance Log for FY21 4. SCMH Member Orientation Binder Itemized List of Contents 5. SCMH PIG Letter to DOH Deputy Director, Behavioral Health Regarding the Impact of Services on Recipients of Mental Health Services (DRAFT) 6. SCMH PIG Retreat Facilitator Proposal 7. OIP Sunshine Law Presentation from the March 2020 SCMH Meeting <p>E-mail with Handout Set 2 of 3 (total of 6 handouts)</p> <ul style="list-style-type: none"> 8. Hawaii SAB January 2020 Meeting Minutes 9. Hawaii SAB February 2020 Meeting Minutes 10. Hawaii SAB March 2020 Meeting Minutes 11. Hawaii SAB May 2020 SCMH Member Report 12. Maui SAB June 2020 Meeting Minutes 13. Oahu SAB February 2020 Meeting Minutes <p>E-mail with Handout Set 3 of 3 (total of 4 handouts)</p> <ul style="list-style-type: none"> 14. SCMH Letter of Support for the Mental Health Block Grant (DRAFT) 15. Mental Health Block Grant Categories 16. Mental Health Block Grant Activities and Expenditures 17. Mental Health Block Grant Federal Fiscal Year 2021 Allocation of Funds 			

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
September 8, 2020
9:00 a.m. – 11:30 a.m.

- Members Present: **Dang, Cynthia “Cindi”;** **Ilyavi, Heidi;** **Knightsbridge, Christopher;** **Lau-James, Eileen;** **Matayoshi, Carol;** **Nagao, Lani;** **Pascual-Kestner, Rusnell;** **Reed, Tara;** **Ries, Richard**
- Members Absent: **Fujii, John**
- Members Excused: **Crozier, Charleen “Naomi”;** **Martinez, Beatrice “Kau’i”;** **Shimabukuro, Scott**
- Guests Present: **Fujisaki, Riley;** **Talisayan, Brian (Mental Health America);**
- DOH Staff Present: **Haitsuka, Stacy;** **Hiraga-Nuccio, Madeleine;** **Keane, Gregory “Greg”;** **Nazareno, Jocelyn**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	Chair R. Ries called the meeting to order at 9:01 a.m. Members and guests introduced themselves. Quorum was not established by 9:06 a.m. Therefore, the meeting continued as an information only meeting.	For information only.		
II. Meeting Announcements	R. Ries shared the following announcements: <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the 	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>meeting to him.</p> <ul style="list-style-type: none"> ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally interject during the meeting to get his attention. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. <ul style="list-style-type: none"> ● In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. ● For Council members who need to take a break and step away from the meeting, please notify him before leaving as the Council needs to keep track of when Council members leave and return to verify quorum. ● If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. ● If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear the person speaking. 			
<p>III. Consideration and Approval of Review Minutes</p> <ul style="list-style-type: none"> ● August 11, 2020 	<p>The draft minutes for the August 11, 2020 meeting were reviewed. There were no amendments.</p> <p>Quorum was established at 9:23 a.m.</p> <p>C. Matayoshi made a motion for the minutes from the August 11, 2020 meeting be approved. E. Lau-James seconded the motion.</p>	<p>Finalize minutes as drafted.</p> <p>Ayes (7); Noes (0); Abstentions (1)</p> <p>Motion passed.</p>	<p>S. Haituka</p>	<p>10/05/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
IV. Community Input	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p> <p>E. Lau-James shared the following feedback as a community member.</p> <ul style="list-style-type: none"> • Parents of children who are attending DOE schools via distance learning are experiencing stress during this time. She is a parent of two young children. • Parents (including those working from home) must be next to their young children for distance learning. The child cannot operate the computer, connect to the video class session and participate independently. • How stress is affecting mental health for parents when they are dealing with the stress of distance learning is a concern. <p>R. Ries commented that he empathizes with parents who are in the situation E. Lau-James shared. He related the situation to building an airplane while flying it. The ability to adapt in a pressured environment can be stressful. He hopes the school system is responsive. He thanked E. Lau-Janes and T. Reed for participating in today’s meeting while they are tending to their children and their distance learning needs.</p>			
V. New Business <ul style="list-style-type: none"> • SCMH Member Orientation Materials for Fiscal Year 2021 	<p>R. Ries asked Council members to review the handout listing the orientation materials. He explained that materials will be shared with all Council members, not just new members, as was done in previous years. Council members can anticipate electronic access to the materials in October 2020.</p> <p>He noted that there is a significant amount copying that will require staff to physically produce copies, order binders, collate the copies into binders with tabbed sections, and arrange for postage and mailing. Staff are not physically in the office every day during the week which will affect the delivery time for physical copies. With the Council’s support of electronic access, we can support “going green” and</p>			

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	<p>reducing the Council’s carbon footprint.</p> <p>If there are any additional items Council members would like to add, please contact Stacy by September 16, 2020.</p>			
<p>VI. Permitted Interaction Group (PIG) Reports</p> <ul style="list-style-type: none"> • PIG for the Letter to the DOH Deputy Director of Behavioral Health Administration (DD BHA) Regarding the Impact of COVID-19 on Recipients of Mental Health Services 	<p>This section of the agenda includes a brief summary of PIG activities since the last Council meeting including meeting dates, discussions, and recommendations on topics approved at previous Council meetings. If sharing a longer report, PIG members may e-mail it to S. Haitsuka no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by R. Ries.</p> <ul style="list-style-type: none"> • A copy of the finalized letter was shared as a handout. • The DOH Is obligated to respond to the Council’s letter. When Mr. Mersereau responds, we will share his response with the Council. • It was noted from last month’s meeting that the Council is interested in having Mr. Mersereau attend a future Council meeting either during Part II of our Council Retreat or a regular Council meeting. • At this time, is the Council supportive of dissolving this PIG at this time? <p>***L. Nagao joined the meeting at approximately 9:23 a.m.*** ***Quorum was achieved at this time.***</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • None. <p>C. Matayoshi and R. Ries made a motion to dissolve this PIG. T. Reed seconded the motion.</p>	<p>Members of this PIG are: C. Knightsbridge, E. Lau-James, T. Reed, and R. Ries</p> <p>Ayes (8); Noes (0); Abstentions (0)</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> • PIG for Website, Social Media, and Advocacy 	<p>The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> • She would like to step down from serving on this PIG. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries suggested that the PIG contact S. Haitzuka to schedule a PIG Zoom meeting to identify what areas of the website, social media and advocacy that the PIG may want to focus on. He suggested agenda items could focus on what information would PIG members find helpful and discuss whether those items are appropriate to recommend for placement on the State Council’s website. • C. Dang suggested that the PIG meet to identify its goals. R. Ries supported this PIG activity and added that the PIG could then present their goals at a future State Council meeting for consensus. • E. Lau-James asked if the State Council website could be outsourced? She suggested the PIG could include this topic as one of its goals. • R. Ries cautioned that outsourcing may have risks involved and may include some challenges. • R. Ries suggested the PIG look into the website’s design. He noted that the State Council is responsible for its website. • H. Ilyavi expressed interest in joining this PIG. • R. Pascual-Kestner expressed interest in joining this PIG. <p>C. Dang made a motion to add H. Ilyavi and R. Pascual-Kestner as members of this PIG. C. Matayoshi seconded the motion.</p>	<p>Motion passed unanimously.</p> <p>Members of this PIG are: C. Knightsbridge, C. Dang, C. Matayoshi, H. Ilyavi, and R. Pascual-Kestner</p> <p>Ayes (8); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p>		

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<ul style="list-style-type: none"> • PIG for Legislation 	<p>The following updates were provided by C. Dang.</p> <ul style="list-style-type: none"> • C. Dang shared her thoughts on scheduling a legislative training for Council members before the 2021 Legislative Session. She was thinking that the legislative training could occur before or after the Council’s Retreat. • She suggests having this training at the Council’s December meeting on 12/8/20 from approximately 9:30 a.m. – 10:00 a.m. • She approximates that the presenter may need about 30 minutes on the agenda (20 minutes to present and 10 minutes for questions). • She also thought that it would be a good idea to send questions to the presenter in advance of the training. • She anticipates DOH will provide legislative priorities related to mental health. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • Council members were generally in support of C. Dang inquiring with a legislator to provide training at the Council’s December meeting. 	<p>Members of this PIG are: C. Knightsbridge, E. Lau-James, T. Reed, and C. Dang</p>		
<ul style="list-style-type: none"> • PIG for the SCMH Retreat 	<p>The following updates were provided by E. Lau-James.</p> <ul style="list-style-type: none"> • The timeframe to process the retreat paperwork is still about six (6) weeks. • The facilitator does need to finish up with a few documents. • The retreat dates is still tentatively for October/November and the plan is to still invite Lt. Governor Josh Green to speak for 15 minutes and asking Deputy Director Edward Mersereau to speak for 15 minutes for Part II, unless the Council would like to invite them to Part I instead. • The retreat start time will be the usual Council meeting start time which is 9:00 a.m. but she is wondering if the Council meeting could start at 8:30 a.m. for a total meeting time of 4.5 hours to allow for the Council to have its formal meeting at the beginning 	<p>Members of this PIG are: Eileen Lau-James and C. Knightsbridge</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>and then have its Retreat for the rest of the time.</p> <ul style="list-style-type: none"> • She is working with the Council’s selected facilitator to coordinate the retreat agenda as well as the meeting materials and supplies. • She is also working with the facilitator for a pre-Retreat assignment. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries stated that the invitation to Lt. Governor Josh Green and Mr. Mersereau will be sent on official Council letterhead. • C. Dang asked for a copy of the retreat agenda when it is ready. • R. Ries stated that a 4.5 hour total Council meeting and Retreat timeframe is reasonable to him. • R. Ries confirmed that due to the paperwork processing timeframe, moving the Retreat to the Council’s November meeting is reasonable but the start and end times for the Council meeting and the Retreat need to be confirmed. <p>E. Lau-James made a motion to have the Council meeting start at 8:30 a.m. (instead of 9:00 a.m.) and end at 1:00 p.m. C. Matayoshi and C. Dang seconded the motion.</p>	<p>Ayes (9); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p>		
<p>VII. Island Reports</p> <ul style="list-style-type: none"> • Kauai Service Area Board 	<p>This section of the agenda includes a brief summary from Council members representing their respective Service Area Board about discussion from their board meetings and when applicable, updates on requested items identified at previous Council meetings. If sharing a longer report, PIG members may e-mail it to S. Haitsuka no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by L. Nagao.</p> <ul style="list-style-type: none"> • KSAB met with quorum at its last meeting. 	<p>For information only.</p> <p>L. Nagao represents the KSAB on the SCM.H.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<p>(KSAB)</p> <ul style="list-style-type: none"> • Maui Service Area Board (MSAB) 	<ul style="list-style-type: none"> • KSAB needs to increase its membership. Currently there are only three (3) members. • CARES Act COVID funding was distributed to community agencies for COVID/behavioral health assistance. • Teen groups and businesses are needed to assist with skatepark maintenance and repairs. • The Child and Adolescent Mental Health Division (CAMHD) Family Guidance Center has had challenges due to staff recently retiring. • There has been an increase in case collaboration as telehealth options continue to expand. • Funding for telepsychiatry through the John A. Burns School of Medicine (JABSOM) Department of Psychiatry is working well. • There were reports about Wilcox Hospital seeing an increase in emergency department visits for drug and alcohol related impairment, severe intoxication and severe alcohol use disorder. • The Hawaii CARES Program is limited to providing only referrals for Alcohol and Drug Abuse Division (ADAD) contracted providers versus all available substance use providers statewide. She is unsure if access to referrals will be expanded. <p>The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> • MSAB met last month • Biggest news is that funding was redirected away from Maui suicide prevention. • One MSAB member works for Mental Health America Hawaii and helped to continue providing informational services and training for suicide prevention and bullying. • The needle exchange program operated through Waikiki Health Center changed its hours. • Telehealth kiosks have been setup at the Maui Community Mental Health Center (CMHC) clinic in Wailuku for consumers to use for attending meetings and communicating with staff. Maui CMHC continues to work on telehealth coordination and technology challenges. 	<p>T. Reed represents the MSAB on the SCM.</p> <p>MSAB meets monthly on the 1st Monday from 2-3 p.m.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> • Oahu Service Area Board (OSAB) • Hawaii Service Area Board (HSAB) 	<p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • C. Dang asked if there is someone on Maui who can work with Oahu on telehealth? Oahu is looking at telehealth services too. T. Reed said she would e-mail the info to S. Haitzuka to share with C. Dang. <p>The following updates were provided by C. Dang.</p> <ul style="list-style-type: none"> • She did not attend last month’s meeting. • Since the meeting was moved to the Central-Leeward Oahu Community Mental Health Center (CLOTSS), this location has made this meeting more accessible. • The OSAB has had the following agenda items: Comprehensive Integrated Service Area Plan (CISAP), recruiting OSAB members, electing OSAB officers, and reviewing OSAB bylaws. • She deferred contacting schools for youth representation in the midst of the COVID-19 pandemic and with distance learning in progress. <p>The following updates were provided by C. Matayoshi.</p> <ul style="list-style-type: none"> • Dr. Hannah Preston-Pita was the presenter at the last HSAB meeting. She works at the Big Island Substance Abuse Council (BISAC). BISAC is breaking ground on a residential/detox facility that will be located at the old Hilo hospital site. • She is having trouble finding a copy of the previous CISAP. S. Haitzuka is also looking for any old copies. • HSAB continues to look at island resources and is collaborating with providers. • Funding for chronically homeless who cycle in and out of jail has been discussed. There are two initiatives – Stepping Up Initiative and Familiar Faces Initiative – are being developed. The Stepping Up Initiative focuses on reducing the number of people with mental illness in jails. The Familiar Faces Initiative is similar to a program developed by King County Jail in Seattle, Washington. The program focuses on helping individuals who have a mental 	<p>C. Dang represents the OSAB on the SCMH.</p> <p>OSAB meets monthly on the 3rd Wednesday from 9-10 a.m.</p> <p>C. Matayoshi represents the HSAB on the SCMH.</p> <p>HSAB meets monthly on the 4th Tuesday at 9:30 a.m.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>health diagnosis and/or a substance use disorder and have been booked four (4) or more times in a 12 month period. For more information about these initiatives, please visit: https://csgjusticecenter.org/states/hawaii (Stepping Up) and https://www.naco.org/sites/default/files/documents/Familiar%20Faces%20Brief.pdf (Familiar Faces)</p> <ul style="list-style-type: none"> • According to a report from Nolan Espinda, previous Public Safety Division (PSD) Director, it costs approximately \$190/jail day. • She asked if the Council is interested in writing a letter to DOH on these two initiatives. She noted that providing mental health services during this time in jail would be great. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries asked C. Matayoshi to consider asking the HSAB to write a letter including data to support their position to support the initiatives. Then, the State Council could consider their letter and consider writing a letter of support on top of the HSAB letter. • L. Nagao expressed that she feels it costs more than \$190/jail day. • C. Matayoshi shared that PSD’s annual budget was reported as \$280M which is a large sum and includes funding for correctional facilities. • L. Nagao shared that the Native Hawaiian population is over-represented in Hawaii jails. <p><u>Comprehensive Integrated Service Area Plans (CISAP)</u> The Council will review CISAPs which are island/County-based plans that includes information and data about current and future mental health services. With this CISAP information, the Council may then review and consider what is presented and use that information for Council discussions.</p>			

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	<p>Reviewing the CISAP is a covered activity under the SAB and State Council Bylaws. Each island SAB representative is responsible for obtaining a copy of the most recently completed CISAP.</p>			
<p>VIII. State Agency Representative Reports</p> <ul style="list-style-type: none"> • Hawaii Public Housing Authority (HPHA) • Department of Health Child Adolescent Mental Health Division (DOH CAMHD) • Department of Human Services (DHS) MedQUEST (MQD) Division Medicaid Program • Department of Human Services (DHS) 	<p>This section of the agenda includes a brief summary from Council members representing their respective state agencies about agency data, agency information related to behavioral health and when applicable, updates on requested items identified at previous Council meetings. If sharing a longer report, PIG members may e-mail it to S. Haitsuka no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by K. Martinez.</p> <ul style="list-style-type: none"> • No report. <p>The following updates were provided by S. Shimabukuro.</p> <ul style="list-style-type: none"> • No report. <p>The following updates were provided by J. Fujii.</p> <ul style="list-style-type: none"> • No report. <p>The following updates were provided by R. Pascual-Kestner.</p> <ul style="list-style-type: none"> • He would like to share State Council information with DVR staff including information about his role on the Council. 	<p>For information only.</p> <p>K. Martinez represents HPHA on the SCMH.</p> <p>S. Shimabukuro represents DOH CAMHD on the SCMH.</p> <p>J. Fujii represents DHS MQD Medicaid Program on the SCMH.</p> <p>R. Pascual-Kestner represents DHS DVR on the SCMH.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
Division of Vocational Rehabilitation (DVR)	<ul style="list-style-type: none"> • He is known as the “data guy” based on his experience working with DVR. • He would like to know what information he can share with his DVR leadership. • Approximately 70% of DVR participants live with a disability and are in need mental health services. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries noted that this Council is a great way to hear from other members about how their experiences and areas of specialty are affected by or are related to mental health. • R. Ries suggested that the Council member’s role could be a Retreat topic. • The Council’s voice needs to be known/heard and shared with DOH. Even if DOH doesn’t act on the Council’s recommendations, a response is required. 			
IX. Specialty Area Representative Reports <ul style="list-style-type: none"> • Hawaii Advisory Committee on Drug Abuse and Controlled • Mental Health Providers 	<p>This section of the agenda includes a brief summary from Council members representing specialty areas about activities related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings. If sharing a longer report, PIG members may e-mail it to S. Haitsuka no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by J. Fujii.</p> <ul style="list-style-type: none"> • No report. <p>The following updates were provided by R. Ries.</p> <ul style="list-style-type: none"> • He is currently working 9-11 hour workdays and is doing a lot of crisis call responses. He knows he is not the only provider who is extending their time to assist individuals who need support. 	<p>For information only.</p> <p>J. Fujii represents HACDACS on the SCM.</p> <p>R. Ries represents mental health providers on the SCM.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> • More and more telehealth insurance claims are being denied by health insurance companies. • A concern is for providers who have small office spaces. Many providers want to consider dropping services. The patients still need to access services elsewhere but, due to the type of health insurance they have, they cannot get telehealth and are only eligible for face-to-face services. • Some providers like R. Ries offer services pro bono or publico services which does hurt the providers business because they are not charging for their time or their services. • The law allows to have telehealth provided. • There is a low reimbursement rate for some health insurance plans. As a result, some providers only accept commercial health insurance plans. • He has advocated for providers accepting individuals with health insurance plans with low reimbursement rates and has considered writing a letter to the insurance commissioner regarding this insurance rate and reimbursement issue. • Regarding the COVID-19 pandemic, the # of positive cases has increased, the # of COVID related deaths continues to rise and there is an increase in the # of individuals who need support. • There has been good COVID-19 messages on Oahu but patients are confused about what to do when they test positive. Providers are doing COVID-19 related education including wearing a face covering and physically distancing from other people. • There is a rising concern about domestic violence as well as concerns for mental health, riots/civil unrest and political tension. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • L. Nagao commented that she has experienced being required to use a certain online platform to access her healthcare provider’s telehealth services. She acknowledged that the insurer is looking out for the patient’s confidentiality and protected health 			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> Parents and Family Members of Mental Health Service Recipients 	<p>information (PHI).</p> <ul style="list-style-type: none"> R. Ries shared that his experience with using online portals is good but feels that providers should not be required to use a specific online platform to provide services to their patients. L. Nagao mentioned that SB2395 during the 2016 legislative session required parity for telehealth services. In part, the bill stated that, “Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a healthcare provider and a patient.” <p>The following updates were provided by H. Ilyavi.</p> <ul style="list-style-type: none"> Young children with in-person treatment needs are struggling with online services. Parents need and want to access services for their children who need mental health support but services are all waitlisted. She is sympathetic but is looking to the Department of Education (DOE) for guidance and is trying to help these individuals by linking them with free tutoring services. There are many resources that need to be vetted, sorted by island and sorted by type of resource. She has had to use Google to search for resources. If someone is in crisis, it is not appropriate to send them a list of online resources. That would be too overwhelming. Another concern is mobilizing contact tracing. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> C. Knightsbridge noted that the Substance Abuse and Mental Health Services Administration (SAMHSA) funds mental health technology centers that provide resources and supports. For more information about SAMHSA’s Mental Health Technology Transfer Center Network, view their website at: https://mhttcnetwork.org 	<p>H. Ilyavi and E. Lau-James represent parents and family members of mental health service recipients on the SCMH.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> Consumer Advocates 	<ul style="list-style-type: none"> C. Knightsbridge shared that as a consumer and a parent of two children, he understands that working at home while the children are at home participating in their distance learning classes is difficult. And, kids need to eat too (a lot)! There is a lack of structure to help parents and parents are taking on a bigger role as an educator during this time of distance learning. C. Knightsbridge mentioned that one community resource he is familiar with is www.oneOahu.org. While every island and county is different, he feels that there should also be a website for oneHawaii.org as we are one state. R. Ries mentioned that this could be an area for the Website, Social Media and Advocacy PIG. <p>The following updates were provided by E. Lau-James.</p> <ul style="list-style-type: none"> She has two (2) young children distance learning online at home. Technology goes in and out. She is constantly listening to teachers manage large groups of children in their virtual classrooms. It is complete chaos! For parents, finding a room in their house for kids to participate in their distance learning sessions is challenging. Each child needs access to technology hardware and a space where they are not distracted. Parents like me are working from home at the same time. Her husband lives with a mental illness and with his bipolar disorder, he is also at home listening to the kids doing distance learning. She plans to attend the National Alliance for Mental Illness (NAMI) Hawaii meeting tonight and will share broader feedback about family members. <p>The following updates were provided by N. Crozier.</p> <ul style="list-style-type: none"> No report. 	<p>N. Crozier, C. Knightsbridge and T. Reed are consumer advocates on the</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> As an advocate, she feels that resources are not being given fairly. For example, she feels that resource distribution is not fairly distributed with consideration for individuals who live on a fixed income. These are individuals who do not qualify for additional resources. The cost of lunch for children who are now distance learning at home is an added expense. Transportation and other costs are also expenses that someone living on a fixed income may need help with. <p>The following updates were provided by C. Knightsbridge.</p> <ul style="list-style-type: none"> He likes the idea of having the Council website be a resource center. He doesn't want to alienate teachers and wants the Council to act by advising the DOH to lean on (apply pressure to) the DOE to increase access to resources. He feels the Council can advise about resources and how the DOH is allocating funding for those resources. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> E. Lau-James commented that Mental Health America has a resource list on their website. Their resource list can be accessed through: https://mentalhealthhawaii.org/help/ R. Ries asked how mental health service participants access the equipment they need for their educational supports? He suggested doing a survey to get input about supporting educators. L. Nagao shared that she wants the Council to look at their strengths and move forward by focusing on our strengths, lifting up and empowering each other. There is enough negativity around us. C. Dang commented that discussion is needed about what each member sees as their role and how they see the Council evolving as a resource center. 	SCMH.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> R. Ries suggested that the Council consider inviting professional mental health organizations such as NAMI Hawaii and Mental Health America Hawaii to a future Council meeting. C. Knightsbridge suggested focusing on transparency in resources and sharing simple charts with simple captions are ways the Council could highlight citizens' positivity and their strengths. 			
X. Presentation/ Guest Speaker	<p>R. Ries introduced Dr. Amy Curtis as the guest speaker.</p> <p>Dr. Amy Curtis, Adult Mental Health Division (AMHD) Administrator, shared the following updates.</p> <ul style="list-style-type: none"> The focus of work has been on COVID-19 rapid response, specifically to address isolation and quarantine. AMHD currently provides both state-operated and purchase of service (POS) contracted services including inpatient and outpatient treatment, case management, and community support services. Inpatient services are provided at the Hawaii State Hospital (HSH) and thru Sutter Health dba Kahi Mohala. She noted that any information the Council would like about the HSH can be directed to Dr. Run Heidelberg, HSH Administrator. When Mr. Mersereau became the Deputy Director for the DOH Behavioral Health Administration (BHA), he wanted to look at areas where overlap was occurring and identify system silos. Statutory mandates that require AMHD to provide services for include court examinations for fitness and when the court places an individual in the custody of the Director of Health. These individuals are justice involved and are released into the community on Conditional Release (CR), Released on Conditions (ROC), participating in mental health court or jail diversion, or are released on probation. AMHD works to reduce and prevent serious mental illness (SMI) and promotes mental health holistically statewide. 			

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	<ul style="list-style-type: none"> • AMHD services individuals who are uninsured or underinsured. • Areas where AMHD is examining include stabilization services for individuals who are returning to the community and options for detox services. • BHA is looking to be a one stop shop system where individuals can receive help from a statewide coordinated entry system. The Hawaii CARES Program merged with the Crisis Line of Hawaii. This means that all callers can receive telephonic behavioral health support from one statewide call center. This includes support for mental health, substance abuse and behavioral health services. The Hawaii CARES Program is also the entry point for the Hawaii Behavioral Health and Homelessness Statewide Unified Response Group (BHHSURG) Isolation and Quarantine (Iso/Quar) Hotel placements. • Additional Hawaii CARES Program staff have been hired to assist with COVID/CARES and it has been challenging to get services up and running in a short timeframe. • AMHD's strategic plan focuses on four (4) priority areas: <ol style="list-style-type: none"> 1. Telehealth – Using technology to provide health services including in-home treatment. Federal grant funds pay for telepsychiatry services. 2. Integration – Coordinating primary and behavioral health services in a holistic person-centered care setting. 3. Evidence-based practice – Using evidence-based practices and data driven decision making. 4. Special populations – Addressing the needs of consumers diagnosed with co-occurring substance use conditions, other chronic or physical conditions, including intellectual/developmental disabilities, and/or who are justice involved. • AMHD is also looking at staff roles and examining organizational efficiency. • HB1620 (2020 legislative session) will become law on September 15th. This bill is meant to assist with efforts to decriminalize 			

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	<p>individuals who live with mental illness. If a question about the individual's fitness is raised, and a fitness evaluation for petty misdemeanor charges is ordered, there is a pilot project with the first district court to see how the system can better determine appropriate supports for individuals who need them. The goal is to have quick evaluation turn around times and quick linkage to treatment. This bill is a step in the right direction.</p> <p>https://www.capitol.hawaii.gov/measure_indiv.aspx?billtype=HB&billnumber=1620&year=2020</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries wants the Council to be known by Dr. Curtis and vice versa. He recognized the diversity of the Council's membership. • L. Nagao shared that COVID Act CARES funding originally with the Alcohol and Drug Abuse Division (ADAD) for addiction and CARES navigation included a directory of ADAD providers versus all providers. Dr. Curtis shared that the intent is for the Hawaii CARES Program to be a one stop shop to obtain information about substance abuse, mental health and behavioral health services but she isn't speaking specifically about services that ADAD contracts for. • C. Dang asked Dr. Curtis to suggest initiatives the Council could support AMHD's goals. Dr. Curtis referred back to AMHD's strategic plan and the four (4) priority areas. She also mentioned looking at the Hawaii CARES Program. She mentioned that help is needed by thinking outside the box about ways to integrate primary care and behavioral health care services. 			
XI. Old Business	There were no old business agenda items.			
X. Closing Announcements/ Meeting Evaluation	<p>There were no closing announcements shared.</p> <p>R. Ries invited members to share their feedback about today's meeting including what they felt was good about the meeting, constructive</p>	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>criticism about what could be improved, and offer suggestions for improvements.</p> <ul style="list-style-type: none"> • R. Ries shared that this is the 2nd time the Council is using the new meeting format. He feels that it has been a positive change for the Council’s meetings and meeting discussion. • R. Ries encouraged constructive criticism about the meeting and welcomes all feedback. • T. Reed commented, “Great job today!” <p>The next SCMH meeting is scheduled for Tuesday, October 13, 2020 via Zoom from 9:00 a.m. to 11:30 a.m.</p>			
IX. Future Agenda Items	R. Ries encouraged Council members to share any future presenters or new agenda items if they think of any.	For information, only.		
X. Adjournment	The meeting was adjourned at 11:28 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <p>E-mail with Handout Set 1 of 3 (total of 5 handouts)</p> <ol style="list-style-type: none"> 1. September 2020 Meeting – Agenda 2. August 2020 Meeting – Draft Minutes 3. August 2020 Meeting – FY21 Attendance Log 4. September 2020 Meeting – New Business, SCMH Member Orientation Materials List 5. September 2020 Meeting – Closing Announcement, CDC Article <p>E-mail with Handout Set 2 of 3 (total of 7 handouts)</p> <ol style="list-style-type: none"> 6. August 2020 Meeting – New Business, Mental Health Block Grant Letter of Support (FINAL) 7. August 2020 meeting – PIG, Letter to Deputy Director Behavioral Health Administration (FINAL) 8. August 2020 Meeting – PIG, Retreat Facilitator Bio Statement 	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>9. August 2020 Meeting – PIG, Retreat Tentative Agenda</p> <p>10. August 2020 Meeting – Island Report, HSAB Familiar Faces Brief</p> <p>11. August 2020 Meeting – Island Report, HSAB Going Home HI Grant Application</p> <p>12. August 2020 Meeting – Island Report, HSAB Stepping Up Overview</p> <p>E-mail with Handout Set 3 of 3 (total of 8 handouts)</p> <p>13. August 2020 Meeting – State Agency Report, DOE Ho’o’ha’aeo February Newsletter</p> <p>14. August 2020 Meeting – State Agency Report, DOE Return to Learn School Reopening Plan</p> <p>15. August 2020 Meeting – State Agency Report, DOE Speak Now Anti-Bullying App</p> <p>16. August 2020 Meeting – State Agency Report, DOE Student Services Branch</p> <p>17. August 2020 Meeting – State Agency Report, HPHA Slides</p> <p>18. July 2020 Meeting – Presentation, BHHSURG</p> <p>19. July 2020 Meeting – Presentation, HI CARES Program</p> <p>20. HSAB – Meeting Minutes, May 2020</p>			

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
October 13, 2020
9:00 a.m. – 11:30 a.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Crozier, Charleen “Naomi”; Dang, Cynthia “Cindi”; Ilyavi, Heidi; Knightsbridge, Christopher; Koyanagi, Dina; Lau-James, Eileen; Martinez, Beatrice “Kau’i”; Matayoshi, Carol; Nagao, Lani; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Ries, Richard; Shimabukuro, Scott**

Members Absent: **Fujii, John**

Members Excused:

Guests Present: **Ulep, Aldric**

DOH Staff Present: **Haitsuka, Stacy; Keane, Gregory “Greg”; Nazareno, Jocelyn**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	Chair R. Ries called the meeting to order at 9:01 a.m. Members and guests introduced themselves. R. Ries welcomed three new SCMH members whose interim terms started on October 1, 2020 and will end on June 30, 2021. <ul style="list-style-type: none"> • Katherine Aumer – Representing family members of individuals in recovery • Antonino Beninato – Representing students as a youth advocate • Dina Koyanagi – Representing the Department of Human Services, Child Welfare Services Quorum was established by 9:07 a.m.	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
II. Meeting Announcements	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally interject during the meeting to get his attention. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who need to take a break and step away from the meeting, please notify him before leaving as the Council needs to keep track of when Council members leave and return to verify quorum. • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. • If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear the person speaking. 	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
III. Consideration and Approval of Minutes <ul style="list-style-type: none"> • September 8, 2020 	<p>The draft minutes for the September 8, 2020 meeting were reviewed.</p> <p>The minutes were amended as follows:</p> <ul style="list-style-type: none"> • Page 10, HSAB report, Bullet 4: Remove Face-to-Face Initiative; replace with Familiar Faces Initiative, a program in the King County Jail in Seattle, WA focusing on individuals with four or more arrests in a 12 month period who live with a mental illness and/ or substance use disorder (SUD). • Page 11, HSAB report, Bullet 2: Remove \$180M; replace with \$280M <p>T. Reed made a motion for the minutes from the September 8, 2020 meeting be approved as amended. C. Matayoshi seconded the motion. A. Beninato and K. Martinez abstained from approving these minutes as they were not present at the last meeting.</p>	<p>Finalize minutes as amended.</p> <p>Motion passed.</p>	<p>S. Haituka</p>	<p>10/29/20</p>
IV. Community Input	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p> <ul style="list-style-type: none"> • T. Reed shared that she is not working and is spending more time at home. She has found that it is hard to find resources. She doesn't qualify for benefits. • C. Knightsbridge added that he qualified for some benefits but it is hard to get in touch with the Unemployment Insurance Division. He is aware of Facebook groups that discuss this issue. He noted that while the Unemployment Insurance Division is overloaded with claims processing, the lengthy delay is especially impacting the mental health of claimants and their families. • R. Ries asked Council members to think about the specialty areas they represent and offer ideas for how the Council may assist. 			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
V. New Business	None			
VI. Permitted Interaction Group (PIG) Reports <ul style="list-style-type: none"> • PIG for Website, Social Media, and Advocacy 	<p>This section of the agenda includes a brief summary of PIG activities since the last Council meeting including meeting dates, discussions, and recommendations on topics approved at previous Council meetings. If sharing a longer report, PIG members may e-mail it to S. Haitsuka no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by members of this PIG.</p> <ul style="list-style-type: none"> • This PIG did not meet. • C. Knightsbridge is wondering what is the budget for the Council? He is interested in knowing whether the Council’s website can be contracted out. • C. Dang shared that she is not aware of any guidelines that exist for the website maintenance. She is interested in doing succession planning for the website and is hoping that this PIG will meet to discuss this. • C. Knightsbridge shared that he is interested in the Council advocating for a contact tracing app, similar to OneOahu.org. He sees this being heavily related to mental health and for safety. Hawaii is not a state who opted in. Only 14 states have opted in to use the contact tracing app that is available on both Android and iPhone devices. He would like the Council to write a letter to the DOH asking to opt into the contact tracing app so the public is better informed. <ul style="list-style-type: none"> ○ T. Reed requested that the meeting get back on track and asked that this topic be discussed in this PIG’s meeting. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • Regarding the Council website, <ul style="list-style-type: none"> ○ R. Ries noted that the Council website is a slower moving ship. He asked who designed the website and who is responsible for maintenance? 	<p>Members of this PIG are: C. Knightsbridge, C. Dang, C. Matayoshi, H. Ilyavi, and R. Pascual-Kestner</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> PIG for Legislation 	<ul style="list-style-type: none"> Regarding the contact tracing app, <ul style="list-style-type: none"> R. Ries mentioned that a pro for using a contact tracing app is increased communication such as how Singapore has shown in its contact tracing app use. But he also noted that there are some concerns about digital surveillance. H. Ilyavi expressed interest in learning more information, details and facts about the app and having a discussion with other members of this PIG. R. Ries noted that the Council is not designed to be quick moving. He encouraged this PIG to get together and draft a letter so it can be shared before the next meeting. Council action for this PIG: <ul style="list-style-type: none"> C. Knightsbridge volunteered to be the lead for this PIG. Initially, a motion was made by C. Knightsbridge and seconded by N. Crozier to have this PIG draft a letter strongly encouraging the Department of Health (DOH) to use the contact tracing app; after discussion, the motion was altered by C. Knightsbridge and seconded by H. Ilyavi as follows: <ul style="list-style-type: none"> Draft a letter to the DOH strongly encouraging that they explore this program (app), create an app, and consider participating in this program with 14 other states. C. Knightsbridge will draft the letter and e-mail it to S. Haitzuka and R. Ries; draft letter will be distributed to members of this PIG and will be shared in the packet of handouts for the next meeting. The following updates were provided by members of this PIG. <ul style="list-style-type: none"> This PIG did not meet. C. Knightsbridge stated that he sees Hawaii's Sunshine Law as a barrier to the Council being able to advocate in-person. T. Reed does not want to be the lead for this PIG but she is willing to continue to participate as a member of this PIG. 	<p>E-mail S. Haitzuka with suggested PIG meeting dates/times.</p> <p>Ayes (14); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p> <p>Draft letter for distribution.</p> <p>Members of this PIG are: E. Lau-James, C. Knightsbridge, T. Reed, and C. Dang</p>	<p>C. Knightsbridge</p> <p>C. Knightsbridge</p>	<p>10/20/20</p> <p>10/31/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> • C. Dang shared that one way Council members can participate is by going to the legislature’s website. Anyone can go to the Hawaii State Legislature’s website at www.capitol.hawaii.gov to establish an account where they can customize the settings for receiving hearing notices and where you can also submit testimony. • C. Dang will schedule a legislative training for the Council but there has been a delay in legislators being available due to their focus on the state’s COVID-19 response. • T. Reed clarified that as an individual, she can endorse anything she wants but as a Council members, she is representing the Maui Service Area Board (MSAB) and she needs to take information from this Council meeting back to the MSAB for their feedback. She is here on this Council as Maui’s voice. • T. Reed encouraged this PIG to schedule a time to meet. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • Regarding HB1620 (Act 026-20), R. Ries mentioned that this bill reminds him of the Familiar Faces Initiative in King County Jail in Seattle, WA. • Regarding SB2395 (Act 226-16), R. Ries noted that his experience with this type of legislation has been that billing health insurance company HMAA for telehealth as a mode of treatment results in a denied claim which are unresolved. He feels it is illegal for health insurance companies to deny telehealth claims that are directly related to treatment. • R. Ries shared that the Council needs to be ahead of the game in terms of hearing about bills before they are passed. He would like to see the Council be in a position to advise stakeholders about bills because the Council’s voice matters! • L. Nagao suggested that this PIG could be reviewing bills in real time and providing the Council with updates. • E. Lau-James mentioned that Arwyn Jackson, a previous 			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> • PIG for the SCMH Retreat 	<p>Council member, gave a presentation and showed the Hawaii State Legislature's website where the public can follow bills. She's wondering who else on the Council has expertise/knowledge of the legislative process?</p> <p>Council action for this PIG:</p> <ul style="list-style-type: none"> • C. Dang to work on scheduling legislative training for the Council's December 2020 or January 2021 meeting. • Council members may e-mail their legislative questions to S. Haitsuka and she will forward them to C. Dang. <p>The following updates were provided by E. Lau-James.</p> <ul style="list-style-type: none"> • This PIG has not met. • E. Lau-James apologized for the unintended oversight of N. Crozier not being included as a member of this PIG. She was confirmed as a member at a 2019 Council meeting. • Facilitator's paperwork has been submitted and is pending approval. • Quote is based on 18 attendees. • The draft Retreat agenda was shared as a meeting handout. • Facilitator will send final invoices but it is unclear whether she can bill for services prior to February's Retreat (Part II) or if she needs to wait for both parts of the Retreat to be completed before billing. • Pre-retreat questionnaire was distributed as a meeting handout. Responses will be collected online and will be anonymous to other Council members. S. Haitsuka will send the link after today's meeting. The deadline to submit responses is Friday, October 30, 2020. • Prior to the Retreat, the Council will have its business meeting from 8:30 a.m. to 9:00 a.m. and the Retreat will be from 9:00 a.m. to 1:00 p.m. • Facilitator provided a pre-retreat video which was shared during the Council meeting. A copy of the video file will be 	<p>Schedule training.</p> <p>Submit questions.</p> <p>Members of this PIG are: E. Lau-James, C. Knightsbridge, and N. Crozier</p>	<p>C. Dang</p> <p>Council members</p>	<p>11/10/20</p> <p>10/31/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>available for Council members to view via the Council’s online member orientation materials.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • Council members expressed they are looking forward to the Retreat and thanked S. Haitsuka for her help with coordinating the facilitator’s paperwork. • R. Ries wanted to confirm that invitations to both Lt. Governor Josh Green and DOH Deputy Director, Behavioral Health Administration, E. Mersereau were sent. S. Haitsuka stated the letters have not been sent yet. <p>Council action for this PIG:</p> <ul style="list-style-type: none"> • Send invitation letters to R. Ries for approval; then send to Lt. Governor Green and E. Mersereau. 	E-mail draft letters to R. Ries.	S. Haitsuka	10/13/20
<p>VII. Island Reports</p> <ul style="list-style-type: none"> • Kauai Service Area Board (KSAB) 	<p>This section of the agenda includes a brief summary from Council members representing their respective Service Area Board about discussion from their board meetings and when applicable, updates on requested items identified at previous Council meetings. If sharing a longer report, PIG members may e-mail it to S. Haitsuka no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by L. Nagao.</p> <ul style="list-style-type: none"> • There is a need to increase KSAB membership. • Telehealth with the John A. Burns School of Medicine (JABSOM) is being used five days per week. Initially there was a concern about participation and some apprehension about using the telehealth setup but after trying it, participants have expressed that they really like it. Both consumers and staff are getting more comfortable with using telehealth. Devices are being provided to some consumers. • Despite negative impact of COVID-19, there have been some positive activities such as telehealth for addiction treatment 	<p>For information only.</p> <p>L. Nagao represents the KSAB on the SCMH.</p> <p>KSAB meets monthly on the last Thursday from 1-3:30 p.m.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> • Maui Service Area Board (MSAB) • Oahu Service Area Board (OSAB) • Hawaii Service Area Board (HSAB) 	<p>programs and engaging with participants in virtual groups.</p> <ul style="list-style-type: none"> • It is acknowledged that there is stigma/psychological factors with driving to and attending group meetings in-person. • One KSAB member is an emergency department manager at Wilcox Memorial Hospital. They report seeing an increase in co-occurring/substance use issues with concern for overdose and severe substance abuse in younger cases. • Friendship House Clubhouse on Kauai continues to provide services on rotation throughout the COVID-19 pandemic. <p>The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> • No quorum at the last MSAB meeting; it was an info only meeting. • Telehealth kiosks at the mental health clinic are going well. • Hawaii Health and Harm Reduction Center www.hhhrc.org coordinates the needle exchange program and their report is forthcoming. <p>The following updates were provided by C. Dang.</p> <ul style="list-style-type: none"> • Due to some confusion about last month's meeting due to lost meeting minutes; there was no OSAB meeting last month. • C. Dang thanked T. Reed for sharing information requested at last month's meeting regarding the telehealth kiosk contact information. She will share that information at the next OSAB meeting as Oahu is also looking at using telehealth kiosks. <p>The following updates were provided by C. Matayoshi.</p> <ul style="list-style-type: none"> • There was quorum at the last HSAB meeting. • A presentation by Community Oriented Correctional Health Services, a national organization, was shared at the last HSAB meeting. • The HSAB membership has changed with one recent resignation and one recent interim appointment which is H. Ilyavi. A staff member at West Hawaii Community Health Center is interested in being a member. 	<p>T. Reed represents the MSAB on the SCMH.</p> <p>MSAB meets monthly on the 1st Monday from 2-3 p.m.</p> <p>C. Dang represents the OSAB on the SCMH.</p> <p>OSAB meets monthly on the 3rd Wednesday from 9-10 a.m.</p> <p>C. Matayoshi represents the HSAB on the SCMH.</p> <p>HSAB meets monthly on the 4th Tuesday at 9:30 a.m.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> • The HSAB continues to work on developing its CISAP. She is wondering when the CISAP is due. • HSAB continues to increase community awareness about the HSAB and its role. • The West Hawaii Family Guidance Center office was closed on 8/31/20 but the center has seen an increase in referrals. • Hale ‘Oluea Clubhouse in Hilo has Capital Improvement Project (CIP) funds that will be used for renovations. • Training topics for staff at the Hawaii Community Mental Health Center (CMHC) branch and clinics will include TigerConnect and crisis intervention training. <p><u>Comprehensive Integrated Service Area Plans (CISAP)</u> The Council will review CISAPs which are island/County-based plans that includes information and data about current and future mental health services. With this CISAP information, the Council may then review and consider what is presented and use that information for Council discussions. Reviewing the CISAP is a covered activity under the SAB and State Council Bylaws. Each island SAB representative is responsible for obtaining a copy of the most recently completed CISAP.</p>			
<p>VIII. State Agency Representative Reports</p> <ul style="list-style-type: none"> • Hawaii Public Housing Authority (HPHA) 	<p>This section of the agenda includes a brief summary from Council members representing their respective state agencies about agency data, agency information related to behavioral health and when applicable, updates on requested items identified at previous Council meetings. If sharing a longer report, PIG members may e-mail it to S. Haitsuka no less than 10 calendar days prior to the next meeting.</p> <p>The following updates were provided by K. Martinez.</p> <ul style="list-style-type: none"> • HPHA supports families living in public housing during COVID-19. One way HPHA is providing support is by partnering with the DOH and the Hawaii National Guard to canvas its public housing 	<p>For information only.</p> <p>K. Martinez represents HPHA on the SCM.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<ul style="list-style-type: none"> Department of Health Child Adolescent Mental Health 	<p>properties, offer free COVID-19 testing and outreach to provide education to individuals living in public housing about COVID-19. Statewide since May 2020, interpreters are onsite to assist with communication for those who have limited English proficiency. A few more canvassing events are scheduled in October 2020.</p> <ul style="list-style-type: none"> Using CARES COVID-19 funding through HiEMA, HPHA has partnered with the Aloha CARES Emergency Feeding Program to provide food to families in public housing by bringing meals to individuals in their homes who are disabled, over 65 years old, and tested positive for COVID-19. We wanted these individuals to stay isolated in their homes and not have to come out to get food. The program was extended to include serving the public in non-public housing locations as well. As of September 2020, approximately 3,506 individuals participated and a total of 278,000 meals were served. An additional \$2M in funding was provided by HiEMA which HPHA estimates will allow the program to operate through the end of October 2020. She expressed great appreciation to HiEMA for selecting HPHA to coordinate this statewide mass meal distribution program. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> L. Nagao asked about the funding for this program. K. Martinez explained that the funding is used to provide hot meals. Under this program, meals are provided every other day for two days. For example, distribution on Monday includes meals for M/T; distribution on Tuesday includes meals for T/W, etc. R. Ries acknowledged that this program is a great resources for the community and especially to those in need. <p>The following updates were provided by S. Shimabukuro.</p> <ul style="list-style-type: none"> No updates were shared during the meeting. 	<p>S. Shimabukuro represents DOH CAMHD on the SCM.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<p>Division (DOH CAMHD)</p> <ul style="list-style-type: none"> • Department of Human Services (DHS) MedQUEST (MQD) Division Medicaid Program • Department of Human Services (DHS) Child Welfare Services (CWS) • Department of Human Services (DHS) Division of Vocational Rehabilitation (DVR) 	<p>The following updates were provided by J. Fujii.</p> <ul style="list-style-type: none"> • No updates. <p>The following updates were provided by D. Koyanagi.</p> <ul style="list-style-type: none"> • D. Koyanagi is attending her first Council meeting today. She has been with the CWS unit for over 30 years. She was not aware about the Council until she was asked to participate. She is looking forward to participating as a Council member. <p>The following updates were provided by R. Pascual-Kestner.</p> <ul style="list-style-type: none"> • No updates. 	<p>J. Fujii represents DHS MQD Medicaid Program on the SCMH.</p> <p>D. Koyanagi represents DHS CWS on the SCMH.</p> <p>R. Pascual-Kestner represents DHS DVR on the SCMH.</p>		
<p>IX. Specialty Area Representative Reports</p> <ul style="list-style-type: none"> • Hawaii Advisory 	<p>This section of the agenda includes a brief summary from Council members representing specialty areas about activities related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings. If sharing a longer report, PIG members may e-mail it to S. Haitsuka no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by J. Fujii.</p> <ul style="list-style-type: none"> • No updates. 	<p>For information only.</p> <p>J. Fujii represents HACDACS on the SCMH.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
<p>Committee on Drug Abuse and Controlled Substances</p> <ul style="list-style-type: none"> • Mental Health Providers • Parents and Family Members of Mental Health Service Recipients 	<p>The following updates were provided by R. Ries.</p> <ul style="list-style-type: none"> • He noted that there are high rates amongst providers about rates for suicidality, domestic violence, substance use (previously in remission) where people are falling back into bad habits due to the current environment that we are living in and possibly due to stress and other factors. • Some former patients are calling to reconnect to get support with urgency and he has been accommodating more patients in his schedule, both before and after his standard clinic hours. • Telehealth support group for providers meets weekly to provide a forum to bounce ideas off each other, self-care, compassion fatigue support and to speak with others who can relate. <p>The following updates were provided by K. Aumer.</p> <ul style="list-style-type: none"> • This is her first Council meeting and she hopes to contribute as much as possible as a Council member. She has several family members who live with mental illness. <p>The following updates were provided by H. Ilyavi.</p> <ul style="list-style-type: none"> • She has observed similar issues with needing increased access to support in the community as mentioned by R. Ries. For example, there is a high need for resources and there is a lack of resources in general as all services are either waitlisted or the soonest telehealth appointment is in 2021. • Telehealth for adults is great but with youth it is a challenge. • Students with special needs need in-person services. Trying to do a 20 minute telehealth session is very challenging. • Parents are in a stressful situation and I'm having a challenging time trying to help these parents to cope and to support them. 	<p>R. Ries represents mental health providers on the SCM.</p> <p>K. Aumer, H. Ilyavi, and E. Lau-James represent parents and family members of mental health service recipients on the SCM.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> • We're hitting that COVID-19 six to nine month point where people are seeing things not necessarily improving and they are having to adjust to going back to work, struggling to support children who are distance learning from home. • Need to have more access to local support in the community and she is open to receiving ideas from all Council members about how to help parents and youth/children. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • S. Shimabukuro asked what side of Hawaii Island that H. Ilyavi is working in. She stated she is on the Kona side but she is seeing the issue with intensive in home therapy and MST being a challenge not only in the Kona area. • R. Ries acknowledges the challenges with virtual meetings when students have special needs and they are unable to really stay focused on the conversation. Approximately one third of his practice is focused on treating children. They are playing with the buttons or are not engaged with the provider; they are playing with the buttons or are doing other things while the provider is conducting the virtual meeting. He's provided education to parents about how to support their child during virtual meetings. • S. Shimabukuro asked about using the Zoom Share Screen White Board feature to keep the conversation interactive with the child. <p>The following updates were provided by E. Lau-James.</p> <ul style="list-style-type: none"> • There's a lot on everyone's plate and the additional strain of distance learning at home, shortage of resources or resource overload and no time to research the resources that you become aware of can be extremely overwhelming. • She likes the idea of the Council being a hub option to connect folks to local resources and being creative to address the Council's challenges, such as looking for free services, especially now when financial support may be less available. 			

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<ul style="list-style-type: none"> • Student/Youth Advocate • Consumer Advocates 	<p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries supports dedicating a part of the website for resources. <p>The following updates were provided by A. Beninato.</p> <ul style="list-style-type: none"> • This is his first Council meeting. He is attending the University of Hawaii at Mano and is studying psychology. He has worked with autistic individuals for a little over a year. He has also worked with young children using Pablonian techniques. <p>The following updates were provided by C. Knightsbridge.</p> <ul style="list-style-type: none"> • He finds that as a consumer, it is hard to deal with the waitlists for treatment and COVID-19 has impacted everyone, especially those with generalized anxiety disorder, panic attacks and those at home with kids who are distance learning at home. • It's so hard to get an appointment to see a doctor if you have QUEST health insurance. • He would love to see the question, "What health insurance do you accept?" being illegal because providers should be able to see anyone who needs help. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • L. Nagao commented that health insurers are required to have adequate services for their members. C. Knightsbridge agreed however he knows that in reality, providing services is not always done in practice. • R. Ries shared that a lot of providers don't want to accept lower reimbursement and there is a lot of hassle with reimbursement from some health insurers. • L. Nagao suggested that this could be an issue that the Council and the Legislative PIG looks at to find out whether insurers are carrying an adequate panel. The Council could also look at what the laws are and how the issue is addressed statewide. <ul style="list-style-type: none"> ○ E. Lau-James and C. Dang agree that a PIG meeting to 	<p>A. Beninato is a student/youth advocate on the SCM.</p> <p>N. Crozier, C. Knightsbridge and T. Reed are consumer advocates on the SCM.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>discuss this topic may be a good idea.</p> <ul style="list-style-type: none"> ○ C. Knightsbridge suggested that the Council invite others who may be able to speak on the issue. C. Dang stated that Sen. Rosalyn Baker is quite knowledgeable about this. ○ R. Ries noted that the Mental Health Task Force (MHTF) meetings are chaired by Rep. John Mizuno and facilitated by Trisha Kajimura. Council members can attend the MHTF meetings stating they are a Council member but are not speaking on behalf of the Council. The next meeting is on October 23, 2020 from 1:00 p.m. to 2:15 p.m. <p>The following updates were provided by N. Crozier.</p> <ul style="list-style-type: none"> ● Mental Health Kokua (MHK) Maui has kept its activity center open and has limited participants to no more than five at a time. Activities include feeding the homeless, contacting individuals for follow up and outreach, and conducting assessments via Zoom. MHK is doing the best that they can to continue services throughout the COVID-19 pandemic. <p>The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> ● She shared updates earlier in the meeting. 			
X. Presentation/ Guest Speaker	None.			
XI. Old Business	<p>The following items originally appeared on previous meeting agendas and are listed here for follow up and/or final remarks.</p> <ul style="list-style-type: none"> ● SCMH Member Orientation Materials for Fiscal Year 2021 <p>Starting with Fiscal Year 2021, R. Ries explained that State Council member orientation will be shared with all Council members.</p> <p>He noted that there is a significant amount of copying that will require staff to physically produce copies, order binders, collate the copies into binders with tabbed sections, and arrange for postage and mailing.</p>			

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<ul style="list-style-type: none"> Department of Health Adult Mental Health Division (AMHD) Update 	<p>Additionally, staff are not physically in the office every day during the week. With the Council’s support of electronic access, we can support “going green” and reduce the Council’s carbon footprint.</p> <p>Council members are able to electronically access the member orientation materials listed on the handout and are encouraged to set up their State Council member account within the next seven (7) to ten (10) days. Please watch for an e-mail from S. Haitsuka.</p> <p>Council members are highly encouraged to preview the orientation materials ahead of the November Council Retreat. New members are encouraged to take a deep dive and get oriented to the Council.</p> <p>If any Council members needs hard copies, they can consider going to a printing office otherwise, they can save the orientation materials to their computer for future reference.</p> <p>If you have any questions or need help accessing the materials, please contact S. Haitsuka at stacy.haitsuka@doh.hawaii.gov.</p> <p>R. Ries acknowledged Dr. Amy Curtis, AMHD Administrator, who provided the Council with updates on AMHD activities.</p> <p>He recognized a few of the updates she shared, including:</p> <ul style="list-style-type: none"> How AMHD is involved in COVID-19 rapid response activities such as the Hawaii Behavioral Health and Homelessness Statewide Unified Response Group (BHHSURG) Isolation and Quarantine (Iso/Quar) Program; Designing the Hawaii CARES Program as a statewide one stop shop for coordinating entry to behavioral health services; and Developing a pilot program with the first district court to implement HB1620 (Act 026-20) so individuals who need support are evaluated quickly and linked quickly to treatment. <p>https://www.capitol.hawaii.gov/measure_indiv.aspx?billtype=HB&billnumber=1620&year=2020</p>	<p>Access member orientation materials before the November Council Retreat.</p>	<p>Council Members</p>	<p>11/09/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>R. Ries stated that one particular update Dr. Curtis emphasized was the AMHD strategic plan focus on four (4) priority areas including:</p> <ul style="list-style-type: none"> • Telehealth – Using technology to provide health services including in-home treatment. Federal grant funds pay for telepsychiatry services. • Integration – Coordinating primary and behavioral health services in a holistic person-centered care setting. • Evidence-based practice – Using evidence-based practices and data driven decision making. • Special populations – Addressing the needs of consumers diagnosed with co-occurring substance use conditions, other chronic or physical conditions, including intellectual/ developmental disabilities, and/or who are justice involved. <p>R. Ries recalled that C. Dang asked Dr. Curtis how the Council could support AMHD’s goals. Her response was for the Council to consider supporting AMHD in the following ways:</p> <ul style="list-style-type: none"> • Supporting AMHD’s strategic plan focus on the four (4) priority areas she mentioned; • Looking at the Hawaii CARES Program; and • Helping by thinking outside the box about ways to integrate primary care and behavioral health care services. <p>He noted for the Council’s reference, they have:</p> <ul style="list-style-type: none"> • Minutes from September’s meeting for Dr. Curtis’s updates. • Minutes from our July 2020 meeting, where we had Dr. Katherine Boyer present on the Hawaii CARES Program and Dr. Trina Orimoto present on the BHHSURG. In addition to the meeting minutes, we received their presentation slides as well. <p>R. Ries asked Council members for feedback on the updates Dr. Curtis shared and asked Council members to offer their suggestions for specific ways the Council can support the AMHD.</p> <ul style="list-style-type: none"> • C. Dang stated that in the past, Dr. Fridovich provided updates on 			

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	<p>bills that AMHD was looking at.</p> <ul style="list-style-type: none"> L. Nagao stated that she still has a question about the Hawaii CARES Program only providing resources for providers with a contract with the Alcohol and Drug Abuse Division (ADAD). She thought the intent was to expand the directory. L. Nagao appreciated Dr. Curtis coming to present and sharing information and updates. She loves that E. Mersereau has been working to remove silos and address resources in a way that are collaborative with both mental health and substance use disorder providers. R. Ries suggested that Dr. Curtis could return to provide another update at the beginning of the 2021 legislative session. 			
<p>X. Closing Announcements/ Meeting Evaluation</p>	<p>The following closing announcement was shared:</p> <ul style="list-style-type: none"> The next SCMh meeting is scheduled for Tuesday, November 10, 2020 via Zoom. Since this will be our Retreat meeting (Part I), the Council agreed to change the time of the meeting. 8:30 a.m. – 9:00 a.m. Regular Council meeting 9:00 a.m. – 1:00 p.m. Council Retreat <p>All Council members are asked to complete the pre-retreat questionnaire. See the handout provided by the Retreat PIG. Please watch for an e-mail from S. Haisuka regarding this.</p> <ul style="list-style-type: none"> C. Dang shared that KHON2 will air townhall news coverage of “Hostage at Home” which is about intimate partner/domestic violence. It will air on October 21, 2020 at 9:30 p.m. It’s Amazon Prime Day! Buy from Amazon using the Smile Program. Use the link from your favorite charity, school, organization or business. <p>R. Ries invited members to share their feedback about today’s meeting including what they felt was good about the meeting, constructive criticism about what could be improved, and offer suggestions for improvements.</p> <ul style="list-style-type: none"> R. Ries shared that the Council meetings have become more 	<p>Complete pre-retreat questionnaire.</p>	<p>Council Members</p>	<p>10/30/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>meaningful with input from Council members about their respective areas.</p> <ul style="list-style-type: none"> • C. Dang felt that the meeting was productive. • L. Nagao is looking forward to attending the Mental Health Task Force meeting. She reminded Council members about self-care. 			
IX. Future Agenda Items	<p>R. Ries encouraged Council members to share any future presenters or new agenda items if they think of any.</p> <ul style="list-style-type: none"> • One suggestion is to invite a local news/media representative to present on local news coverage of mental health topics. 	For information, only.		
X. Adjournment	The meeting was adjourned at 11:29 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <p>E-mail with Handout Set 1 of 2 (total of 5 handouts)</p> <ol style="list-style-type: none"> 1. October 2020 Meeting – Agenda 2. September 2020 Meeting – Draft Minutes 3. October 2020 Meeting – FY21 Attendance Log 4. October 2020 Meeting – PIG List 5. October 2020 Meeting – PIG, Legislation HB1620 (Act 026-20) <p>E-mail with Handout Set 2 of 2 (total of 5 handouts)</p> <ol style="list-style-type: none"> 6. October 2020 Meeting – PIG, Legislation SB 2395 (act 226-16) 7. October 2020 Meeting – PIG, Retreat Revised Draft Agenda 8. October 2020 Meeting – PIG, Retreat Pre-Retreat Questionnaire 9. October 2020 Meeting – Old Business, SCMH Member Orientation Materials Revised List 10. October 2020 Meeting – Closing Announcement, SAMHSA My Mental Health Crisis Plan App 	For information only.		

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
November 10, 2020
8:30 a.m. – 9:00 a.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Crozier, Charleen “Naomi”; Dang, Cynthia “Cindi”; Ilyavi, Heidi; Knightsbridge, Christopher; Koyanagi, Dina; Lau-James, Eileen; Martinez, Beatrice “Kau’i”; Matayoshi, Carol; Nagao, Lani; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Ries, Richard; Shimabukuro, Scott**

Members Absent: **Fujii, John**

Members Excused:

Guests Present:

DOH Staff Present: **Haitsuka, Stacy; Nazareno, Jocelyn; Pavao, Steven**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 8:37 a.m.</p> <p>Members and guests introduced themselves.</p> <p>The following definition of quorum was added to the agenda: Pursuant to Act 137-18 (SB 203), Chapter 92, Hawaii Revised Statutes: “(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes.”</p>	For information only.		

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	<p>For example, if only 16 of the entitled 21 members are appointed, only 9 members would be necessary to establish a quorum and if only 9 members are present, the affirmative vote of only 5 members is needed to validate a council action.</p> <p>Quorum was established.</p>			
<p>II. Meeting Announcements</p>	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally interject during the meeting to get his attention. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who need to take a break and step away from the meeting, please notify him before leaving as the Council needs to keep track of when Council members leave and return to verify quorum. • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. 	<p>For information only.</p>		

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	<ul style="list-style-type: none"> If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear speaker. <p>R. Ries stated this meeting will end at 9:00 a.m. and the Council's Retreat will begin at that time.</p> <ul style="list-style-type: none"> Of the 16 Council members, there are 15 members who submitted their pre-Retreat questionnaire responses and all 15 indicated they will attend today's Retreat. Retreat materials and supplies were sent in the mail. 			
III. Consideration and Approval of Minutes <ul style="list-style-type: none"> October 13, 2020 	<p>The draft minutes for the October 13, 2020 meeting were reviewed and amended as follows:</p> <ul style="list-style-type: none"> Page 10, HSAB, 2nd bullet Should be: Community Oriented Correctional Health Services. <p>C. Knightsbridge made a motion for the minutes from the October 13, 2020 meeting be approved. C. Matayoshi seconded the motion.</p>	<p>Finalize minutes as drafted.</p> <p>Motion passed unanimously.</p>	S. Haituka	11/17/20
IV. Community Input	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p> <p>[No community input was received.]</p>			
V. Summary of PIG and Council Member Reports with Action Items Carried Forward to the December 8, 2020 Meeting	<p>R. Ries stated that due to today's shortened Council meeting, the regular meeting agenda has been modified. In the interest of time, he gave a summary of the action items that will be carried forward to the December meeting and asked members shared updates, if applicable.</p> <p><u>PIG Reports</u></p> <ul style="list-style-type: none"> Website, Social Media and Advocacy PIG <ul style="list-style-type: none"> C. Knightsbridge will schedule a Zoom meeting with other PIG members to identify possible PIG goals and objectives 	Request to schedule PIG meeting	C. Knightsbridge	12/1/20

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>and propose recommendations for PIG action steps for the Council to consider and vote on.</p> <ul style="list-style-type: none"> ○ C. Knightsbridge will draft a letter to the DOH strongly encouraging that they explore the contact tracing app, create an app, and consider participating in the contact tracing program with 14 other states. <ul style="list-style-type: none"> ● Legislative PIG <ul style="list-style-type: none"> ○ Pending notification from C. Dang regarding the legislative training. The Council is looking to have this training at our December meeting. ○ Council members who have questions regarding the legislative process should submit their questions to S. Haitsuka. She will forward all questions to C. Dang so that they can be reviewed prior to the legislative training. ● Retreat PIG <ul style="list-style-type: none"> ○ Invitation letters for guest speakers were sent to R. Ries and he approved them. They were sent to Lt. Governor Josh Green and Deputy Director Mersereau a couple weeks ago. A copy of the letters are included in the handouts. <ul style="list-style-type: none"> ▪ Mr. Mersereau is tentatively scheduled to attend our December meeting. S. Haitsuka will coordinate with his secretary for his attendance. ▪ Lt. Governor Green’s staff will respond to our request within two to four weeks so we can anticipate a response before Thanksgiving. <p><u>Service Area Board (SAB) Reports</u></p> <ul style="list-style-type: none"> ● There was a question last month regarding the due date for the Comprehensive Service Area Plans (CISAP) and budgets. <ul style="list-style-type: none"> ○ In checking the Hawaii Revised Statutes (HRS) for the SABs and the Council, the law does not list a specific date; 	<p>Draft letter to share with December meeting handouts.</p> <p>Confirm training with S. Haitsuka.</p> <p>Submit questions to S. Haitsuka</p> <p>Confirm approximate time during the December agenda.</p> <p>Confirm status of invitation to Lt. Governor Green.</p> <p>Send a copy of the</p>	<p>C. Knightsbridge</p> <p>C. Dang</p> <p>Council Members</p> <p>S. Haitsuka</p> <p>S. Haitsuka</p> <p>C. Matayoshi</p>	<p>12/1/20</p> <p>12/1/20</p> <p>12/4/20</p> <p>12/1/20</p> <p>12/4/20</p> <p>12/1/20</p>

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	<p>however, timely completion of each County CISAP does aide the Council in its ability to review the County level plans and budgets, and to identify resources, needs and programs that affect two or more County service areas, as is the Council’s responsibility per state law.</p> <ul style="list-style-type: none"> ○ The Council uses the CISAPs to assist with advising the DOH of the Council’s findings and as a in our Statewide Comprehensive Integrated Service Area Plan. ○ Council members may review the member orientation materials. S. Haitsuka provided instructions for electronically accessing the member orientation materials. ○ R. Ries recognized the Maui SAB for their work on the Maui CISAP. The Council will hear about Maui’s CISAP from T. Reed at our December meeting. <p><u>State Agency Reports</u></p> <ul style="list-style-type: none"> ● Hawaii Public Housing Authority (HPHA) <ul style="list-style-type: none"> ○ HPHA opened its Section 8 Waiting List from 10/29/20 to 11/2/20. While not frequently opened, it’s encouraging to see it open for a short time, despite operational challenges during the COVID-19 pandemic. CARES Act funding was used. Applicants must have an existing lease and a landlord willing to accept the housing voucher. ● DOH Child Adolescent Mental Health Division (CAMHD) <ul style="list-style-type: none"> ○ Not discussed. ● DHS MedQUEST Division Medicaid Program <ul style="list-style-type: none"> ○ Not discussed. ● DHS Child Welfare Services (CWS) <ul style="list-style-type: none"> ○ Not discussed. ● DHS Division of Vocational Rehabilitation (DVR) <ul style="list-style-type: none"> ○ Not discussed. 	<p>outdated AMHD Policy and Procedure that references the CISAP to S. Haitsuka.</p> <p>Review member orientation materials.</p> <p>Present Maui CISAP at the December meeting.</p>	<p>Council Members</p> <p>T. Reed</p>	<p>12/7/20</p> <p>12/8/20</p>

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	<p><u>Specialty Area Reports</u></p> <ul style="list-style-type: none"> • Hawaii Advisory Committee on Drug Abuse and Controlled Substances (HACDACS) <ul style="list-style-type: none"> ○ Not discussed. • Mental Health Providers <ul style="list-style-type: none"> ○ Not discussed. • Parents and Family Members of Mental Health Recipients <ul style="list-style-type: none"> ○ Not discussed. • Student/Youth Advocate <ul style="list-style-type: none"> ○ Not discussed. • Consumer Advocates <ul style="list-style-type: none"> ○ Not discussed. <p>R. Ries acknowledged that L. Nagao requested to discuss the Office of the National Coordinator for Health Information Technology (ONC) Cures Act at the December meeting. Information about the ONC Cures Act is explained in the handout.</p> <ul style="list-style-type: none"> • Council members were encouraged do research via their area of representation and through provider contacts identify how this Act will be integrated and what ways the providers plan to support the “app economy” mentioned in the handout. 	Review handout and prepare to discuss at the December meeting.	Council Members	12/7/20
VI. Adjournment	The meeting was adjourned at 9:05 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMh members and individuals on the SCMh e-mail distribution list:</p> <p>E-mail with Handouts (total of 7 handouts)</p> <ol style="list-style-type: none"> 1. November 2020 Meeting – Agenda (Business Meeting) 	For information only.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> 2. November 2020 Meeting – Agenda (Council Retreat) 3. October 2020 – Draft Minutes 4. November 2020 Meeting – FY21 Attendance Log 5. November 2020 Meeting – Act 137-18 (SB203) SCMH Quorum 6. November 2020 Meeting – PIG, Retreat Guest Speaker Invitation Lt. Governor Green 7. November 2020 Meeting – PIG, Retreat Guest Speaker Invitation DOH DD BHA E. Mersereau 8. December 2020 Meeting – Office of the National Coordinator for Health Information Technology (ONC) Cures Act Final Rule. 			

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
November 10, 2020
9:00 a.m. – 1:00 p.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Crozier, Charleen “Naomi”; Dang, Cynthia “Cindi”; Ilyavi, Heidi; Knightsbridge, Christopher; Koyanagi, Dina; Lau-James, Eileen; Martinez, Beatrice “Kau’I”; Matayoshi, Carol; Nagao, Lani; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Ries, Richard; Shimabukuro, Scott**

Members Absent: **Fujii, John**

Members Excused:

Guests Present: **Oliver, Karen (Facilitator)**

DOH Staff Present: **Haitsuka, Stacy; Nazareno, Jocelyn; Pavao, Steven**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Opening Remarks	Chair R. Ries called the meeting to order at 9:05 a.m. He introduced Dr. Karen A. Oliver as the Council’s Retreat Facilitator. <ul style="list-style-type: none"> • Dr. Oliver is an experienced epidemiologist and former program officer and former Chief of Clinical Epidemiology and Quality and Outcomes Programs at the Nation Institute of Mental Health • She previously worked at the Veterans Administration as a Research Health Scientist where she extensively worked on national primary care and mental health integration and telehealth implementation. • She has also worked on benefits consulting, evaluating Maryland’s Medicaid waiver design and their Department of Mental Hygiene. • She has served as an institutional review board member with the University of Wisconsin. • She is trained and published in implementation facilitation, systems 	For information only.		

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	<p>redesign and process improvement. Her areas of expertise include quality improvement, implementation science and facilitation in public and private sectors, primarily for mental health and substance use disorders.</p> <ul style="list-style-type: none"> • She is an Advanced Implementation Specialist for the Opioid Response Network technical assistance grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and is a Board Member of the National Institute on Drug Abuse Clinical Trials Network grant which focuses on medications to treat opioid use disorder within American Indian and Alaska Native populations. • She earned her bachelor’s degree from Princeton University in Biology and Science in Human Affairs and her Ph.D. from Yale University in Epidemiology and Public Health. 			
<p>II. Welcome and Introductions</p>	<p>K. Oliver greeted the Council and thanked Council for the warm welcome.</p> <p><u>Getting to Know Each Other Exercise</u> Attendees shared their lived experience and/or expertise with regards to mental health and shared their favorite musician/band.</p> <ul style="list-style-type: none"> • K. Oliver Experience: Grew up in a rural area in Vermont on the Canadian border; mom was a public health nurse and dad was a teacher; experience in rural health care; started career on the East Coast, then in the mid-West in Wisconsin before moving to Seattle where she is now based; has family members with mental illness. Musician/band: Bruce Springsteen. • A. Beninato Experience: Oahu; young individual’s perspective with a varied background; worked with many types of individuals. Musician/band: Jazz; Strip club to Classical; Herbie Hancock. • K. Aumer Experience: Oahu/Honolulu; Family/friends with mental illness/ substance abuse; Ph.D. in psychology; employed as a professor. Musician/band: Nirvana; Jazz; Miles Davis 			

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	<ul style="list-style-type: none"> • N. Crozier Experience: Maui; Person in recovery sharing her experience; has worked for Mental Health Kokua for 10+ years as a case manager. Musician/band: Yo-Yo Ma; Led Zeppelin • C. Dang Experience: Oahu; Expertise is working with domestic violence survivors and individuals who have experienced trauma. Musician/band: Ed Sheeran; Led Zeppelin • H. Ilyavi Experience: Big Island; Background in working with people who live with mental illness and substance abuse; Currently working with parents of youth receiving mental health and substance abuse services through Child and Family Services. Musician/band: Harry Connick, Jr.; Jazz from Chicago • D. Koyanagi Experience: Oahu; Worked at Child Welfare Services (CWS) and Child Protective Services (CPS) for 30+ years. Musician/band: 80s Rock music • C. Knightsbridge Experience: Oahu/Manoa Valley/Honolulu; a consumer of mental health services; Family members with mental health and substance abuse issues; brings his authentic experience to the Council. Musician/band: LMFAO • E. Lau-James Experience: Oahu/Kapahulu/Waikiki area; Husband lives with mental illness and substance abuse issues; Friends with mental illness and substance abuse issues; owns a veterinarian hospital and cat clinic. Musician/band: Amuse; The Cure • K. Martinez Experience: Oahu/Kaneohe; 27 years with state government in Hawaii Housing Authority (HHA) now known as Hawaii Public Housing Authority (HPHA) and with the Department of Health, Adult Mental Health Division (AMHD); areas of work experience include homelessness, public housing and community mental health services 			

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	<p>and supports. Musician/band: Country music; George Straight; Nora Jones</p> <ul style="list-style-type: none"> • C. Matayoshi Experience: Big Island/Hilo; Friends who live with mental illness and substance abuse issues; worked for 25+ years with homeless, mental ill/substance abuse (MI/SA) and justice involved populations. Musician/band: Adam Lambert; Queen • L. Nagao Experience: Kauai; Represents Kauai and Lanai on the Council; advocate for collaboration and for Neighbor Islands having a voice in conversations; has family members who live with mental health and substance use disorders; experienced gaps in services on the Neighbor Islands and challenges for accessing care off island; worked in substance use disorder (SUD) treatment for the past 10 years; involved in rural health organizations for Hawaii/Kauai. Musician/band: Classical; Country; Likes to free dance to music; Uses music in her work • R. Pascual-Kestner Experience: Oahu/Waikiki/Honolulu; Certified vocational rehabilitation counselor for 15 years; family members who live with mental health issues; family members who are psychiatric nurses. Musician/band: Eclectic variety; Chicago; Eagles; Lady Gaga (has friends on tour with her; Jazz music (nephew attends Berklee College of Music); YouTube music • T. Reed Experience: Maui; Graduated from UH Manoa with a degree in social work; Working on her graduate degree in Forensic Psychology; is a survivor of “the system”; motivated to change “the system” Musician/band: Tool and Maynard James Keenan • R. Ries Experience: Oahu/Chinatown/Honolulu; As a young boy, lived in a suburban area at the south end of Chicago; parents were hippies; dad was a psychologist; recalls a time when a teenager with a history of being abused by their father moving into his family’s garage; recalls 			

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	<p>taking long walks in the woods with a man who believed he was Jesus Christ (looked/sounded like it); even at a young age and being exposed to different people, he realized people are beautiful. From age 7, he grew up in NYC; At age 15, was briefly homeless and taken in by an immigrant Salvadorian family who barely spoke English; he lived in their basement; the uncle in that family had a mental illness; By age 19, he worked in hospice helping with physical care needs for the terminally ill; Now, a clinical psychologist with expertise in in-depth psychotherapy, not just symptom reduction; is a trauma and hospice psychotherapist serving adults and child/adolescents.</p> <p>Musician/band: He is a professional percussionist; has played at the Blue Note, Hard Rock Café, Jazz Minds, and other night clubs; Little Dragon (met and kissed the lead singer!)</p> <ul style="list-style-type: none"> • S. Shimabukuro Experience: Honolulu; Public mental health; clinical psychology board certified in family psychology Musician/band: Pat Metheny • S. Haituka Experience: Oahu/Kaneohe/Mililani/Pearl City/Honolulu; Supporting the Council's efforts to address Hawaii's mental health system Musician/band: Adds songs to Pandora; Hawaiian; cover bands; Jazz • J. Nazareno Experience: Oahu/Pearl City; Supporting AMHD and the Council Musician/band: 80s music 			
III. Retreat Orientation	<p>K. Oliver reviewed the Retreat agenda and acknowledged the Council's diverse areas of representation and background.</p> <p>She confirmed Council members received their Retreat Box of materials and supplies. She encouraged members to be creative with using supplies during the Retreat. Snacking is okay during the Retreat when not speaking.</p> <p>She thanked Council members for submitting pre-Retreat questionnaire responses which helped her to prepare Retreat activities.</p>			

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IV. Goals and Objectives of Strategic Planning	<p>K. Oliver summarized the goals and objectives of strategic planning.</p> <ul style="list-style-type: none"> • Strategic planning is a dedicated time to pause and look at ways that the Council can be less reactive and more active; • It's an opportunity for the Council to identify what it would like to do, whether little or big, that might increase its efficiency and action; • An opportunity for the Council to influence their environment; and • The Council's Strategic Plan provides a clear direction with action steps and measurable objectives for the Council to use as it works towards achieving the goals identified in the plan. <div data-bbox="562 574 1167 959" style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p style="text-align: center; background-color: #0070C0; color: white; padding: 5px;">Agenda: 1) Strategic Planning</p> <ul style="list-style-type: none"> * Tool to change mode of operating from less reactive to more active * Anticipate, plan and create the future * Clear direction to maximize options to influence your environment <p style="font-size: small; margin-top: 5px;">* Reference: C4 Innovations Building Infrastructure and Sustainability: A Training Institute for Peer-Run/Recovery Community Organizations</p> </div> <p>She added that strategic planning involves visualizing where the Council wants to be and considering where the Council has been.</p>			

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	<div data-bbox="562 212 1165 358" style="background-color: #0070C0; color: white; padding: 10px; border-radius: 5px; text-align: center;"> <h2 style="margin: 0;">Agenda: 1) Strategic Planning</h2> </div> <ul style="list-style-type: none"> * Where are we today? Review and clarify your vision, mission, and values. * Where do we want to be in the future? See where your organization is heading. * How will we get there? What are the key activities that will get you where you want to be? Set strategic focus areas, objectives and action items, and decide how to make it happen <p>K. Oliver shared about the Center for Social Innovation’s (C4) website; a recovery organization in Boston providing, “training, technical assistance and consultation” to “substance use, mental health, trauma challenge healthcare and human service programs, communities and systems.”</p> <p>She defined three strategic planning terms:</p> <ul style="list-style-type: none"> • Focus Area: Desired result; broad and longer-term (2-year period) • Objectives: Includes measurable goals WITH completion dates (i.e. what will be accomplished in a particular timeframe); for example, increase or decrease by x%. • Action Plan: A detailed breakdown that identifies the steps that will be taken to accomplish the objectives within the given timeframe; specifies who, when, what, where and how. <p>Role of Council Members</p> <ul style="list-style-type: none"> • Be familiar with the Council’s member orientation materials including the Council’s Vision, Mission, and Who We Are statements; Bylaws; purpose (Hawaii Revised Statutes (HRS), Hawaii law); and expectations for Council member participation. 			

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	<div data-bbox="558 212 1169 365" style="background-color: #0070C0; color: white; padding: 10px; text-align: center; border-radius: 5px;"> <h2 style="margin: 0;">Council on Mental Health</h2> </div> <ul style="list-style-type: none"> * <u>Vision Statement</u> The Vision of the State Council on Mental Health is for a Hawai'i where people of all ages with mental health challenges can enjoy recovery in the community of their choice * <u>Mission Statement</u> The Mission of the State Council on Mental Health is to advocate for a Hawai'i where all persons affected by mental illness can access treatment and support necessary to live a full life in the community of their choice * The State Council on Mental Health, also known as the Council, is a diverse group of individuals comprised of consumers of mental health services, family members, representatives from each of the four county Service Area Boards, representatives of state agencies, and other community stakeholders. <p>R. Ries and K. Oliver responded to E. Lau-James who asked for clarification on the Council's Vision and Mission Statements. He shared that the Vision Statement is what the Council aspires towards and is philosophical, involving the action of advocacy; a Mission Statement is what the Council's goals are (what the Council does) to advocate. They may be written similarly in wording.</p> <p>S. Shimabuku and C. Knightsbridge inquired about the possibility of amending the Bylaws and what the procedure is for amending. S. Haitsuka stated that the Council is responsible for revising its Bylaws and does not require external approval.</p>	<p>Verify that the Bylaws can be revised by the Council.</p>	<p>S. Haitsuka</p>	<p>11/7/20</p>

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	<p style="text-align: center;">BY-LAWS of the State Council on Mental Health</p> <ul style="list-style-type: none"> * Purpose: work towards the establishment of a comprehensive community-based mental health system, utilizing public and private resources to prevent and reduce mental disorders and substance abuse among children and adults. * Role: serve as an advisory body to the Department and shall not include any clinical, administrative or supervisory functions of the Department. * Functions (page 1 of 2): <ul style="list-style-type: none"> * A) advise the department on allocation of funds and resources, statewide needs, and programs affecting two or more service areas * B) review and comment on the statewide comprehensive integrated service plan and report of the statewide plan * Functions (Page 2 of 2): <ul style="list-style-type: none"> * C) serve as an advocate for adults with SMI, children with SEBD, and other individuals with mental illness or substance use disorder * D) monitor and review and evaluate not less than once each year the allocation and adequacy of mental health services within the State 			
<p>V. Group Activity: Pre-Retreat Assessment</p>	<p>K. Oliver and E. Lau-James facilitated a Council activity focused on roles. Council members shared their input about what they are expected to do in meetings and what they are expected to do between meetings.</p> <p>E. Lau-James explained that she plans to collate responses in a guidebook which includes roles (similar to a brief job description) into a personalized notebook for each Council member to use as a notebook.</p>	<p>Create guidebooks for Council members</p>	<p>E. Lau-James</p>	<p>1/21/21</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>R. Ries provided an example of how this group activity and the use of a guidebook can be helpful in Council meetings. He has taken steps to revise the meeting agenda format to be inclusive of all Council members by assuring everyone has an opportunity at every meeting to share a report from their area(s) of representation.</p> <p>He emphasized that this information sharing gives a broader picture and greater sense of understanding about mental health related discussions in our community and knowing our role may help Council members to focus more and bring updates to meetings.</p> <p>C. Dang shared that she has observed that Council members do not know what to do as a member. She suggests that developing a process; having a job description presented to them ahead of time, will provide a better understanding of what is expected and can ease some of the anxiousness about participating in and attending meetings. For her, learning about what other Service Area Boards do and what service recipients experience helps her to know what to do.</p> <p>L. Nagao said sharing about roles doesn't pigeonhole us into a narrow role.</p> <p>Council members identified expectations applicable to all members.</p> <ul style="list-style-type: none"> • Attendance (Showing up at meetings to achieve quorum) In addition to Council attendance policy stated Hawaii law (HRS), consider asking Council members to sign a commitment statement like a Memorandum of Understanding (MOU); encourage members to share information about their area(s) of representation (i.e. tone of the message is to encourage and reach out to increase participation). • Volunteer as a member of a Permitted Interaction Group (PIG) Encourage members to participate on PIGs; identify new PIGs that would be useful to address opportunities for change. • Show up, be present and contribute Means being physically present AND actively participating in meetings; become a Council of action 			

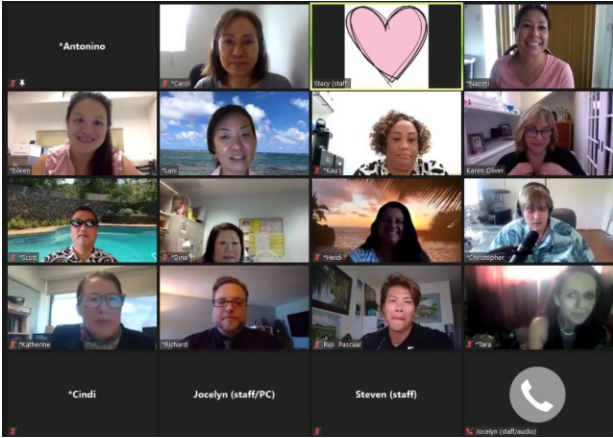
AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> • Meet with members of the community within the Council members area of representation. Share about the Council and ask community members for their feedback. For example, R. Ries represents mental health providers. He is actively linked with other psychologists, psychiatrists, and social workers. He interfaces with health insurance companies and attends Hawaii Psychological Association meetings. He shares about his interactions when he gives his Council report. He also recognizes that he does not have a mental health provider contact on every neighbor island and that connection needs to be established. • Focus on the Council’s purpose Share what Council members are involved in (i.e. state agencies, mental health providers) that relate to mental health; convey the importance of the Council and its value to the community. • Recruit new members Recruit community members to attend Council meetings; encourage the community to actively participate; recruit new members, especially those who live on the neighbor island; include a job description explaining each position on the Council. • Have measurable outcomes Evidence what has been accomplished and what current Council members can contribute to further those achievements. <p>K. Oliver commented that the next group exercise is similar to creating a performance plan for the strategic plan period.</p> <p>E. Lau-James explained that these functions could be general expectations for each area of representation; not requirements; they are guidelines; goal is to empower Council members to participate.</p> <p>R. Ries noted that for now, this is an initial pilot project and each member should be able to identify three points specific to their area of representation and role. In the future, if successful as a working guide and self-assessment, the Council can codify roles formally in its procedures.</p>			

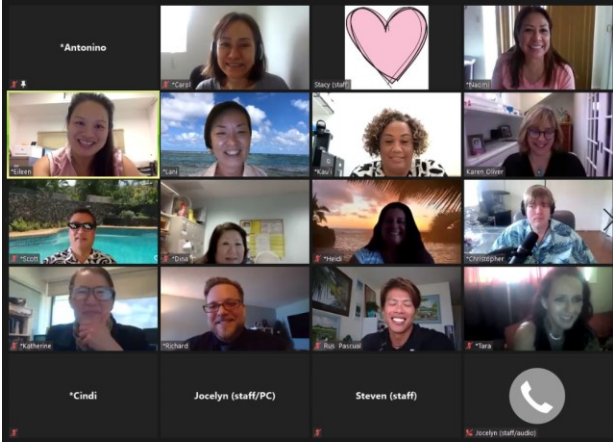

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>Council members identified their commitment statements with at least three functions for their area(s) of representation and personal expectations for themselves.</p> <ul style="list-style-type: none"> • For example, <ul style="list-style-type: none"> ○ I plan to... or I will connect/network with... or ○ I will share with the Council/community about... or ○ ...Expressing how roles are interconnected with mental health (or maybe they are not well connected but should be) • E. Lau-James <p>As a family member representative, she can reach out to organizations in the community that represent families such as the National Alliance for Mental Illness Hawaii (NAMI) to build a bridge between the Council and the organization and share input and feedback at Council meetings.</p> <p>Personally, she is willing to volunteer new ideas for PIG activities.</p> • C. Knightsbridge <p>As a service recipient, he shares his personal experiences (personal choice) to fight/battle stigma; encourages other service recipients to share their experiences (when they are comfortable); is a consumer advocate; and build bridges with service recipients and others. Personally, he is willing to volunteer as a PIG member and take ownership and action when he brings up ideas for the Council to consider; use his skills in social media.</p> • L. Nagao <p>As a Service Area Board representative, representing Kauai, she will focus on service gaps, identify who from her community is involved in mental health and who should be involved/linked with mental health; she can continue to participate in discussions with the Kauai Mental Health Consortium (developed in 2014 in partnership with the Kauai Community Health Initiative), “to improve access to mental</p> 			

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	<p>health services through better coordination” between mental health and primary care providers.</p> <p>Personally, she is willing to learn about roles other Council members have and what resources other Council members share; share about her personal experience and her experience in her specialized field.</p> <ul style="list-style-type: none"> • R. Ries As a mental health provider, he will interface with other mental health providers to gather information as well as with other organizations who provide mental health services and bring this information back to the Council; he will listen to patients and clients as well as community members and share this feedback with the Council; he will stay involved with mental health groups (i.e. Hawaii Psychological Association, City and County of Honolulu groups, Mental Health Task Force, social work and psychiatry) and participate in those groups to gather information for the Council. Personally, he is willing to share themes he sees that are related to mental health; he will continue to Chair Council meetings; he will interface better with leadership, media and press when the Council has consensus and wants to see movement. • C. Dang As a Service Area Board representative, representing Oahu, she is willing to do succession planning by helping the next Oahu Service Area Board member; to pass the baton and help that person via a buddy system by introducing them to the Council (inviting them to attend Council meetings before official appointment). <p>Personally, she is interested in producing a Council member orientation and training video explaining the roles and expectations.</p> <ul style="list-style-type: none"> • C. Matayoshi As a Service Area Board representative, representing Hawaii Island, 			

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	<p>she will continue to promote awareness about the Council and the HSAB by attending community meetings, introducing herself, and talking about the Council and HSAB; she will continue to have discussions in the community about mental health related topics; in the past, she has asked providers to give a survey about mental health services to service recipients;</p> <p>Personally, she is willing to invite people to testify at HSAB meetings.</p> <ul style="list-style-type: none"> • K. Martinez As a state agency representative from the Hawaii Public Housing Authority (HPHA), she will continue addressing housing service gaps by supporting opportunities to increase access to mental health services beyond the Hawaii State Department of Health (DOH) Adult Mental Health Division (AMHD) contracted providers; she will continue to share knowledge she has about AMHD funded services with HPHA staff to increase awareness of mental health and crisis services available to HPHA residents and families. <p>Personally, she will continue reaching out to mental health providers and AMHD staff; she will continue arranging mental health trainings for HPHA staff including case management and crisis support.</p> • S. Shimabukuro As a state agency representative from the DOH Child and Adolescent Mental Health Division (CAMHD), he will share Behavioral Health Administration (BHA) activities with the Council; he will share CAMHD reports with the Council; if the Council has questions for other DOH BHA Divisions such as AMHD, Alcohol and Drug Abuse Division (ADAD) and Developmental Disabilities Division (DDD) he will assist with getting the information back to the Council; he will report mental health related legislative activities to the Council. <p>Personally, he would like to know what tools are available to the</p> 			

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	<p>Council to advocate for service utilizers and what tools the Council is empowered to use, will help him to contribute.</p> <ul style="list-style-type: none"> <p>A. Beninato</p> <p>As a youth/student representative, I'm willing to go into the educational community and into the schools to ask students about their experiences with mental health and their experiences during the COVID-19 pandemic. He started asking for feedback and has received some responses about how the COVID-19 pandemic has affected youth/students and their mental health. He is willing to share his findings at the next Council meeting.</p> <p>Personally, on my own and to gather information informally, I'm willing to create a survey to ask for feedback from students and teachers about their experiences but since there's no incentive for participation (gift card) there may not be a lot of participation.</p> <p>R. Pascual-Kestner</p> <p>As a state agency representative from the Hawaii State Department of Human Services (DHS) Division of Vocational Rehabilitation (DVR), he plans to bring awareness to the Council and its stakeholders of the provision of vocational rehabilitation services for persons with disabilities, including individuals who have a mental health diagnoses, in preparing for, obtaining, retaining, maintaining and advancing in employment.</p> <p>Personally, he will make a concerted effort to facilitate communication between the Council and DVR related to what DVR is currently doing or is planning to implement and how DVR serves participants with mental health and employment challenges.</p> 			
VI. Break	At 10:57 a.m., K. Oliver announced a 15 minute break. She encouraged Council members to stand up and stretch during the break.			

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	<div data-bbox="558 214 1167 370" style="background-color: #4a90e2; color: white; padding: 10px; text-align: center; border-radius: 10px 10px 0 0;"> <p style="font-size: 1.2em; margin: 0;">Agenda: BREAK</p> </div> <p data-bbox="611 376 1115 509" style="text-align: center; margin-top: 20px;"> *Tell Me: What is it you plan to do with your one wild and precious life? </p> <p data-bbox="762 516 1041 545" style="text-align: center; margin-top: 5px;"> <i>* Mary Oliver (no relation)</i> </p> <p data-bbox="405 578 1310 683" style="margin-top: 20px;"> During the break, E. Lau-James hosted a group break activity. She shared the game “I Dissent” and everyone who wanted to participate shared their opinions about the statements on the cards. </p>			
<p data-bbox="90 729 361 794">VII. Post-Break Group Exercise</p>	<p data-bbox="405 729 1075 758">The Council reconvened Retreat activities at 11:15 a.m.</p> <p data-bbox="405 802 1299 867">Council members took a few Zoom group photos. E. Lau-James will place photos in the personalized notebooks she’s making for Council members.</p> <div data-bbox="558 898 1167 1333" style="text-align: center; margin-top: 20px;">  </div>			

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VIII. Questions from Morning Session	<p><u>Pre-Retreat Questionnaire Responses</u></p> <p>K. Oliver thanked Council members for submitting their responses. She was careful to share results without potentially identifying a specific Council member. Responses fell within the following priority areas:</p>			

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	<p style="text-align: center;">Pre-Retreat Questionnaire Over the next two (2) years, what would you like to see as priority areas for the Council?</p> <p style="text-align: center; color: green;">Mahalo for your responses!</p> <ol style="list-style-type: none"> 1) Knowledge, Education, Training 2) Public Policy and Legislation 3) Communication/Dissemination about existing services/Resources <p style="text-align: center;">Pre-Retreat Questionnaire Over the next two (2) years, what would you like to see as priority areas for the Council?</p> <ol style="list-style-type: none"> 1) Knowledge, Education, Training <ul style="list-style-type: none"> -Anti-stigma, -Internal suicide intervention training -Onboarding course for new members -Filling of vacant Council positions 2) Public Policy and Legislation <ul style="list-style-type: none"> -Improved Access to services -Address service gap within housing -Develop community programs with Dept of Public Safety -Council role to advise and check DOH -Advocacy for de-criminalizing MH and SUD -Work more closely with Legislature -Use of peer specialists -Develop integrated community behavioral health centers 			

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	<p>3) Communication/Dissemination about existing services/Resources</p> <ul style="list-style-type: none"> -Disseminate information about existing resources -Easier access to existing resources -Consideration of Insurance in Accessing resources -Social Media and Public Outreach for Council plans -Use of technology -Create and advertise directory of resources <p>She explained that Council members identified <u>system related</u> issues that create barriers and limitations for the Council to address priority areas including:</p> <ul style="list-style-type: none"> • Financial resources; • Retaining qualified and skilled professionals; • Barriers to accessing existing mental health services; • Lack of clarity about health insurance company policies; and • Increased use of peer specialists. <p>She also noted that Council members identified <u>Council related</u> issues that create barriers and limitations for the Council to address priority areas including:</p> <ul style="list-style-type: none"> • The Council’s broader influence and political reach; • Public connections; • Structure limits the Council’s ability to respond to legislature in real time (i.e. research required before decision meeting); • PIGs need to be assessed; and • Need a balance of decisiveness vs. consideration. <p><u>Council’s FY2018 Strategic Plan</u> K. Oliver summarized the Focus Areas identified in the FY2018 plan.</p>			

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	<div data-bbox="562 214 1167 370" style="background-color: #0070C0; color: white; padding: 10px; border-radius: 5px;"> <p style="margin: 0;">3) FY2018 SCMH Strategic Plan Focus Areas</p> <ul style="list-style-type: none"> * 1. Website * 2. Legislative Bills related to MH * 3. Recruit and Retain State Council and Service Area Board Members * 4. Human Trafficking – mandated reporting * 5. De-stigmatization, Access * 6. Addiction Services </div> <p data-bbox="405 643 1192 708">E. Lau-James suggested going step-by-step through each FY2018 trend/problem need.</p> <p data-bbox="405 753 1268 818">Council members reviewed the FY2018 Plan and shared comments and updates regarding the status of trend/problems needs identified.</p> <p data-bbox="405 863 892 896"><u>Trend/Problem Need 1: Council website</u></p> <ul style="list-style-type: none"> <li data-bbox="441 902 1318 967">• Objectives: Website is functional but the gathering of information has not been completed. <li data-bbox="441 1013 1283 1078">• Actions/Strategies: The developer designed the website per the Council’s Scope of Work but procedures have not been developed. <li data-bbox="441 1123 1283 1188">• Outcome/Products: A PIG is assigned and routine website updates are done; information mental health is incomplete. <li data-bbox="441 1234 1299 1481">• Council members comments about Trend/Problem Need 1: <ul style="list-style-type: none"> <li data-bbox="512 1273 1299 1338">○ E. Lau-James asked about the status of the website developer and whether the developer is still working on the website. <li data-bbox="512 1344 1299 1481">○ C. Dang stated she would research the developer’s status; she recalls the developer was an authorized vendor with knowledge of the state website who may still be in business and may be able to help with website updates. 	<p data-bbox="1346 1357 1629 1455">Identify the authorized vendor and website Scope of Work.</p>	<p data-bbox="1703 1357 1801 1390">C. Dang</p>	<p data-bbox="1881 1357 1990 1390">11/30/20</p>

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	<ul style="list-style-type: none"> ○ C. Knightsbridge stated he had friends do audits of the website and they told him that the website developer may not have known about the accessibility requirements that have fines if missing from the website. ○ C. Knightsbridge wants to know who has access to the website for updates. He stated there are dead links and last checked the website a week ago. ○ C. Knightsbridge feels that the Council’s payment of \$15K was too much for the website. S. Haitsuka stated she is not aware of ongoing payments to the website vendor. ○ H. Ilyavi stated she feels the PIG needs to meet to review the website, what needs to be changed and what direction the PIG will recommend that the Council take. C. Dang added she is interested in agenda items in addition to cost and accessibility such as functionality and succession planning and PIG members should e-mail their agenda items to S. Haitsuka. ○ T. Reed expressed her frustration about the lack of actual progress being taken on the website issues that have been identified. This is why she requested to leave this PIG. ○ C. Knightsbridge volunteered to continue to lead this PIG. <p><u>Trend/Problem Need 2: Legislation</u></p> <ul style="list-style-type: none"> ● Objectives: The Council is not timely in responding to bills. ● Actions/Strategies: AMHD and CAMHD have regularly provided updates to the Council regarding legislation; A PIG is assigned but they do not track bills and alert members about bills; A rotating list of persons to testify on bills was developed and testimony was written (for the previous legislative session, not upcoming). ● Outcomes/Products: A PIG is assigned to this item; A process has not been developed for the Council to address legislation. 	<p>Schedule PIG meeting.</p> <p>Check for accessibility and dead links.</p> <p>Check J. Clarke’s files for website vendor info</p> <p>Send PIG agenda items to S. Haitsuka</p>	<p>C. Knightsbridge</p> <p>S. Haitsuka</p> <p>S. Haitsuka</p> <p>Website/Social Media/ Advocacy PIG</p>	<p>11/30/20</p> <p>11/30/20</p> <p>11/30/20</p> <p>11/30/20</p>

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	<ul style="list-style-type: none"> • Council members comments about Trend/Problem Need 1: <ul style="list-style-type: none"> ○ E. Lau-James stated that this item is still being worked on and is still a priority for the Council. ○ R. Ries noted that the Council has received updates from AMHD and CAMHD; however, he would like the Council to receive non-DOH feedback so other voices are represented in the meeting. ○ E. Lau-James suggested NAMI. ○ C. Knightsbridge suggested Mental Health America. ○ R. Ries suggested Hawaii Psychological Association. ○ C. Dang suggested the Council interface with the Mental Health Task Force and wonders if Representative Mizuno will continue to co-Chair the task force for the next legislative session. She states they do a lot of heavy duty work on legislative bills. ○ E. Lau-James and R. Ries suggest members of the Legislative PIG and other Council members attend task force meetings. ○ Not all Council members are familiar with the Mental Health Task Force. C. Dang stated the Mental Health Task Force was co-Chaired by Rep. Mizuno and T. Kajimura, who used to work at Mental Health America Hawaii. They collectively worked together to identify areas in the community that could benefit from mental health initiatives. They came up with a significant amount of legislation and got together with stakeholders, consumers and other advocates to go through the bills. She felt the task force was productive. C. Knightsbridge agreed. ○ C. Dang stated to ask T. Kajimura the meeting notes and handouts and have them forwarded to Council members including attending meetings. R. Ries stated the next task force meeting is on 12/4/20 from 1:00 – 2:15 p.m. via Zoom. <p><u>Trend/Problem Need 3: Council/Service Area Board Recruitment/Retention</u></p> <ul style="list-style-type: none"> • Objectives: The Council/some Service Area Boards have vacancies. • Actions/Strategies: Legislation was successfully passed to change the requirement for quorum. 	<p>Get Mental Health Task Force meeting notes and info to share with Council members.</p>	<p>S. Haituka</p>	<p>11/25/20</p>

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	<ul style="list-style-type: none"> • Outcomes/Products: The Council and some Service Area Boards struggle to recruit and retain members. • Council members comments about Trend/Problem Need 3: <ul style="list-style-type: none"> ○ R. Ries suggested that the wording be changed to instead say, “Complete recruitment.” ○ R. Ries stated that he is aware there is at least one additional applicant for the Council’s student/youth vacancy. ○ S. Haituka noted that Council vacancies are listed on the Council’s monthly meeting Attendance Log. ○ R. Ries stated that there still needs to be work done to address vacancies on some of the Service Area Boards. ○ R. Ries volunteered to lead this trend/problem need. <p><u>Trend/Problem Need 4: Human Trafficking</u></p> <ul style="list-style-type: none"> • Objectives: The Council continues to seek additional knowledge about sex trafficking including resources, data and needs. • Actions/Strategies: The Council invited V. Lamb to speak at a Council meeting. She presented sex trafficking community education. She works with Susannah Wesley, an organization contracted by the Department of Human Services (DHS). • Outcomes/Products: The Council continues to identify the needs and problem areas within sex trafficking to be an advocate. • Council members comments about Trend/Problem Need 4: <ul style="list-style-type: none"> ○ D. Koyanagi shared that she is the sex trafficking liaison for DHS Child Welfare Services (CWS) and is more than willing to help. ○ S. Shimabukuro and D. Koyanagi both participate on the Hawaii Commercial Sexual Exploitation of Children (HI CSEC) task force. This task force was originally convened by Judge Radius and stakeholder attendees include representatives from the 			

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	<p>19 has created challenges relative to sex trafficking.</p> <ul style="list-style-type: none"> ○ D. Koyanagi is willing to put together information about sex trafficking, including Susannah Wesley and other agencies that are involved including HPD, Homeland Security, and the FBI as well as the state and federal prosecutors. ○ H. Ilyavi extended a reach out to D. Koyanagi offering to assist if D. Koyanagi lets the Council know what kind of help is needed. ○ S. Shimabukuro shared that he recently visited the new Pearl Haven facility on the North Shore. CAMHD was planning to support a Pearl Haven anti-sex trafficking program; due to COVID-19, funding is no longer available. ○ C. Knightsbridge suggested that the Council advise the DOH on funding as S. Shimabukuro shared. <p><u>Trend/Problem Need 5: Destigmatization</u></p> <ul style="list-style-type: none"> ● Objectives: The Council is not yet fully activated in its advocacy role relative to awareness activities, legislation, media campaigns, or letters to the editors. ● Actions/Strategies: A calendar of advocacy events was not created. ● Outcomes/Products: The Council continues to prioritize increasing awareness of mental health and stigmatization through the media. ● Council members comments about Trend/Problem Need 5: <ul style="list-style-type: none"> ○ C. Dang suggested that this trend/problem need be combined with trend/problem need 1. H. Ilyavi concurred adding that it could be a subgroup within the existing website/social media/ advocacy PIG. ○ K. Oliver noted that SAMHSA provides many resources about brain development and functioning. ○ C. Knightsbridge stated that he spoke with the mental health technology center (MHTTC) and they are willing help. ○ E. Lau-James doesn't think this trend/problem need should be 	Provide current information about sex trafficking in Hawaii.	D. Koyanagi	11/30/20

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	<p>combined with the website/social media/advocacy PIG since there is advocacy specific for mental illness, separate from social media. C. Knightsbridge and L. Nagao concurred.</p> <p><u>Trend/Problem Need 6: Addiction Services</u></p> <ul style="list-style-type: none"> • Objectives: There has been limited advocacy to restore addiction services and co-occurring programs on the neighbor islands. • Actions/Strategies: The Council has not written letters to the DHS or to the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) on the issue of lack of services on the neighbor islands. • Outcomes/Products: The Council has not restored publicly funded addiction services and co-occurring programs on neighbor islands. • Council members comments about Trend/Problem Need 6: <ul style="list-style-type: none"> ○ L. Nagao asked what services were targeted to be restored. ○ C. Dang remembered that a Maui Council member identified an effective program on Maui that was cut due to funding and the issue was brought to the Council. ○ L. Nagao shared that she feels that creating self-reliance and sustainable programs that do not rely solely on state funds is going to be important for any program’s structure due to the vulnerability of closing due to the state’s funding situation and the time it will take our economy to recovery. ○ R. Ries mentioned there are departments with staff devoted to addiction services as are community organizations/agencies who focus on addiction services. He sees the Council as a partner in these existing (i.e. partnering with HACDACS) ○ C. Dang concurred with R. Ries noting that by partnering with others, the Council will not be reinventing the wheel. 			

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	<p>K. Oliver introduced the FY2020 Strategic Plan template. She noted the template is an adaptation of the Council’s FY2018 Plan and the Hawaii Opioid Action Plan. The Council may want to revise it if there is too much or not enough detail.</p> <p>NOTE: Template slightly updated based on Retreat discussion.</p> <p style="text-align: center;">Hawaii State Council on Mental Health Strategic Plan 2020 - 2022</p> <p><i>Purpose:</i> In response to stakeholder feedback about areas of Hawaii’s mental health service system that need improvement, the State Council on Mental Health (SCMH) developed its Strategic Plan to prioritize (1) issues that directly affect more than one County service area (Statewide Comprehensive Integrated Service Area Plan; SCISAP); (2) opportunities for the Council to advocate for mental health services; and/or (3) specific ways the Council can be more effective in its advisory role to the Department of Health.</p> <table border="1" data-bbox="562 589 1165 1464"> <thead> <tr> <th colspan="2" data-bbox="562 589 1165 654">Focus Area #1 XX</th> </tr> </thead> <tbody> <tr> <td data-bbox="562 654 730 743">Strategic Planning: <i>Identified during the Council’s Retreat</i></td> <td data-bbox="730 654 1165 743"> Category: <input type="checkbox"/> Public Policy and Legislation <input type="checkbox"/> Knowledge, Skill-Building, Education and Training <input type="checkbox"/> Communication/Dissemination of Mental Health Information </td> </tr> <tr> <td data-bbox="562 743 730 987">Area(s) of Need Addressed: <i>Council’s purpose and responsibilities as required by Hawaii law</i></td> <td data-bbox="730 743 1165 987"> Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council’s advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP) (c) <input type="checkbox"/> Council’s linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council’s knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c, e) </td> </tr> <tr> <td data-bbox="562 987 730 1044"><i>Includes a narrative statement describing the problem/issue.</i></td> <td data-bbox="730 987 1165 1044">XX</td> </tr> <tr> <td data-bbox="562 1044 730 1125">Outcome(s)/Product(s): <i>What the Council wants to see</i></td> <td data-bbox="730 1044 1165 1125"><input type="checkbox"/> XX</td> </tr> <tr> <td data-bbox="562 1125 730 1279">Measurable Objective(s): <i>What the Council wants to accomplish and by when</i></td> <td data-bbox="730 1125 1165 1279">1.1 – XX 1.2 – XX</td> </tr> <tr> <td data-bbox="562 1279 730 1385">Internal/External Partners: <i>Internal: Council members per their area(s) of representation;</i> <i>External: Specific organizations, agencies and individuals</i></td> <td data-bbox="730 1279 1165 1385"> Internal: <input checked="" type="checkbox"/> X <input checked="" type="checkbox"/> X External: <input checked="" type="checkbox"/> X <input checked="" type="checkbox"/> X </td> </tr> <tr> <td data-bbox="562 1385 730 1458">Strategies: <i>Action steps the Council will take including PIGs (existing or new), requests for SABs and specialty areas, etc.</i></td> <td data-bbox="730 1385 1165 1458"> <input type="checkbox"/> XX <input type="checkbox"/> XX <input type="checkbox"/> XX </td> </tr> <tr> <td data-bbox="562 1458 730 1464">Status: <i>Updated quarterly (reviewed as a meeting agenda item; 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Status: <i>Updated quarterly (reviewed as a meeting agenda item; 3rd month each quarter)</i>	<input type="checkbox"/> Began in/Continued from (Month/Year) <input type="checkbox"/> In progress (Month/Year) <input type="checkbox"/> Completed (Month/Year)																					

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	<p>In addition to the strategic plan samples shared in the Retreat Box materials (i.e., SAMHSA Strategic Plan FY2019-FY2023), she felt that a local strategic plan has an excellent format and style.</p> <p>Elements from the Hawaii Opioid Initiative's plan were included in the Council's strategic plan template since the structure of their plan may help the Council as an ongoing, living document; to update, adjust and define PIGs as progress on each focus area is made.</p> <p>She explained each area of the template:</p> <ul style="list-style-type: none"> • Focus Area (heading): Desired result; broader and longer-term (2-year period) <p>EXAMPLE: The Council's FY2018 plan indicated focus areas such as its website; addiction; destigmatization; recruiting and training Council members; and sex trafficking.</p> <p>EXAMPLE: The Hawaii Opioid Initiative indicated six focus areas such as access to treatment; prescriber education/pain management practices; data informed decision making; prevention/public education; pharmacy-based interventions/support law enforcement; and first responders.</p> <ul style="list-style-type: none"> • Strategic Planning The Council's pre-Retreat questionnaire responses fell within three categories. This section ties the Council's strategic planning process with its Strategic Plan by identifying the category that the focus area most naturally identifies with. • Area(s) of Need Addressed This section ties the Council's Strategic Plan with its purpose as identified in §334-10, Hawaii Revised Statutes. It includes a brief narrative statement describing the problem/issue and how it relates 			

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	<p>to addressing the state mental health system.</p> <ul style="list-style-type: none"> • Outcome(s)/Product(s) States what the Council wants to see (i.e., the change, the tangible item, etc.) as the end result. The outcome(s)/product(s) are within the Council's abilities to attain. <p>EXAMPLE: The Council's FY2018 plan includes one outcome/product statement for each identified problem.</p> <p>EXAMPLE: The Hawaii Opioid Initiative identified several outcomes/ products including improving opioid and related prescribing practices by working with healthcare providers; implementing system-wide routine data collection, sharing resources to increase knowledge and inform practice; coordinating operations/services, assuring effective law and policies and offering specialized training for first responders.</p> <ul style="list-style-type: none"> • Measurable Objective(s) Includes measurable goals WITH completion dates (i.e. what will be accomplished in a particular timeframe). <p>EXAMPLE: K. Oliver shared examples of measurable objectives.</p> <ul style="list-style-type: none"> ○ Complete # stigma related trainings for Council members ○ Present a school mental health topic to 500 youth/students <p>EXAMPLE: The Hawaii Opioid Initiative identified several measurable objectives for each of its Focus Areas including:</p> <ul style="list-style-type: none"> ○ By December 2019, expand coordinated entry system pilot to a statewide system or all ADAD-contracted providers; ○ By October 2019, increase prescriber education regarding 			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>access to and use of PMO... by an additional 20%; and</p> <ul style="list-style-type: none"> ○ By October 2019, develop data needs and coordinate with the DME on data resources, collection and reporting. <ul style="list-style-type: none"> ● Internal/External Partners Includes individuals and organizations the Council will work with. <p>EXAMPLES:</p> <p>K. Oliver shared examples of internal/external partners the Council may work with who are dedicated to working on the focus area.</p> <ul style="list-style-type: none"> ○ Who is the Council working with in the DOH/Legislature? ○ Who are stakeholders/partners the Council wants to include? <p>EXAMPLE:</p> <p>In addition to its members, the Hawaii Opioid Initiative identified several partners including DOH ADAD/EMS-IPB, HI APRN Nursing Program, HPD/KPD/MPD/HCPD, DCCA Board of Pharmacy, UH School of Pharmacy, JABSOM, HI SA Coalition, and tx/recovery providers.</p> <ul style="list-style-type: none"> ● Action Steps Strategy statements with a detailed breakdown steps to accomplish the objectives; specifies who, when, what, where and how. <p>EXAMPLE ACTION STEP STATEMENTS:</p> <p>K. Oliver noted that these strategies identify the Council's incremental approach to meeting each measurable objective.</p> <ul style="list-style-type: none"> ○ Receive training on... or Meet with... or Create a PIG for... or ○ Research information about... or Develop... or Draft a... <ul style="list-style-type: none"> ● Status Provides a quarterly update on progress made for accountability. <p>Council members shared the following feedback about the template.</p> <ul style="list-style-type: none"> ● E. Lau -James stated she likes the template structure. ● C. Dang shared that she liked the template because it hones in on the 			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>ideas shared in the pre-Retreat questionnaire responses. She added that this format gives a better idea about how, when and why the Council will work on its goals.</p> <ul style="list-style-type: none"> • L. Nagao related the template to a treatment plan. • C. Dang concurred with L. Nagao’s comment. • C. Dang recommended goals and timelines for PIGs be in the plan. • L. Nagao stated PIGs be part of the strategy to address focus areas. 			
IX. Next Steps	<p>K. Oliver highly encouraged Council members to take an active role in identifying the focus areas that will be included in the FY2020 Plan.</p> <p>L. Nagao asked the Council to discuss whether K. Oliver will gather the Council’s information and draft the plan or whether the Council prefers to draft the plan on its own.</p> <p>C. Dang asked L. Nagao to clarify if she was asking for a summary of today’s Retreat discussion be provided to assist with completing the template. L. Nagao concurred with C. Dang’s suggestion.</p> <p>R. Ries supports K. Oliver drafting plan content stating the Council justified having a facilitator assist with the strategic plan because it would help the Council be productive. He envisions finalizing the draft plan in February.</p> <p>K. Oliver felt the request was reasonable and will confirm with the Scope of Work quote. She confirmed the strategic plan template does not need to be completed today. She will propose template content for the Council to review and decide upon. Initial template content will in part be identified through the Council’s interim work between December and before February’s Retreat.</p> <p>C. Dang shared that she would like the Council to consider first prioritizing all of the ideas, focus on the top three, then upon completion of the top 3, look at other ideas. R. Pascual-Kestner and R. Ries concurred.</p>	<p>Confirm drafting of the Council’s Strategic Plan is included in the Scope of Work.</p> <p>Prioritize strategic planning ideas to identify the top 3.</p>	<p>K. Oliver</p> <p>Council Members</p>	<p>11/30/20</p> <p>12/8/20</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>R. Ries noted that one of the Council’s responsibilities is to generate a report to the Legislature describing what the Council has done. S. Haitsuka noted that the deadline for the report is before Christmas. The Council will review a draft report at the December meeting.</p> <p><u>Interim Work</u></p> <div data-bbox="562 461 1165 623" style="border: 1px solid blue; background-color: #4699ED; color: white; padding: 10px; text-align: center; margin: 10px 0;"> <p>Agenda: Interim work for February Retreat</p> </div> <ul style="list-style-type: none"> * Review 2019 Legislative report * draft Eileen’s Task list * draft Strategic Plan Page (s) <ul style="list-style-type: none"> * 2018 list * Areas identified in re-retreat survey * Other <ul style="list-style-type: none"> ● Legislative Report The 2020 draft report will be reviewed at the December meeting. It may be helpful for Council members to review the 2019 report. ● Task List with Role and Commitment Statements E. Lau-James is waiting for several Council members to share their roles and commitment statements so she can compile and create guidebooks for each member. ● FY2020 Strategic Plan If there are additional focus areas that were not discussed during today’s Retreat, please e-mail them to S. Haitsuka for K. Oliver to add to the list. <p>K. Oliver will work on adding content to the Strategic Plan template after receiving the Council’s prioritized list of focus areas.</p>	<p>Draft report and distribute with the December meeting handouts.</p> <p>Draft report for Council members to review and finalize.</p> <p>Submit information to S. Haitsuka for E. Lau-James.</p> <p>E-mail additional focus areas to S. Haitsuka for K. Oliver.</p> <p>Draft template content.</p>	<p>R. Ries and S. Haitsuka</p> <p>R. Ries S. Haitsuka</p> <p>K. Aumer; N. Crozier; H. Ilyavi; D. Koyanagi; T. Reed; J. Fujii</p> <p>Council Members</p> <p>K. Oliver</p>	<p>11/30/20</p> <p>11/30/20</p> <p>12/7/20</p> <p>11/30/20</p> <p>1/4/21</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>K. Oliver thanked Council members in advance for submitting their post-Retreat questionnaire responses which she will use to complete the post-Retreat facilitator summary.</p> <p>Agenda for February 9, 2021 (Retreat Part II)</p> <ul style="list-style-type: none"> • Reviewing roles and commitment statements (E. Lau-James' Council Member Guidebook) • Reviewing and editing the FY2020 Strategic Plan (including the Focus Area template with measurable objectives and strategies) • Strategic planning activities to help the Council with next steps (including an Action Plan checklist with deadlines based on the Focus Area measurable objectives and strategies) 			
X. Closing Remarks	<p>R. Ries thanked K. Oliver for facilitating the Council through four hours of strategic planning activities and discussions. He thanked Council members for their attendance and participation throughout the Retreat.</p> <p>R. Ries stated the post-Retreat questionnaire link was shared in the Zoom chat. S. Haitsuka will also e-mail the link. He encouraged members to complete the questionnaire asap while it's fresh in their mind.</p> <p>R. Ries asked Council members to share feedback about today's Retreat.</p> <ul style="list-style-type: none"> • C. Dang stated, "What a productive retreat! Many mahalos to everyone for being here." • L. Nagao stated, "Appreciated everyone's participation, loved hearing all your input and efforts and learning from you!" • C. Matayoshi said, "Thank you all!!!" • C. Dang stated, "Thanks Karen for the great work!" • S. Shimabukuro thanked S. Haitsuka for her help. • C. Dang thanked S. Haitsuka for, "all the work that connected the dots in facilitation." • T. Reed said, "Thank you for everyone's hard work/commitment." • E. Lau-James stated, "A huge Mahalo to Stacy for the enormous amount of work she put into making the Retreat happen!" 	Complete post-Retreat questionnaire	Council Members	11/13/20

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>R. Ries noted that K. Oliver will provide the Council with a post-Retreat summary to review at the December meeting. Retreat (Part II) will be on 2/9/2. He encouraged members to complete interim work before then.</p> <p>He wished everyone a Happy Thanksgiving before adjourning at 12:59 p.m.</p>			
Retreat Materials and Supplies	<p>The following hard copy handouts were provided to Council members:</p> <ul style="list-style-type: none"> • Retreat cover letter and agenda • State Council – Vision, Mission, Who Are We? • State Council – Strategic Plan FY18 – FY20 • Hawaii Revised Statutes (HRS) – State Council • SAMHSA Strategic Plan FY19-FY23 • SAMHSA Prevention Framework • SAMHSA Best Practices for State Behavioral Health Planning Councils • OnStrategyHQ.com – Strategic Planning Process • OnStrategyHQ.com – Strategic Planning/SWOT Analysis Template • WashingtonNonprofits.org – Sample Strategic Plan Timeline • TCC Group – 10 Keys to Successful Strategic Planning • Post-Retreat Questionnaire Form <p>The following supplies were provided to Council members to aide in their engagement and participation in Retreat activities:</p> <ul style="list-style-type: none"> • Pens, Markers, notebook, sticky notes, page flags, stress ball, face mask, laminated expression signs, and facilitator’s business card • Blank thank you card and individually packaged snacks • SAMHSA Mental Health Friend CD; 2020 AMHD Recovery Guide 			
Reference Links to Recommended Reading and Online Resources	<p>The following resources were recommended reading and online resources in preparation for the Retreat.</p> <ul style="list-style-type: none"> • National Council of Non-Profits – How America’s Charitable Non-Profits Strengthen Communities and Improve Lives https://www.nonprofitimpactmatters.org/site/assets/files/1/nonprofit-impact-matters-sept-2019-1.pdf 			

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<ul style="list-style-type: none"> • National Council of Non-Profits – Strategic Planning for Non-Profits https://www.councilofnonprofits.org/tools-resources/strategic-planning-nonprofits • Nolo.com – Creating a Strategic Plan for your Non-Profit https://www.nolo.com/legal-encyclopedia/create-strategic-plan-nonprofit-29521.html 			
Reference Links to Resources Mentioned During the Retreat	<p>The following resources were shared during the Retreat.</p> <ul style="list-style-type: none"> • Center for Social Innovation (C4) https://c4innovates.com/ • Hawaii Opioid Initiative website https://www.hawaiiopioid.org/ • Hawaii Opioid Initiative Initial Plan https://health.hawaii.gov/substance-abuse/files/2013/05/The-Hawaii-Opioid-Initiative.pdf • Hawaii Opioid Initiative Updated Plan https://health.hawaii.gov/injuryprevention/files/2019/01/The-Hawaii-Opioid-Initiative-2.0.pdf 			

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
December 8, 2020
9:00 a.m. – 11:30 a.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Dang, Cynthia “Cindi”; Ilyavi, Heidi; Knightsbridge, Christopher; Lau-James, Eileen; Martinez, Beatrice “Kau’i”; Matayoshi, Carol; Nagao, Lani; Ries, Richard; Shimabukuro, Scott**

Members Absent: **Fujii, John; Pascual-Kestner, Rusnell “Rus”**

Members Excused: **Crozier, Charleen “Naomi”; Koyanagi, Dina; Reed, Tara**

Guests Present: **Talisayan, Bryan (Mental Health America Hawaii); Young, Keanu (Public Access Room)**

DOH Staff Present: **Ganir, Ashley; Haitsuka, Stacy; Mersereau, Edward; Nazareno, Jocelyn; Pavao, Steven**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 9:00 a.m.</p> <p>Members and guests introduced themselves.</p> <p>The following definition of quorum was added to the agenda as of the November 10, 2020 agenda: Pursuant to Act 137-18 (SB 203), Chapter 92, Hawaii Revised Statutes: “(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes.”</p> <p>For example, if only 16 of the entitled 21 members are appointed, at least</p>	For information only.		

	<p>9 must be present to establish a quorum. To validate a council action, of the 9 members present, an affirmative vote from at least 5 is required.”</p> <p>Quorum was established.</p>			
<p>II. Meeting Announcements</p>	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally get his attention during the meeting. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who take a break and step away from the meeting, please notify him before leaving as the Council needs to track of when Council members leave and return to verify quorum. • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. • If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear speaker. 	For information only.		
<p>III. Presentation/ Guest Speaker</p>	<p>R. Ries introduced E. Mersereau, Deputy Director of the Department of Health’s Behavioral Health Administration (BHA).</p>	For information only.		

	<p>R. Ries shared that the BHA includes four Divisions:</p> <ul style="list-style-type: none"> • Alcohol and Drug Abuse Division (ADAD) • Adult Mental Health Division (AMHD) • Child and Adolescent Mental Health Division (CAMHD) • Developmental Disabilities Division (DDD) <p>The Council sent E. Mersereau two letters. One on August 28, 2020 regarding the impact of COVID-19 on mental health services and a second on October 20, 2020 inviting him to attend a Council meeting.</p> <p>Mr. Mersereau shared the following information and BHA updates:</p> <ul style="list-style-type: none"> • Thanked members for their volunteer efforts to advocate for behavioral health services. He specifically thanked members for sharing ideas, participating and being more active not only for COVID-19 response but for all support provided to the BHA to improve the behavioral health system of care. He looks forward to working closely with the Council. • He reviewed information shared by S. Haitzuka about the Council’s activities and reviewed the Council’s monthly meeting minutes, including the minutes from the Council’s Retreat. • BHA COVID-19 responses has focused on a few priority areas: #1 Quarantine and Isolation Centers Neighbor island counties work with their District Health Officers to plan and design quarantine and isolation centers. On Oahu, as of August 2020, in coordination with the City and County of Honolulu, we opened the first and only medical quarantine and isolation center in the state where individuals can get non-hospital-based medical and psychiatric support during their stay. It is likely that four of the five quarantine and isolation sites will continue for a longer period of time after December 2020 and after COVID-19 CARES funding ends. <p>For example, from August 2020 to November 7, 2020, the capacity for quarantine and isolation increased 7-fold from 80 units</p>			
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	<p>statewide to 554 units.</p> <p>In the white paper, and based on approximately 50 participants, about 96% of participants were also effectively supported with services such as substance use treatment, supported housing, and more stabilized linkage to community services. This proof of validated the need of funding for and operation of short-term sub-acute stabilization, which is a missing key component for the behavioral health continuum of care.</p> <p>#2 Hawaii CARES Program Hawaii CARES call center was redesigned in July 2020 as the primary hub for centralized access to behavioral health services including mental health, substance abuse, crisis response and quarantine and isolation referrals and coordination.</p> <p>For example, the call center saw a significant increase in incoming call volume. Since August 2020, the Hawaii CARES call center fielded approximately 2,550 calls related to quarantine and isolation.</p> <p>On Oahu between August and November 2020,</p> <ul style="list-style-type: none"> - There were over 10k active cases of which 12% received quarantine and isolation by the BHA. - One if five individuals who received quarantine and isolation were identified as homeless. - About 403 families received quarantine and isolation by the BHA of which 45% shared that their ethnicity was either Native Hawaiian or Other Pacific Islander. <p>#3 Fleet of Transportation for COVID-19 Care These vehicles are coordinated through the Hawaii CARES call center. Vehicles are dispatched when individuals do not have other means of personal transport between, for example, the hospital and their residence, or urgent care/emergency department to quarantine and isolation.</p>			
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	<p>#4 Providing Personal Protective Equipment to Behavioral Health and Homelessness providers and community-based social service staff statewide.</p> <p>#5 Partnership with the University of Hawaii Working with the UH Manoa Myron B. Thompson School of Social Work has focused on data-driven initiatives including creating a behavioral health data dashboard that includes as real-time data as is available. Victoria Fan, ScD is an awesome resource and the Council should consider asking her to present areas of her work at a future Council meeting. Eventually, we'd like this data to be accessible to the public.</p> <p>One data dashboard item will be to validate the Hawaii CARES incoming call volume. For example, incoming call volume over the last four months has broken the record of highest monthly call volume four times. In other words, data has confirmed incoming call volume has increased per capita more in the last four months than in any month in the last nine years.</p> <ul style="list-style-type: none"> • Communication and dialogue with the legislature is critical for the upcoming session. It has been identified that the state will be facing a \$1.5 to \$2 billion dollar deficit each year for the next four years. Hugh cuts are anticipated and a lot of jockeying for sustaining funding for their programs (versus having funds cut or eliminated). We know that everyone needs to bring something to the table as far as what costs they are willing and able to cut; but for BHA, we are hoping that our relationships and regular dialogue with our legislators, especially those who are leading the health committees understand what BHA is doing and how we are operating at the BHA level and within each of the BHA Divisions. <p>Council members had the following comments:</p> <ul style="list-style-type: none"> • R. Ries thanked E. Mersereau for his time and sharing updates. • R. Ries noted that the Council would like to have him attend Council meetings regularly but recognize he is busy. That said, the 	<p>Invite V. Fan to present her work at a future Council meeting.</p>	<p>R. Ries/ S. Haitsuka</p>	<p>April/ May 2021</p>
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	<p>Council will work with S. Shimabukuro and S. Haitzuka to keep updated on BHA activities.</p> <ul style="list-style-type: none"> • R. Ries emphasized the Council’s advisory role to the DOH and BHA and we want to be in good communication with him to be supportive of DOH and BHA activities. He noted one area that makes the Council stand out compared to other boards is that the Council has service recipients and family members of service recipients serving on the Council. Our discussions may be different from discussions that occur in other board meetings. Our voice has been largely voiceless in the past but we hope to partner with you as we look at areas where the Council can deliberate and check in with him about to be in good communication. • L. Nagao shared that she had initial concerns about Hawaii CARES being positioned to expand beyond its original purpose which was to help navigate substance use treatment. She asked about the process for Hawaii CARES referrals to non-DOH funded substance use providers including private and QUEST providers. <p>E. Mersereau affirmed that it has always been the intent to be “go to” referral hotline for behavioral health services. He clarified that Hawaii CARES is like the spoke and wheel where their position as the central hub is to be the resource for behavioral health, mental health, substance use, and homelessness. BHA touches a lot of sectors and specialized populations. Being in a position to quickly and seamlessly connect and match individuals with the appropriate agency is the overall goal.</p> <p>E. Mersereau shared his vision for de-siloizing and universalizing areas of BHA where processes across BHA Divisions can be universalized broadly so energy can be spent on patient/individual/service-recipient-centric activities.</p> <ul style="list-style-type: none"> • C. Knightsbridge asked about the quarantine and isolation model used on Oahu and how it could be replicated to the Neighbor 			
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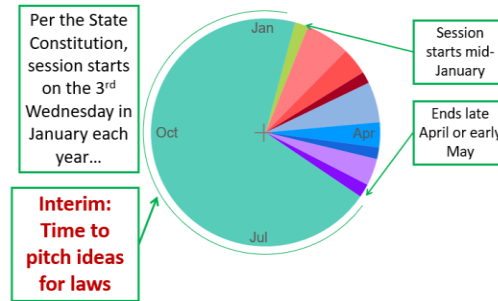
	<p>Islands as it feels sometimes that they are neglected. Hawaii is not Honolulu. Are there plans to replicate and mirror these efforts on Neighbor Islands?</p> <p>E. Mersereau affirmed the Neighbor Islands are neglected in part due to Oahu-centric thinking. Oahu has so much of the resources on island whereas the Neighbor Islands do not have the same access. That said, BHA recognizes that each neighbor island has different systems and structures so it's important not to dictate Oahu-centric ideas with the expectation that neighbor islands will be in a position to replicate it; however, we do want to share Oahu's experiences and provide support to Neighbor Islands, such as the District Health Officers.</p> <p>For example, AMHD was successful in opening a second Palekana 24-hour specialized residential program in Hilo which builds off of the original Palekana program located at Leahi Hospital on Oahu.</p> <p>R. Ries thanked E. Mersereau for joining the Council at today's meeting and for sharing information about BHA activities.</p>			
<p>IV. Education/Training</p>	<p>R. Ries introduced K. Young, Assistant Public Access Coordinator with the Public Access Room (PAR), a Division of the Legislative Reference Bureau (LRB) which is located at the State Capitol.</p> <p>R. Ries thanked C. Dang for her help with setting up today's legislative training through Senate Vice-President Michelle Kidani's office.</p> <p>Council members received copies of the legislative training handouts in the handouts for today's meeting.</p> <p>K. Young provided an overview of the following topics:</p> <ul style="list-style-type: none"> • Public Access Room at the State Capitol Located on the 4th Floor in Room 401 (808) 587-0478 phone / email: par@capitol.hawaii.gov • Branches of Government Three SEPARATE branches: Legislative (makes laws), Executive 	<p>For information only</p>		

(implements laws), and Judiciary (interprets the law)

- Legislative Branch
THREE levels: National (U.S. Congress passes laws governing the COUNTRY), State (State Legislature passes laws governing HAWAII), and County (County Councils pass laws that govern their COUNTY)
- State Legislature
Each regular session = TWO years (biennial) starting in each odd year and ended in each even year. Two-year budget operates on a fiscal year calendar from July 1st to June 30th.
The Legislature meets for 60 session days (approximately 100 calendar days; weekends/holidays/recess days are excluded).

State Legislature

In Session: Mid-January – early May



- Hawaii State Legislature
TWO Chambers = Senate (25 State Senators) and House of Representatives (51 State Representatives)
- State Senate
25 members = 24 Democrats + 1 Republican
4-year terms
16 subject matter committees
Has Advise and Consent power to confirm the Governor’s appointments to the Courts, Executive Agencies, and Boards and Commissions.
- State House of Representatives
51 members = 47 Democrats + 4 Republicans
2-year terms
18 Subject matter committees




Has Impeachment power.

- **Bill Introduction**

1 week after start of session

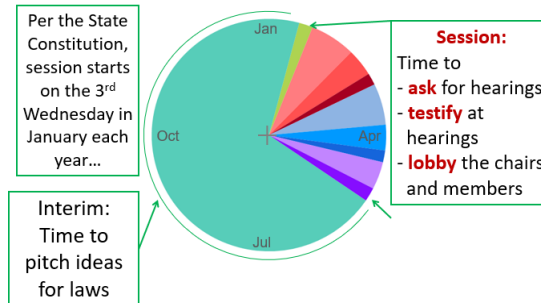
Use the session calendar to keep track of deadlines. The session moves quickly!

Here's a brief glimpse of what's to come in a bill's life...

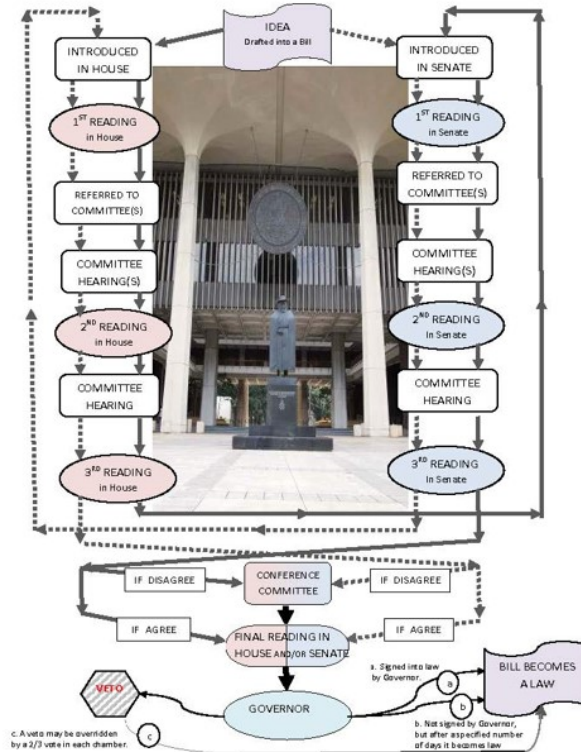
- Successfully pass through all **committees** the House and Senate have referred it to 
- and*
- Successfully pass **three readings in both the House and Senate chambers** (where all the members convene) 
- and*
- Have both House and Senate agree on **exact wording** 
- and*
- Be signed or allowed to come into law by **Governor**, or House and Senate successfully overrides his veto

State Legislature

In Session: Mid-January – early May

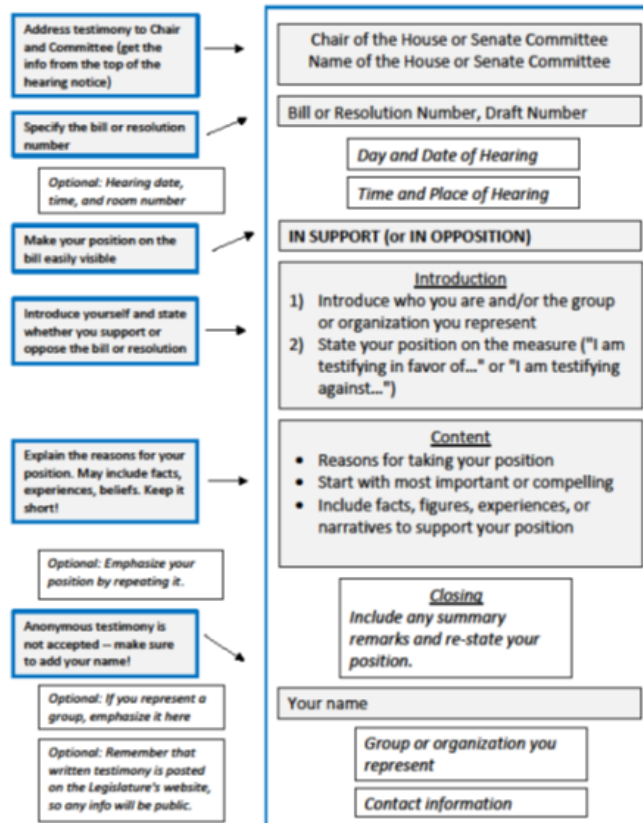


QUICK VIEW OF HOW A BILL BECOMES LAW IN HAWAII



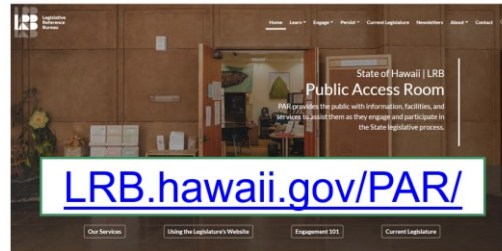
- Testifying on a bill
Offer why the bill should become law (or shouldn't)
Submit testimony in writing that includes the bill number or reference number, Council's name, bill position, and why.

Sample Written Testimony: The Basics



- Hawaii State Legislature preview included the following areas:
 - Overview of how to sign up for an account;
 - How to find legislators and committees;
 - How to track bills and how to generate reports/lists;
 - How to find hearing notices;
 - How to find bill webpages and committee reports; and
 - Where to submit written testimony.
- Legislative Reference Bureau (LRB)
The public is welcome to contact PAR and LRB anytime for assistance with the State legislative process.

**For helpful handouts,
and to learn more, head to the
Public Access Room's website**



Public Access Room (PAR)



808/587-0478
room 401
par@capitol.hawaii.gov

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 [@Hawaii_PAR](#)

<https://lrb.hawaii.gov/par>

R. Ries thanked K. Young for providing legislative training to the Council.

He noted that if there are additional questions regarding the legislative training, the Council will ask S. Haitsuka to follow up with K. Young or Council members are welcome to contact K. Young directly if they need help with the [Hawaii State Legislature's website](#). He can be reached via e-mail at k.young@capitol.hawaii.gov and by telephone at 587-0478 (Oahu); 974-4000 x7-0478 (Hawaii Island); 984-2400 x7-0478 (Maui); 274-3141 x7-0478 (Kauai); (808) 468-4644 x7-0478 (Moloka'i/Lana'i).

V. Consideration and Approval of Minutes
• November 10,

The draft minutes for the November 10, 2020 business meeting and

Finalize minutes as

S. Haitsuka

12/16/20

2020	Retreat were reviewed. No amendments were offered. C. Matayoshi made a motion for the business meeting and Retreat minutes from the November 10, 2020 meeting be approved. E. Lau-James seconded the motion.	drafted. Motion passed unanimously.		
VI. Community Input	Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time. [No community input was received.]			
VII. Old Business	<p>R. Ries announced that each of the Council’s Permitted Interaction Groups (PIGs) have updates to share. In the meeting handouts, Council members received a copy of the meeting notes from the PIGs and post-Retreat handouts.</p> <p><u>Legislative PIG (LEG-PIG)</u></p> <p>C. Dang briefly summarized the report for the Legislative PIG (LEG-PIG). She noted the purpose of the meeting was to address the two tasks assigned to the LEG-PIG by the Council which included:</p> <ul style="list-style-type: none"> • Scheduling a legislative training for Council members; and • Assisting with the Council’s legislative activities, including drafting testimony. <p>Regarding legislative training for Council members, this item has been completed as legislative training occurred during today’s meeting.</p> <p>Regarding the Council’s legislative activities, the LEG-PIG discussed the following items (discussion is summarized in the LEG-PIG Meeting Notes handout for todays’ meeting):</p> <ul style="list-style-type: none"> • Bill tracking • How DOH BHA tracks bills relative to behavioral health topics • Concern for PIG vs. Committee work (Sunshine Law) • Council’s list of priority bills • State agency legislative updates • Succession planning for the Council’s legislative activities • LEG-PIG meetings 			

	<p>C. Dang noted that that LEG-PIG met for 45 minutes and were able to address all these items which shows that there is power in having PIGs.</p> <p>E. Lau-James shared that S. Haitsuka provided an enormous amount of knowledge and support for the LEG-PIG with scheduling meetings and sharing information about her legislative activities.</p> <p>Of the items discussed above, the LEG-PIG requested the Council’s approval for five (5) activities.</p> <p>R. Ries asked the Council to vote on the five items the LEG-PIG recommended for Council approval.</p> <ul style="list-style-type: none"> • #1: Bill Tracking <ul style="list-style-type: none"> The recommendation is for the Council to approve receiving two legislative lists. One is for the one-time behavioral health related bill list (List 1) and the second list is a daily update with DOH BHA bills, which includes bills from AMHD, CAMHD and DDD (List 2). Council members shared the following comments: <ul style="list-style-type: none"> ○ C. Matayoshi and H. Ilyavi agreed that these lists will be a great resource. ○ E. Lau-James noted that these are lists that S. Haitsuka has access to as a member of the DOH BHA Legislative team and is willing to share. ○ C. Dang noted that the Council will be able to see all the bills (List 1) and all the bills that DOH BHA is tracking (List 2). These lists will help the Council to prioritize bills it wants to track. ○ R. Ries proposed adding a due date for List 1 of February 2, 2021. That way, the Council will receive List 1 as a handout for the February 2021 Council meeting. ○ R. Ries noted that Council members will receive many e-mails from S. Haitsuka because she will send an updated List 2 daily until the end of the legislative session and a final updated List 2 after the bill signing deadline. 			
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	<p>C. Matayoshi motioned to approve the above recommendation with a February 2, 2021 due date. C. Knightsbridge seconded the motion.</p> <p>Council members voted to approve LEG-PIG recommendation #1: Bill Tracking with a February 2, 2021 due date for List 1.</p> <ul style="list-style-type: none"> • #2: Council’s Priority Bills The recommendation is for the Council to approve the LEG-PIG to recommend the top five bills for the Council to support, oppose or comment on and to report these top five bills to the Council at our February meeting. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ R. Ries proposed adding a due date of February 2, 2021 for the LEG-PIG to recommend the top five bills. That way, the Council will receive the list as a handout for the February 2021 Council meeting. <p>C. Dang made a motion to approve the above recommendation with a February 2, 2021 due date. C. Matayoshi seconded the motion.</p> <p>Council members voted to approve LEG-PIG recommendation #2: Council’s priority bills with a February 2, 2021 due date for the LEG-PIG to recommend the top five bills the Council will support, oppose or comment on.</p> <ul style="list-style-type: none"> • #3: State Agency Legislative Updates The recommendation is for the Council to approve regularly scheduling legislative updates from DOH BHA Division leaders including Amy Curtis for AMHD, S. Shimabukuro for CAMHD and Ami Aiona for ADAD. 	<p>Ayes (11); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p> <p>Ayes (10); Noes (0); Abstentions (1)</p> <p>Motion passed.</p>		
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	<p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ C. Dang stated that in addition to updates from DOH BHA (including ADAD, AMHD, and CAMHD), having legislative updates from all Council members who represent state agencies would be great to share. ○ R. Ries encouraged the Council’s state agency representatives to share their agencies legislative priorities at future Council meetings. ○ S. Shimabukuro commented that this recommendation should be fine because historically, the Council has invited these DOH BHA Division leaders to provide legislative updates at Council meetings. ○ R. Ries encourages regular updates to be provided. <p>C. Dang made a motion to approve the above recommendation. C. Knightsbridge seconded the motion. Council members voted to approve LEG-PIG recommendation #3: Regularly scheduled State agency legislative updates from DOH BHA Division leaders.</p> <ul style="list-style-type: none"> ● #4: Succession Planning/Written Guidelines The recommendation is for the Council to approve the LEG-PIG to develop an initial draft of written guidelines for the Council’s legislative activities with a January 5, 2021 due date. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ C. Dang shared that the intent is to provide standard guidelines for the Council’s legislative activities. ○ C. Dang noted that guidelines could also be helpful for the other PIGs because the guidelines specify where and when the PIGs would meet and generally what the PIGs activities and responsibilities are. ○ R. Ries agreed that the Council could benefit from having a routinized process for legislative activities. ○ R. Ries noted that drafting of the guidelines for the Council’s legislative activities is an appropriate short-term assignment 	<p>Ayes (10); Noes (0); Abstentions (1) Motion passed unanimously.</p>		
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	<p>for the LEG-PIG.</p> <ul style="list-style-type: none"> ○ R. Ries proposed adding a due date of January 5, 2021 for the LEG-PIG to share an initial draft of the guidelines. That way, the Council will receive the draft as a handout for the January 2021 Council meeting. <p>C. Dang made a motion to approve the above recommendation #4: drafting written guidelines for the Council’s legislative activities with a January 5, 2021 due date. C. Matayoshi seconded the motion.</p> <p>Council members voted to approve LEG-PIG recommendation #4: Drafting of the Council’s written guidelines for legislative activities with a January 5, 2021 due date.</p> <ul style="list-style-type: none"> ● #5: Succession Planning/Testimony Template The recommendation is for the Council to approve the LEG-PIG to develop the Council’s testimony template. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ R. Ries mentioned that as individual citizens, Council members may testify on any bill they would like; however, with the Council’s template, this will be for official testimony that the Council is submitting. ○ R. Ries stated that having a testimony template would be very efficient and would allow the Council a consistent way of sharing its testimony with legislators. ○ L. Nagao wanted to know who approves the content of the template. R. Ries explained that the Council has the responsibility for reviewing and approving the content of the testimony. Assuming the Council has consensus, the testimony can be finalized and submitted to the legislature when the hearing is scheduled. If no consensus on the content of the testimony, they Council may decide not to testify. ○ C. Dang emphasized that the template is going to be general and will include the required elements of testimony 	<p>Ayes (11); Noes (0); Abstentions (0)</p> <p>Motion passed.</p>		
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	<p>including the Council’s position on the bill, committee identification, and the hearing information.</p> <ul style="list-style-type: none"> ○ E. Lau-James added that the template will have standard “boiler plate” language and will include fill-in statements such as, “According to _(bill #)_, this bill seeks to ___” and “The Council testifies _(position)_ of this bill for the following reasons: x, y, z.” ○ L. Nagao, noting that she is taking about a different issue than recommendation #5, asked if the Council’s testimony needs to be “approved” by the government. S. Haituka noted that the template is created at the Council’s purview and as C. Dang noted, will include the required elements of testimony. The content would align with the Council’s position on the bill. C. Dang added that the content would be related to Council discussions so testimony should be familiar to Council members. ○ R. Ries noted that if the Council were to disagree with DOH’s position, the Council could ask for an explanation but, for the most part, the Council will be on the same page for position on the Council’s priority bills. ○ K. Aumer clarified this recommendation is only asking for the Council to approve the LEG-PIG to create the Council’s testimony template. ○ R. Ries proposed adding a due date of December 29, 2020 for the LEG-PIG to share an initial draft of the guidelines. That way, the Council will receive the draft as a handout for the January 2021 Council meeting. <p>C. Dang made a motion to approve the above recommendation #5: drafting the Council’s testimony template with a December 29, 2020 due date. L. Nagao seconded the motion.</p> <p>Council members voted to approve LEG-PIG recommendation #5: draft a testimony template with a December 29, 2020 due date.</p>	<p>Ayes (11); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p>		
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	<p><u>Website, Social Media and Advocacy PIG (WSA-PIG)</u></p> <p>H. Ilyavi briefly summarized the report for the Website, Social Media and Advocacy PIG (WSA-PIG). She noted the purpose of the meeting was to address the two tasks assigned to the WSA-PIG by the Council which included (discussion is summarized in the WSA-PIG Meeting Notes handout for today's meeting):</p> <ul style="list-style-type: none"> • Identify the WSA-PIG's goals • Present goals at a future Council meeting for approval <p>Regarding the Council's website, social media and advocacy activities, the WSA-PIG discussed the following goals:</p> <ul style="list-style-type: none"> • Website goals • Social Media goals <p>Regarding the Council's website maintenance, the WSA-PIG discussed the following items:</p> <ul style="list-style-type: none"> • Who has access to the website and who is responsible for maintaining the website including updating content and providing links to relevant resources? • Are there limitations for what the Council can do with the website per the vendor's scope of work/contract? <p>Regarding the Council's website content, the WSA-PIG discussed the following items:</p> <ul style="list-style-type: none"> • Tiered-based approach with a visual diagram/tool • Structure of the website Resources tab – Local first, followed by state, then national/federal. • Re-word information about Hawaii CARES. • WSA-PIG selecting content for the website on an ongoing basis. <p>Regarding social media, the WSA-PIG discussed the following items:</p> <ul style="list-style-type: none"> • Importance of social media and the Council's social media presence. <p>Regarding the WSA-PIG's ongoing meetings, the WSA-PIG discussed the following items:</p>			
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	<ul style="list-style-type: none"> • Use of a “living document” and/or collaboration app to increase the speed of the WSA-PIGs work/activities. <p>Of the items discussed above, the WSA-PIG requested the Council’s approval for one activity.</p> <p>R. Ries asked the Council to vote on the one item the WSA-PIG recommended for Council approval.</p> <ul style="list-style-type: none"> • #1: Website, Social Media and Advocacy PIG (WSA-PIG) Goals The recommendation is for the Council to approve the goal of assuring the Council’s website is fully functional, that it fulfills its fundamental purpose, and is aligned with its intent for use and access by advocating and communicating, and sharing purposeful, relevant and mental health-focused content and resources; and For succession planning and monitoring of website related goals, developing a written tiered-based approach to address website maintenance which includes decision tree options for “go” versus “no go” to make the decision making process consistent and efficient by assessing responses to: “Is it purposeful?”; “Is it relevant”; and “is it behavioral health-focused?” <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ C. Dang mentioned that the WSA-PIG is looking to capture the information and tier it in a way that visually shows how the website can go to the next tier. ○ R. Ries supports the WSA-PIGs proposed goals and plans for developing the tiered-based visual tool. ○ L. Nagao commented that it’s a good idea to have an exit strategy with succession planning for the website, social media and advocacy activities. <p>E. Lau-James made a motion to approve the above recommendation. C. Matayoshi seconded the motion.</p> <p>Council members voted to approve WSA-PIG recommendation #1:</p>	<p>Ayes (11); Noes (0); Abstentions (0)</p> <p>Motion passed</p>		
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	<p>WSA-PIG Goals.</p> <p><u>Rescind Motion for Sending a Letter to DOH About Contact Tracing</u> R. Ries asked the Council to vote to rescind the motion for the Council to send a letter to DOH regarding Hawaii’s participation in the contact tracing app.</p> <p>He noted it is evident from both the media and the We Are Aloha Safe contact tracing website, that the DOH is actively involved in the development, testing and the public’s use of a contact tracing app for Hawaii. Therefore, writing a letter to encourage DOH to participate is not necessary.</p> <p>R. Ries recalled that C. Knightsbridge was to draft a letter and share it at our November 2020 meeting but, to my knowledge, the draft letter was not submitted to the Council to review.</p> <p>C. Knightsbridge made a motion to rescind the Council’s previous motion to draft a letter to DOH strongly encouraging Hawaii’s participation in the contract tracing app with 14 other states. L. Nagao seconded the motion.</p> <p>Council members voted to rescind the drafting of the letter to DOH regarding contact tracing.</p> <p><u>Retreat PIG</u> E. Lau-James briefly summarized the report for the Retreat PIG, including two post-Retreat handouts.</p> <ul style="list-style-type: none"> • Post-Retreat Facilitator Summary K. Oliver, the Retreat Facilitator, submitted the post-Retreat facilitator summary which includes descriptions of pre-, during and post-Retreat (Part 1) activities as well as planning for Retreat (Part 2) and a list of resources. • Prioritizing of the Council’s Strategic Plan Focus Areas 	<p>unanimously.</p> <p>Ayes (11); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p>		
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	<p>The Council identified wanting to prioritize the Strategic Plan Focus Areas that were identified during the Retreat (Part 1).</p> <p>K. Oliver is asking the Council to rank order the focus areas using a questionnaire format. Council members are asked to rank the lists of focus areas. Results will be shared at January’s Council meeting. Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ R. Ries emphasized that all Council members need to participate and rank the priority focus areas. This interim work assignment is mandatory for all Council members. ○ R. Ries asked that two additional focus areas be added: Neighbor Islands need to have increased representation in Council actions and stronger advocacy for the emotional well-being of the community. ○ A. Beninato commented that lots of positive change has been enabled by the COVID-19 pandemic such as ways that E. Mersereau shared. For example, A. Beninato mentioned that some individuals and families have been in strained situations before but now, as a result of the COVID-19 pandemic and resources, some of these individuals and families have had a stronger motivation to change their situation. <p>R. Ries noted that the lists of focus area categories and focus area items to rank was provided as a handout and S. Haitzuka will share the link to the online questionnaire to submit ranked responses.</p> <p>S. Haitzuka noted that the online questionnaire includes five questions. Each question lists several focus area items for Council members to rank. To avoid a violation of the Sunshine Law regarding hidden/anonymous voting, Council members are required to provide their first name when they submit their ranked responses. Council members’ name and ranking results will be disclosed in writing as a handout for the January 2021 Council meeting.</p> <p>The due date for submitting responses is Tuesday, December 22, 2020.</p>	<p>Send the link to Council members via e-mail.</p> <p>Submit ranked responses for Retreat priority focus areas.</p>	<p>S. Haitzuka</p> <p>All Council members</p>	<p>12/8/20</p> <p>12/22/20</p>
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<p>VIII. New Business</p>	<p><u>Draft State Council Annual Report to the Legislature</u> R. Ries stated the Council’s annual report to the legislature and Governor is due before the January Council meeting. He asked Council members to share their comments and revisions to the draft report.</p> <p>Council members shared the following comments/revisions:</p> <ul style="list-style-type: none"> • R. Ries asked that an additional goal be added on the last page of the report to address the Council’s increased presence as an advisory Council to the DOH and as an advocate for neighbor island stakeholders and communities. <p>C. Matayoshi made a motion to approve the annual report as amended. E. Lau-James seconded the motion.</p> <p>Council members voted to approve the annual report as amended with the additional goal requested by R. Ries.</p> <p><u>Maui Service Area Board (MSAB) Comprehensive Integrated Service Area Plan (CISAP)</u> T. Reed was unable to attend today’s meeting and will share this topic at the January 2021 Council meeting.</p> <p>R. Ries noted that in the meeting handouts, C. Matayoshi provided a copy of the AMHD policy for State, County and Service Plans and S. Haitsuka provided a copy of the AMHD policy for the Role and Functions in Support of the Council and Service Area Boards.</p> <p>He stated that this additional policy information is very helpful and encouraged Council members to electronically access the Council’s member orientation materials to check out more information.</p> <p><u>Office of the National Coordinator for Health Information Technology (ONC) Cures Act</u> L. Nagao briefly summarized the handout she shared.</p> <ul style="list-style-type: none"> • The Cures Act involves regulation of open notes and behavioral health is included as part of the medical component for 	<p>Ayes (10); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p> <p>Present at the January 2021 Council meeting.</p>	<p>T. Reed</p>	<p>1/12/21</p>
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	<p>implementing the Cures Act.</p> <ul style="list-style-type: none"> • Advocating for consumer rights to information in their medical records is a primary reason for this Cures Act. • She doesn't have enough information and did not research the Cures Act further. She received the information from a medical student who shared it with her. • She asked Kauai Community Mental Health Center (CMHC) staff if they were familiar with this Cures Act and changes to open notes but at this time, there are no changes planned. <p>R. Ries stated that it is good for the Council to be aware of and to monitor progress as time goes by.</p> <p>L. Nagao asked if Council members are aware of changes being made in their respective areas related to the Cures Act to share that information.</p>			
<p>IX. Closing Announcements/ Meeting Evaluation</p>	<p>R. Ries encouraged members to share their feedback about how today's Council meeting went either by sharing them verbally or typing their feedback in the chat.</p> <ul style="list-style-type: none"> • E. Lau-James shared that she feels excited and feels that today's Council meeting is the most productive meeting to date. She looks forward to working more with the Council. <p>L. Nagao shared that the University of Hawaii, Department of Psychiatry will hold their 2nd virtual conference in April 2021. If the Council has any questions regarding topics being covered or what resources to share at the virtual conference, to please let her know via S. Haitsuka.</p> <p>R. Ries thanked all Council members for their participation, for the work done by the PIGs between Council meetings.</p> <p>He asked the PIGs to schedule their December 2020 meetings as soon as possible because it is a shorter month's timeframe before the January 2021 Council meeting due to the Christmas and New Year's holidays.</p> <p>He reminded Council members to complete the mandatory post-Retreat</p>			

	<p>Interim work to rank the priority focus areas. The due date to submit ranked responses is Tuesday, December 22, 2020.</p> <p>The next Council meeting is on Tuesday, January 12, 2021 from 9:00 a.m. to 11:30 a.m.</p> <p>Before adjourning the meeting, R. Ries encouraged Council members to take care of themselves because good self-care is important. He encouraged Council members to remain connected with loved ones.</p>			
VI. Adjournment	The meeting was adjourned at 11:28 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <p>E-mail (1 of 3) with handouts (total of 11 handouts)</p> <ol style="list-style-type: none"> 1. December 2020 Meeting – Agenda 2. November 2020 Meeting – Draft Business Minutes 3. November 2020 Meeting – Draft Retreat Minutes 4. December 2020 Meeting – FY21 Attendance Log 5. December 2020 Meeting – PIG, Legislation 12/2/20 Mtg Notes 6. December 2020 Meeting – PIG, Website/Social Media/Advocacy 11/24/20 Mtg Notes 7. December 2020 Meeting – PIG, Retreat Post-Retreat Facilitator Summary 8. December 2020 Meeting – PIG, Retreat Post-Retreat Follow-Up 11/12/20 E-mail 9. December 2020 Meeting – PIG, Retreat Post-Retreat Follow-Up Draft Council Brochure 10. December 2020 Meeting – PIG, Retreat Post-Retreat Follow-Up Website Scope of Work 11. December 2020 Meeting – PIG, Retreat Post-Retreat Follow-Up Interim Work Prioritizing Focus Area Statements <p>E-mail (2 of 3) with handouts (total of 4 handouts)</p> <ol style="list-style-type: none"> 12. December 2020 Meeting – Legislative Training All Handouts 13. December 2020 Meeting – New Business, Draft Annual Legislative 	For information only.		

	<p>Report</p> <ol style="list-style-type: none"> 14. December 2020 Meeting – New Business, Maui Service Area Board (SAB) Comprehensive Integrated Service Area Plan 2020 15. December 2020 Meeting – New Business, Office of the National Coordinator for Health Information Technology (ONC) Cures Act Final Rule <p>E-mail (3 of 3) with handouts (total of 11 handouts)</p> <ol style="list-style-type: none"> 16. December 2020 Meeting – Handout, AMHD Policy and Procedure, Role and Functions in Support of the State Council and SABs on Mental Health and Substance Abuse 17. December 2020 Meeting – AMHD Policy and Procedure, State, County and Service Plans 18. December 2020 Meeting – Minutes, Kauai SAB 7/30/20 19. December 2020 Meeting – Minutes, Kauai SAB 8/27/20 20. December 2020 Meeting – Minutes, Hawaii SAB 5/26/20 21. December 2020 Meeting – Minutes, Hawaii SAB 7/28/20 22. December 2020 Meeting – Minutes, Hawaii SAB 9/22/20 23. December 2020 Meeting – Minutes, Hawaii SAB 10/27/20 24. December 2020 Meeting – Notes, Mental Health Task Force 9/25/20 25. December 2020 Meeting – Notes, Mental Health Task Force 10/23/20 (Draft) 			
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STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
January 12, 2021
9:00 a.m. – 11:30 a.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Dang, Cynthia “Cindi”; Fujii, John; Ilyavi, Heidi; Knightsbridge, Christopher; Koyanagi, Dina; Lau-James, Eileen; Matayoshi, Carol; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Ries, Richard; Shimabukuro, Scott**

Members Absent: **Crozier, Charleen “Naomi”**

Members Excused: **Martinez, Beatrice “Kau’i”; Nagao, Lani**

Guests Present: **Reyno Yeomans, Raelyn; Stevens, Jessica (HI Health Systems Corp/Hilo Medical Center); Talisayan, Bryan (Mental Health America Hawaii)**

DOH Staff Present: **Haitsuka, Stacy; Nazareno, Jocelyn**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 9:00 a.m.</p> <p>Members and guests introduced themselves. In addition to Council members and DOH staff, the following individuals were present:</p> <ul style="list-style-type: none"> • Bryan Talisayan – Executive Director, Mental Health America Hawaii • Raelyn Reyno-Yeomans – Community Member • Jessica Stevens – Inpatient Psychiatric Nurse, Hilo Medical Center <p>The following definition of quorum was added to the agenda as of the November 10, 2020 agenda: Pursuant to Act 137-18 (SB 203), Chapter 92, Hawaii Revised Statutes: “(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting</p>	For information only.		

	<p>begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes.”</p> <p>For example, if only 16 of the entitled 21 members are appointed, at least 9 must be present to establish a quorum. To validate a council action, of the 9 members present, an affirmative vote from at least 5 is required.”</p> <p>Quorum was established.</p>			
<p>II. Meeting Announcements</p>	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • The SCMh continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally get his attention during the meeting. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who take a break and step away from the meeting, please notify him before leaving as the Council needs to track of when Council members leave and return to verify quorum. • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and 	<p>For information only.</p>		

	<p>rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option.</p> <ul style="list-style-type: none"> • If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear speaker. 			
III. Consideration and Approval of Minutes December 8, 2020	<p>The draft minutes for the December 8, 2020 meeting were reviewed. No amendments were offered.</p> <p>C. Matayoshi made a motion for the meeting minutes to be approved. E. Lau-James seconded the motion. T. Reed and J. Fujii abstained.</p>	<p>Finalize minutes as drafted.</p> <p>Motion passed.</p>	S. Haitzuka	01/29/21
IV. Community Input	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p> <p>[No community input was received.]</p>			
V. Permitted Interaction Group (PIG) Reports	<p>R. Ries explained that in this section of the agenda, PIG members may briefly summarize the PIG activities since the last Council meeting including meeting dates, discussions, and recommendations on topics approved at previous Council meetings.</p> <p>He asked that oral summaries be brief and if PIG members would like to share a longer report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <ul style="list-style-type: none"> • PIG for Website, Social Media, and Advocacy (WSA) • PIG for Legislation (LEG) <p>The WSA-PIG did not meet in December 2020 or January 2021 prior to today's Council meeting. WSA-PIG members were encouraged to participate in scheduling WSA-PIG meetings when S. Haitzuka e-mails the Doodle poll for meeting availability.</p> <p>C. Dang briefly summarized the report for the Legislative PIG (LEG-PIG). The LEG-PIG met three times in December 2020 on the 14th, 15th and the 20th.</p>	For information only.		

	<p>The purpose of the meetings on December 14th and 15th was to:</p> <ol style="list-style-type: none"> 1. Review the LEG-PIG recommendations approved by the Council at the December 2020 Council meeting. 2. Identify what the LEG-PIG will do to meet the due dates for each of the approved recommendations. 3. Begin working on the draft testimony. <p>The purpose of the meeting on December 20th was to:</p> <ol style="list-style-type: none"> 1. Continue discussion and planning about what the LEG-PIG will do to meet the due dates for each of the approved recommendations (from the Council’s 12/8/20 meeting). 2. Finalize the Council’s draft testimony template. 3. Continue working on the draft Participation Guidelines for Council Legislative Activities. 4. Review the draft bill regarding changes to the Sunshine Law. <p>The LEG-PIG discussed the following items (discussion is summarized in the LEG-PIG handouts for today’s meeting):</p> <ul style="list-style-type: none"> • LEG-PIG meeting notes for its 12/14/20 meeting • LEG-PIG meeting notes for its 12/29/20 meeting • 12/29/20 Draft Participation Guidelines for Council Legislative Activities • 12/29/20 Draft Letterhead for Council testimony • 12/9/20 Civil Beat article about the Office of Information Practices and their plans to introduce a bill to allow boards and commissions to continue to meet using interactive conference technology such as Zoom. • 11/20/20 Department of the Accounting and General Services (DAGS) Justification Sheet for a bill relating to Sunshine Law boards. • 11/20/20 Draft bill Relating to Sunshine Law Boards. <p>She noted that having one LEG-PIG versus multiple LEG-PIGs working on various legislative activities is preferred.</p>			
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	<p>The LEG-PIG requested the Council’s approval for three (3) activities.</p> <ul style="list-style-type: none"> • #1: Testimony Template The recommendation is for the Council to approve the Council’s testimony template as drafted to be used by the LEG-PIG to draft testimony for the Council’s priority bills. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ C. Dang shared that one advantage of having the testimony template is for the Council to submit real time response/testimony for bills. ○ R. Ries commended the LEG-PIG for its work and for meeting three times in December 2020. He noted that this LEG-PIG is one significant example of how this Council is different from other boards and commissions. ○ T. Reed encouraged island Service Area Boards to consider using a template too. ○ R. Ries noted that Council members who wish to have their licensure, certifications and/or college degrees included after their name in the left margin of the Council’s letterhead to please type that information into the chat so that those changes can be made. <p>E. Lau-James motioned to approve the above recommendation. T. Reed seconded the motion.</p> <p>Council members voted to approve LEG-PIG recommendation #1: Testimony Template.</p> <ul style="list-style-type: none"> • #2: Participation Guidelines The recommendation is for the Council to approve the draft Participation Guidelines for Council Legislative Activities to be piloted by the LEG-PIG between January 2021 and May 2021 and revised as needed. At the conclusion of the regular 2021 Legislative Session, the LEG-PIG will share revised guidelines (at the June 2021 Council meeting) and ask for Council feedback, edits and approval. 	<p>Ayes (13); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p>		
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	<p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ C. Dang noted that time is lost when having to get organized to start legislative activities. Having the guidelines upfront will help the Council to being work quicker. ○ R. Ries mentioned that he liked that the participation guidelines are written in a chronological table with a description of the legislative tasks, who is responsible for each of them and when. ○ R. Ries proposed that the Council have a separate discussion about its Bylaws. He recognized that several areas of the Bylaws are outdated and that the Council can work on revising the Bylaws before attaching the participation guidelines as an appendix. <p>C. Dang made a motion to approve the above recommendation. E. Lau-James seconded the motion.</p> <p>Council members voted to approve LEG-PIG recommendation #2: Participation Guidelines.</p> <ul style="list-style-type: none"> ● #3: Sunshine Law Bill The recommendation is for the LEG-PIG to defer action on the proposed Sunshine Law bill, for the Council to read the handouts pertaining to the proposed Sunshine Law bill and to send comments to S. Haitsuka. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ R. Ries thanked the LEG-PIG committee for sharing the draft bills far in advance of the legislature convening and hearing being scheduled. He noted this bill will have an impact on not just this Council but all boards, councils, commissions and Service Area Boards statewide. ○ R. Ries added the due date of January 26, 2021 for Council members to share their feedback. He asked that S. Haitsuka send a reminder to Council members for this deadline. 	<p>Ayes (13); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p>		
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<ul style="list-style-type: none"> • PIG for the SCMH Retreat 	<p>C. Dang made a motion to approve the above recommendation. C. Knightsbridge seconded the motion.</p> <p>Council members voted to approve LEG-PIG recommendation #3: Sunshine Law Bill.</p> <p>The Retreat PIG did not meet this month; however, E. Lau-James briefly summarized post-Retreat planning activities.</p> <ul style="list-style-type: none"> • Ranked Results Council members were given interim work. Council members were asked to rank order the focus areas in each of the four (4) categories identified during the Council’s Strategic Planning Retreat (Part 1). <p>In our meeting handouts, a copy of the results showing how each Council member ranked each focus area item was included. It was necessary to identify each Council member’s ranked responses to avoid any violation of Sunshine Law because secret voting is not allowed.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ C. Dang indicated the LEG-PIG would use the ranked results to inform selection of the Council’s top priority bills. ○ There were two Council members who did not submit their ranked responses. D. Koyanagi noted that she struggled with options for ranking the focus areas. C. Knightsbridge stated he needed more time. ○ After explaining that there is no additional time and that the Council can either move forward without their ranked responses, D. Koyanagi and C. Knightsbridge stated they were willing to do so during the meeting. S. Haitsuka provided the link to the ranked response submission form. <p>Upon submission of D. Koyanagi and C. Knightsbridge’s ranked responses, S. Haitsuka presented a revised ranked order handout on the Zoom screen. A copy will be shared via e-mail. Council</p>	<p>Ayes (13); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p>		
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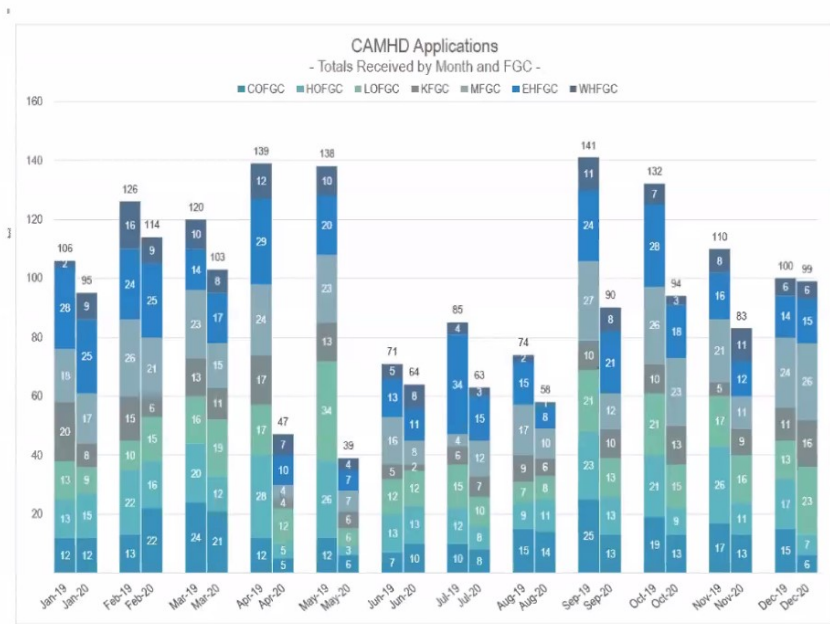
	<p>members shared the following comments:</p> <ul style="list-style-type: none"> ○ Focus is on the top 5 focus areas in each Strategic Plan Category. ○ These ranked results will be transmitted to Karen for her to assist the Council with drafting its Strategic Plan. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ C. Dang noted that the LEG-PIG is using the strategy whereby additional bills are being lined up should the initial priority bills not proceed forward during the legislative session. She suggested that the Council could take a similar approach by also looking at the ranked responses to identify additional Strategic Plan focus areas that can be worked on after the Council has addressed its initial priorities. R. Ries concurred. <ul style="list-style-type: none"> ● Council Member Guidebook The intent was to present the guidebook as a memento for Council members; a feel good souvenir from the Retreat to remind members about a positive teamwork experience; something sentimental with Council member reflections and role statements. <p>Most Council members submitted their commitment and role statements during the Retreat.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ C. Dang shared that the Retreat can follow a standardized process for future Retreat planning similar to the LEG-PIG’s draft participation guidelines with the pilot option and pending request to attach it to the Council Bylaws as an appendix. 			
<p>VI. Island Representative Reports</p>	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective Service Area Board may briefly summarize their board meetings and when applicable, share updates on requested items identified at previous Council meetings.</p>			

<ul style="list-style-type: none"> • Kauai Service Area Board (KSAB) • Maui Service Area Board (MSAB) • Oahu Service Area Board (OSAB) 	<p>He asked that oral summaries be brief and if members would like to share a longer Service Area Board report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>No update was provided.</p> <p>The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> • The MSAB met in January 2021 and set its priorities. • The Maui Service Area Administrator who works at the Maui Community Mental Health Center Branch retired. • The MSAB meeting focused on the three primary goals they identified: <ul style="list-style-type: none"> ○ MSAB members recognized the need for education regarding the needle disposal, education about the needle exchange program and hours of service. ○ Maui does not have an adolescent unit. MSAB wrote a letter was written to Renee Friend, Maui Memorial Nurse to invite her to speak at a future MSAB meeting about the Maui Memorial adolescent unit. ○ Having a mental health nurse practitioner be available in the emergency department at Maui Memorial Medical Center to provide coverage 24/7. <p>The following updates were provided by C. Dang.</p> <ul style="list-style-type: none"> • The OSAB did not meet for the 2nd time in six months due to not filing the agenda on time. She elevated her concern and support will be provided to the Oahu Service Area Administrator to assist with OSAB support activities. • Working on the CISAP is a priority and she hopes the OSAB will meet in January. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries offered to provide support to elevate the concern for lack of OSAB support. If needed, she will address her concerns with E. 			
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<ul style="list-style-type: none"> Hawaii Service Area Board (HSAB) 	<p>Mersereau if it occurs a 3rd time in FY21.</p> <p>The following updates were provided by C. Matayoshi.</p> <ul style="list-style-type: none"> The HSAB did not meet but will get together in January. She met with members of the Hawaii Island Cultural Advancement Resiliency Independence and Nurturing Growth (CARING) group. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> Regarding changes in environmental conditions, C. Dang asked C. Matayoshi if Hawaii Island sees an uptick in mental health services when environmental conditions change. C. Matayoshi stated she feels that there is a great need for mental health services on Hawaii Island. S. Shimabukuro inquired about how the uptick is observed? C. Matayoshi stated she receives input from service providers, case managers, and people who report being unable to access mental health services. R. Ries is wondering about the use of technology in rural areas. He acknowledge the division of resources and the lack of technology access for those who do not have access. C. Knightsbridge commented that this is a very good point and that it is often overlooked in terms of making sure people have access. C. Dang noted that a future PIG could be focused on looking at resources, equity issues and how to collaborate with other agencies and stakeholders similarly to the work DHS is doing as shared by J. Fujii. 			
<p>VII. State Agency Representative Reports</p>	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective state agency may briefly summarize agency data, agency information related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p>			

<ul style="list-style-type: none"> Department of Education (DOE) and Judiciary 	<p>Council membership positions are vacant. R. Ries encouraged other Council members to ask individuals to apply for DOE and Judiciary positions.</p> <p>C. Dang emphasized that filling positions benefits the Council and the state agency by having dual communication between the Council and the state agency.</p> <p>R. Ries is inclined to do a soft inquiry first. He is actively working to fill these slots. He would like to make this inquiry knowing that there are many other things that are being done within the agencies and this may not be on their radar.</p> <p>C. Dang made a motion to send a letter to DOE and Judiciary to nominate and fill Council positions. T. Reed seconded the motion.</p> <p>The motion passed unanimously.</p> <p>R. Reyno-Yeomans suggested to include the Department of Public Safety (PSD); however, PSD is not a statutorily required as an area of representation on the Council. R. Reyno-Yeomans shared that an interview with a psychiatrist at Oahu Community Correctional Center (OCCC) identified that approximately 30% of males and 50% of females have a serious mental illness.</p> <p>The interview/webinar is available on the Hawaii Appleseed Center for Law and Economic Justice website. It was posted on Facebook on 9/16/20 (see below).</p>  <p>https://www.facebook.com/Hawaii.Appleseed/videos/375708416766370</p>	<p>Ayes (12); Noes (0); Abstentions (0)</p>		
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<ul style="list-style-type: none"> Hawaii Public Housing Authority (HPHA) Department of Health Child Adolescent Mental Health Division (DOH CAMHD) 	<p>L</p> <p>No updated was provided.</p> <p>The following updates were provided by S. Shimabukuro:</p> <ul style="list-style-type: none"> DOH Behavioral Health Administration (BHA) has been very busy with COVID-19 vaccination POD clinic at Windward Health Center. Clinic staff are slowing working their way up in administering vaccinations. Last week staff administered approximately 300/day. This week, they administered approximately 800/day. Hopefully next week, they will be able to administer approximately 1000/day. <p>Target groups are kupuna 75 years and older as well as direct service provider staff, correctional facility staff and other first responders.</p> <ul style="list-style-type: none"> CAMHD is working with the University of Hawaii (UH) Department of Psychiatry to help provide psychiatrist coverage in emergency departments statewide. There is an increased need for mental health care and calls to the statewide Hawaii CARES call center have increased. Looking at the bar graph below, there was a dip in the summer for applications for CAMHD services which is typical because school is out for summer break. New referrals to CAMHD are just now getting back to normal. COFGC means Central Oahu Family Guidance Center (Leeward Health Center, Pearl City, Oahu). 			
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- Department of Human Services (DHS) MedQUEST (MQD) Division Medicaid Program

The following updates were provided by J. Fujii:

- Community Care Services (CCS) is the DHS MQD program for the Medicaid population for Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI).
- Procurement in November 2020: Request for Proposals (RFP) was released and proposals are due back this month. The questions and answers for the RFI were completed and posted. This RFP is a big update for behavioral health and input from the DOH Behavioral Health Administration including the Alcohol and Drug Abuse Division (ADAD), Adult Mental Health Division (AMHD), and the Child and Adolescent Mental Health Division (CAMHD) as well as DHS staff was included.
- ‘Ohana CCS is the current contractor for the CCS program and they delegate community services to a number of other subcontracted providers statewide. One change with the new procurement includes requiring a psychiatrist to be present where they may not have previously been required and for face-to-face case management to occur for clinical reasons within COVID-19 safety

<ul style="list-style-type: none"> • Department of Human Services (DHS) Child Welfare Services (CWS) • Department of Human Services (DHS) 	<p>guidelines versus connecting with CCS members by phone call or by text messaging.</p> <ul style="list-style-type: none"> • DHS is also in the middle of procurement for their QUEST Integration (QI) RFP which was released in December 2020. This RFP was originally procured two years ago but the current procurement includes a Level 5 option which indicates higher intensity of illness relative to the support services provided. • For the QI service, there was a protest in March 2020 and procurement was rescinded. The reason for last year’s protest was due to procedural steps related to authorizing services and policies for the health plan and health insurance coverage. In December 2020, it was reissued. • New procurement revamps the case management model to reduce fragmentation and look at whole-person care. It features individualized care plans with an integrated point-of-view. <p>R. Ries shared that he is aware some providers are frustrated with being denied claims and the appeal process not resolving issues that prevent payment for their services. This results in the providers not wanting to provide care to individuals with insurance payment/authorization barriers. J. Fujii asked R. Ries to share details with him as he is not aware of these types of situations.</p> <p>The following updates were provided by D. Koyanagi:</p> <ul style="list-style-type: none"> • There has been a significant rise in the number of child welfare cases which is likely due to people staying home during the COVID-19 pandemic. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries is interested in reviewing metric data, if available. D. Koyanagi can provide data from the CWS hotline and statewide information. <p>The following updates were provided by R. Pascual-Kestner:</p> <ul style="list-style-type: none"> • DVR continues to provide services to waitlisted individuals. In the last two years, approximately, 700 individuals who were cleared 			
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<p>Division of Vocational Rehabilitation (DVR)</p>	<p>from the waitlist. MSD means most significantly disabled; SD means significantly disabled; Non-SD means not significantly disabled.</p>			
<p>VIII. Specialty Area Representative Reports</p> <ul style="list-style-type: none"> • Hawaii Advisory Committee on Drug Abuse and Controlled • Mental Health Providers • Parents and Family Members of Mental Health Service Recipients 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective specialty area may briefly summarize specialty area activities related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by J. Fujii:</p> <ul style="list-style-type: none"> • HACDACS set its priorities for 2021 including: <ul style="list-style-type: none"> ○ Prevention programming in school-based settings ○ Methamphetamine use in Hawaii ○ Substance use treatment in the criminal justice system ○ Hawaii Coordinated Access Resource Entry System (CARES) for behavioral health services ○ Workforce development <p>The following updates were provided by R. Ries</p> <ul style="list-style-type: none"> • Stress level within organizations he is affiliated with indicates that there are a lot of providers who are overwhelmed while trying to take care of everyone else. Self-care is important. <p>The following updates were provided by H. Ilyavi:</p> <ul style="list-style-type: none"> • There are no resources for childcare as parents are returning to work. • COVID-19 funds ended and students need resources especially as parents return to work and students return to in-person learning part-time, especially students who have behavioral health needs. 			

<ul style="list-style-type: none"> Consumer Advocates 	<p>The following updates were provided by E. Lau-James:</p> <ul style="list-style-type: none"> Stressed the need to keep things simple because when people are overwhelmed they have a hard time processing the deluge of resources and wading through how to get help. <p>The following updates were provided by C. Knightsbridge:</p> <ul style="list-style-type: none"> CDC report about mental health identified significant fourfold increases in individuals diagnosed with depressive disorder and anxiety disorder. Approximately one in 10 individuals indicate they are suicidal. Suicide is on the rise. Substance use disorder also increased by approximately 13%. There has been an increase in prescription drug use associated with these behavioral health disorders. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> K. Aumer noted that she reviewed the CDC data and noted seeing a similar increase in these diagnoses for individuals in Hawaii. She is interested in reviewing local data. <p>The following updates were provided by T. Reed:</p> <ul style="list-style-type: none"> She noted that she has not found resources for individuals on a fixed income. She is using more resources to care for her family and pay for her obligations. She doesn't qualify for stimulus aid but at the same time, her expenses have increased during the pandemic. 			
<p>IX. Presentation/ Guest Speaker</p>	<p>There were no presentations or guest speakers scheduled.</p>			
<p>X. Old Business</p> <ul style="list-style-type: none"> Hawaii State Department of Health 	<p>R. Ries noted that anytime the Council has a new business agenda item that needs to be continued to the next month's meeting, the Council will have those agenda items listed the following month as Old Business agenda items.</p> <p>After hearing Mr. Eddie Mersereau's presentation last month, R. Ries asked if Council members had feedback. As noted in the minutes, Mr. Mersereau shared several updates about the Behavioral Health</p>			

<p>Behavioral Health Administration Update</p> <ul style="list-style-type: none"> Hawaii State Legislature (HSL) Training HSL Website Overview and Website Features 	<p>Administration’s (BHA) priorities and areas that are being focus on going into the 2021 Legislative Session.</p> <p>R. Ries recalled that Mr. Mersereau shared about BHA COVID-19 response efforts via the Hawaii Behavioral Health and Homelessness Statewide Unified Response Group (BHHSURG) including efforts to develop quarantine and isolation hotels, transportation between hospitals and quarantine and isolation facilities for individuals who test positive for COVID-19.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> None. <p>Also last month, the Council received legislative training from Keanu Young, the Assistant Public Access Coordinator with the State Capitol Public Access Room (PAR), which is a Division of the Legislative Reference Bureau and is located at the State Capitol.</p> <p>R. Ries noted that a copy of the presentation he shared last month was included in our handouts for today’s meeting. In his presentation, he explained the three branches of government, the member ship of the state Senate and House of Representatives, shared information about how bills become law in Hawaii, tips for testifying on bills and how to use the Hawaii State Legislature website.</p> <p>R. Ries thanked C. Dang for helping to arrange the Council to receive legislative training. She was in contact with Senator Michelle Kidani’s office staff who helped to identify K. Young for our Council training.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> C. Dang recommends putting legislative training as a fixed annual Council training in December since the Council is dynamic and always in flux with new members and members ending their term. 			
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<p>XI. New Business</p> <ul style="list-style-type: none"> Maui Service Area Board (MSAB) CISAP 	<p>T. Reed shared some highlights about the MSAB Comprehensive Integrated Service Area Plan (CISAP). A copy of the CISAP was included as a handout for today's meeting.</p> <ul style="list-style-type: none"> The MSAB identified three (3) goals Data was provided by the Maui Community Mental Health Center (CMHC) Branch and from the Healthcare Association of Hawaii. Maui's CISAP design can definitely be used to present research on island/County numbers including population and services. She recommends that SABs create goals to be worked on at the County level. A summary of findings emphasized the areas of need on Maui including the aging population and limited access to technology. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> C. Dang commented that developing a standardized template for the CISAP could be done so that all SABs use the same style. It could include fill in style prompts so County data can be reported similarly. Regarding the voluntary COVID-19 vaccination, there was a recent poll that identified approximately 30% of people decline the vaccine. R. Ries noted that there could be legitimate reasons for refusing the vaccine and people's beliefs should be respected and offer sympathy. C. Matayoshi mentioned that SAMHSA provides a CISAP template. 	<p>E-mail template to S. Haitzuka</p>	<p>C. Matayoshi</p>	<p>2/2/21</p>
<p>XII. Closing Announcements</p>	<p>Council member shared the following announcements:</p> <ul style="list-style-type: none"> C. Dang shared that the 18th Annual Hawaii International Virtual Summit on Preventing, Treating and Assessing Trauma (IVAT) is scheduled for April 26-30, 2021. <div data-bbox="753 1284 947 1425" data-label="Image"> </div> <p>Website: https://www.ivatcenters.org/hawaii-summit</p>			

The following chart identifies the cost for registration:

18 th Hawai'i Virtual Summit Registration Fees		
ADMISSION ITEMS	EARLY BIRD (Jan 25– Feb 28)	REGISTRATION FEE (Mar 1 – Apr 20)
Full Summit Registration <i>April 27-30, 2021</i>	\$350	\$385
3 Days Summit Registration <i>April 27-29, 2021 OR April 28-30, 2021</i>	\$300	\$335
2-Days Summit Registration <i>April 27-28, 2021 OR April 28-29, 2021 OR April 29-30, 2021</i>	\$220	\$255
1-Day Summit: Tuesday ONLY <i>April 27, 2021</i>	\$125	\$150
1-Day Summit: Wednesday ONLY <i>April 28, 2021</i>	\$125	\$150
1-Day Summit: Thursday ONLY <i>April 29, 2021</i>	\$125	\$150
1-Day Summit: Friday ONLY <i>April 30, 2021</i>	\$125	\$150

She wants to know if registration can be subsidized by DOH. There are 12 tracks and group discounts are available. She stated DOH is an event sponsor. She is also interested in knowing whether the Council would like virtual poster presentation/marketing at the event. For example, whether the Council would like to share a summary of the Retreat.

The next Council meeting is on Tuesday, February 9, 2021. The Council's business meeting will be from 8:30 a.m. to 9:00 a.m. and the Council's Retreat (Part 2) will be from 9:00 a.m. to 1:00 p.m.

XIII. Meeting Evaluation / Future Agenda Items

R. Ries encouraged members to share their feedback about how today's Council meeting went either by sharing them verbally or typing their feedback in the chat.

- S. Shimabukuro shared, "I think it's been terrific."
- T. Reed shared that the, "Meeting went well."
- K. Aumer agreed the meeting was "terrific."
- J. Stevens shared her, "Deepest Mahalo to all of you for the great work that you do for the community and agencies throughout the state. Your commitment and dedication is greatly appreciated. Hilo Medical Center – Behavioral Health Unit would like to serve as a resource in anyway necessary."

	<ul style="list-style-type: none"> R. Reyno-Yeomans shared she felt it was a, “Great Council meeting. As a community guest, very informative and good flow.” 			
VI. Adjournment	The meeting was adjourned at 11:26 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <p>E-mail (1 of 3) with handouts (total of 11 handouts)</p> <ol style="list-style-type: none"> January 2021 Meeting – Agenda December 2020 Meeting – Draft Minutes December 2020 Meeting – FY21 Attendance Log <p>E-mail (2 of 3) with handouts (total of 4 handouts)</p> <ol style="list-style-type: none"> January 2021 Meeting – PIG, Legislation 12/14/20 Meeting Notes January 2021 Meeting – PIG, Legislation 12/15/20 Meeting Notes January 2021 Meeting – PIG, Legislation 12/29/20 Meeting Notes January 2021 Meeting – PIG, Legislation Draft Council Testimony Template January 2021 Meeting – PIG, Legislation Draft Participation Guidelines for Council Legislative Activities January 2021 Meeting – PIG, Legislation Sunshine Law Draft Bill January 2021 Meeting – PIG, Legislation Department of Accounting and General Services Justification Sheet January 2021 Meeting – PIG, Legislation Civil Beat Article (12/9/20) Regarding Proposed Sunshine Law Changes <p>E-mail (3 of 3) with handouts (total of 11 handouts)</p> <ol style="list-style-type: none"> January 2021 Meeting – PIG, Retreat Interim Work – Prioritizing Focus Area Statements, Ranking Results December 2020 Meeting – Legislative Training Presentation Slides December 2020 Meeting – Final Annual Legislative Report January 2021 Meeting – New Business, Maui Comprehensive Integrated Service Area Plan (CISAP) 2020 	For information only.		

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
February 9, 2021
8:30 a.m. – 9:00 a.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Crozier, Charleen “Naomi”; Dang, Cynthia “Cindi”; Fujii, Jon; Ilyavi, Heidi; Knightsbridge, Christopher; Lau-James, Eileen; Martinez, Beatrice “Kau’i”; Matayoshi, Carol; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Ries, Richard; Shimabukuro, Scott**

Members Absent:

Members Excused: **Koyanagi, Dina**

Guests Present: **Reyno Yeomans, Raelyn**

DOH Staff Present: **Haitsuka, Stacy; Nazareno, Jocelyn**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 8:37 a.m.</p> <p>Members and guests introduced themselves.</p> <p>The following definition of quorum was added to the agenda: Pursuant to Act 137-18 (SB 203), Chapter 92, Hawaii Revised Statutes: “(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes.” For example, if only 16 of the entitled 21 members are appointed, only 9 members would be necessary to establish a quorum and if only 9</p>	For information only.		

	<p>members are present, the affirmative vote of only 5 members is needed to validate a council action.</p> <p>Quorum was established.</p>			
<p>II. Meeting Announcements</p>	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally interject during the meeting to get his attention. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who need to take a break and step away from the meeting, please notify him before leaving as the Council needs to keep track of when Council members leave and return to verify quorum. • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. • If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear speaker. <p>R. Ries stated this meeting will end at 9:00 a.m. and the Council’s</p>	<p>For information only.</p>		

	<p>Retreat will begin at that time.</p> <ul style="list-style-type: none"> • Of the 16 Council members, there are 15 members who submitted their pre-Retreat questionnaire responses and all 15 indicated they will attend today's Retreat. • Retreat materials and supplies were sent in the mail. 			
<p>III. Consideration and Approval of Minutes</p> <ul style="list-style-type: none"> • January 12, 2021 	<p>The draft minutes for the January 12, 2021 meeting were reviewed and amended as follows:</p> <ul style="list-style-type: none"> • Page 19: Maui Service Area Board Update <ul style="list-style-type: none"> ○ C. Matayoshi mentioned that SAMHSA provides a template for the CISAP and she e-mailed it to S. Haitsuka <p>T. Reed made a motion for the minutes from the January 12, 2021 meeting be approved. E. Lau-James seconded the motion.</p>	<p>Finalize minutes as drafted.</p> <p>Motion passed unanimously.</p>	S. Haitsuka	02/25/21
<p>IV. Community Input</p>	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p> <p>R. Reyno Yeoman expressed appreciation for the Council doing great things! She explained that a recent House Corrections, Military and Veterans Committee info briefing included a discussion with Fred Hyun, the acting director for the Department of Public Safety (PSD), about challenges with securing dual diagnosis beds for inmates upon release, including waitlists.</p> <p>She stated that she feels that in addition to the lack of beds there is an insufficient amount of programming to meet the needs of inmates upon release and a new facility to replace the aging Oahu Community Correctional Center (OCCC) seems to be the only proposed solution.</p> <p>She recalls that Hawaii Health and Harm Reduction Center (HHHRC) hosted a workshop on mental health issues and the doctor who presented on the topic did not think there was a community bed problem.</p>			

	<p>Council members shared the following feedback:</p> <ul style="list-style-type: none"> • T. Reed noted that there are a few bills that were introduced this legislative session that she has identified and she is willing to connect with R. Reyno Yeoman to share bill information. • R. Ries mentioned that post-legislative collaboration with R. Reyno Yeoman and DOH to support this advocacy topic, and possibly a letter to DOH, etc. could be explored. • C. Matayoshi shared that she is aware of a bill about a moratorium on building prison facilities which mentions that funds can only be used for non-CIP prison related expenses. • S. Shimabukuro shared that he has participated in meetings where bed availability vs. waitlists have been discussed. He understands that there could be a wait list, for example; however, those waiting may be coming from a diversion resource (i.e. a recommendation to step down from a higher level of care) vs. a capacity issue regarding the number of beds/quantity. Thus, the issue may be a nuance, not a misunderstanding as far as to the process of moving along the continuum of care. 			
<p>V. Summary of PIG and Council Member Reports with Action Items Carried Forward to the March 9, 2021</p>	<p>R. Ries stated that due to today's shortened Council meeting, the regular meeting agenda has been modified. In the interest of time, he gave a summary of the action items that will be carried forward to the December meeting and asked members shared updates, if applicable.</p> <p><u>PIG Reports</u></p> <ul style="list-style-type: none"> • Website, Social Media and Advocacy (WSA) PIG <ul style="list-style-type: none"> ○ The WSA PIG met on January 29, 2021 and provided meeting notes as a handout for today's meeting. They reviewed the Council's website and identified several webpages to revise. ○ Some revisions were easily made. Others will need Council approval. For the content revisions that were made, they are now viewable on the Council's website. ○ The WSA PIG will meet again in February to continue their discussion about the Council's website and to work on the 	<p>Schedule next WSA-PIG meeting.</p>	<p>S. Haituka</p>	<p>2/12/21</p>

	<p>tiered structure presented at a previous Council meeting.</p> <ul style="list-style-type: none"> ○ C. Knightsbridge added that WSA PIG members did quite a bit of review for content on the Council’s website and that the plan is to update the website with upcoming events shared during Council meetings. <ul style="list-style-type: none"> ● Legislative (LEG) PIG <ul style="list-style-type: none"> ○ The LEG PIG met three times and provided meeting notes for two of three meetings. ○ For two of their three meetings, they shared in their meeting notes their discussion regarding recommending bills to the Council for its priority bill list and testimony. ○ Yesterday, the LEG-PIG met to review its ranking of the priority bills it identified and to draft testimony. ○ LEG PIG members received a copy of List 1 which included all bills identified by the DOH bill reviewers as behavioral health related. LEG PIG members also received a copy of List 2 which included all bills being tracked by the DOH Behavioral Health Administration and this list is updated daily. A copy of both lists were provided as meeting handouts. ○ Additionally, the group reviewed the Council’s draft Strategic Plan Focus Area ranked responses for Category #1: Public Policy and Legislation and researched bills that aligned within this category. They identified 14 bills of which they rank ordered to identify the top seven ranked bills, with the remaining seven bills in the queue for consideration at a later time should any of the top seven bills die. ○ C. Dang stated the LEG PIG prioritized several bills for the Council to consider one of which is a bill that speaks to adding a member of the Council who has native Hawaiian education and cultural experience. The LEG PIG recognizes that this bill has glitches including requiring that this particular individual be required to possess experience and skills that are not required for applicants to other 			
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	<p>Council positions/areas of representation.</p> <ul style="list-style-type: none"> ○ The LEG PIG will meet again next Monday, 1/15/21 to continue drafting testimony. ○ R. Ries acknowledged the LEG PIGs recommendation for bills to be included in the Council’s priority bill list and to preview two draft testimonies using the approved Council testimony template; however, in the interest of time, and due to the shortened Council business meeting, he asked LEG PIG members whether it would be okay to table the discussion on the priority list until the March meeting. C. Dang stated she was okay with moving on and deferring discussion. Therefore, there was no motion or discussion. <ul style="list-style-type: none"> ● Retreat PIG <ul style="list-style-type: none"> ○ The Retreat PIG did not meet; however, E. Lau-James and S. Haitsuka assisted K. Oliver with pre-Retreat planning prep, answering her questions regarding the Retreat presentation slides, and sharing input about the Retreat agenda items. ○ All members received their Retreat Box with meeting materials, supplies and snacks. ○ After our January 12, 2021 meeting, K. Oliver received a copy of our post-Retreat (Part 1) interim work where we ranked the Strategic Plan Focus Areas in each of the four categories. K. Oliver used our input to draft the Council’s Strategic Plan. ○ Hopefully Council members had an opportunity to review the Retreat handouts, especially the draft Strategic Plan Focus Area and Action Plan templates which were deliverables the Council asked Karen to work on at the end of the Retreat (Part 1) in November 2020. ○ E. Lau-James mentioned that meeting with K. Oliver and S. Haitsuka to assist with Retreat prep, including reviewing the presentation slide content was very helpful. 			
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<p>VI. Council Officer Nominations – Chair, 1st/2nd Vice Chair, Secretary</p>	<p>R. Ries stated that the Council will nominate members to serve in these Executive Officer positions on the Council. At the March 2021 Council meeting, members will vote for nominated members.</p> <p>Council Officers will serve in these positions from March 2021 through January 2022.</p> <p>In summary,</p> <ul style="list-style-type: none"> • The Chair is responsible for signing the Council’s documents and correspondence, facilitating Council meetings, assisting with agenda preparation, and monitoring the status of Council membership. • The 1st Vice Chair is responsible for all of the responsibilities of the Chairperson should the Chairperson be absent or unable to perform his or her duties. • The 2nd Vice Chair is responsible for all the responsibilities of the Chairperson and the 1st Vice Chairperson if both are absent or unable to perform their duties. • The Secretary is responsible for verifying attendance at each meeting and confirming quorum at the beginning of each meeting. For voting, the Secretary records each Council members’ vote and verbally confirms the number of yeas, nays and abstentions for each motion the Council votes on. <p>A copy of the Council Officers’ Responsibilities handout is included in the Council member orientation handouts that Council members may access online anytime using the instructions on the handout S. Haitsuka provided several months ago.</p> <p>The following Council members were nominated or self-nominated and accepted the nomination for Council Chair:</p> <ul style="list-style-type: none"> • R. Ries Nominated by E. Lau-James; seconded by C. Knightsbridge <p>The following Council members were nominated or self-nominated and accepted the nomination for the 1st Vice Chair:</p>			
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	<ul style="list-style-type: none"> • C. Knightsbridge Nominated by E. Lau-James; seconded by C. Matayoshi • C. Matayoshi Nominated by C. Dang; seconded by T. Reed <p>The following Council members were nominated or self-nominated and accepted the nomination for the 2nd Vice Chair:</p> <ul style="list-style-type: none"> • T. Reed Self-nominated; seconded by R. Ries • K. Aumer Nominated by R. Ries; seconded by N. Crozier <p>The following Council members were nominated or self-nominated and accepted the nomination for the Secretary:</p> <ul style="list-style-type: none"> • E. Lau-James Nominated by C. Knightsbridge; seconded by T. Reed 			
VI. Adjournment	The meeting was adjourned at 9:09 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <p>E-mail with Handouts (total of 7 handouts)</p> <ol style="list-style-type: none"> 1. February 2021 Meeting – Agenda (Business Meeting) 2. February 2021 Meeting – Agenda (Council Retreat) 3. January 2021 Meeting – Draft Minutes 4. January 2021 Meeting – FY21 Attendance Log 5. February 2021 Meeting – PIG, Website/Social Media/Advocacy 1/29/21 Meeting Notes 6. February 2021 Meeting – PIG, Legislation 1/28/21 Meeting Notes 7. February 2021 Meeting – PIG, Legislation 2/4/21 Meeting Notes 8. February 2021 Meeting – PIG, Legislation List 1 All Behavioral Health Related Bills Identified by DOH Staff 9. February 2021 Meeting – PIG, Legislation List 2 All Behavioral Health Related Bills Tracked by DOH BHA Staff 	For information only.		

	<ul style="list-style-type: none">10. January 2021 Meeting – DHS CWS Intakes and Calls from January to November 202011. January 2021 Meeting – MSAB Letter to R. Friend Regarding the Maui Memorial Adolescent Unit12. February 2021 Meeting – State Council Mahalo Letter from L. Nagao			
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STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
February 9, 2021
9:00 a.m. – 1:00 p.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Crozier, Charleen “Naomi”; Dang, Cynthia “Cindi”; Fujii, John; Ilyavi, Heidi; Knightsbridge, Christopher; Koyanagi, Dina; Lau-James, Eileen; Martinez, Beatrice “Kau’i”; Matayoshi, Carol; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Ries, Richard; Shimabukuro, Scott**

Members Absent:

Members Excused:


Guests Present: **Esser, Jacquie; Oliver, Karen (Facilitator); Montero, Jacqueline**

DOH Staff Present: **Haitsuka, Stacy; Nazareno, Jocelyn**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Opening Remarks	<p>Chair R. Ries called the meeting to order at 9:09 a.m.</p> <p>He welcomed Dr. Karen A. Oliver back to the Council. As the Council’s Retreat Facilitator for November 10, 2020 (Part 1) and today (Part 2), K. Oliver is tasked with assisting the Council with (a) discussing and identifying its priority focus areas, (b) drafting and presenting the Council’s Strategic Plan and Action Plan, and (c) helping to prepare the Council for meeting its post-Retreat goals and measurable objectives.</p>	For information only.		
II. Welcome Back and Happy New Year!	<p>K. Oliver greeted the Council and thanked Council for the warm return welcome.</p> <p><u>Getting to Know Each Other Even Better Exercise</u> Attendees shared their response to the ice breaker question, “If you were a</p>			

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	<p>potato, how would you be prepared?"</p> <ul style="list-style-type: none"> • K. Oliver Baked because of the versatility of toppings based on her preference on that day. • A. Beninato Sliced in half and put into the ground. • K. Aumer Mashed with skin left on. • N. Crozier Country fried, tossed lightly in olive oil and salt • C. Dang [Did not answer 2x when name called, but was connected on Zoom. R. Ries asked S. Haitzuka to contact her to make sure she is okay.] • J. Fujii Air fried and crispy • H. Ilyavi Curly fries with seasoning • D. Koyanagi [Did not connect to Zoom/Retreat yet; she joined around 9:30 a.m.] • C. Knightsbridge Sweet potato with sugar • E. Lau-James Finger potato sauteed in garlic sage butter • K. Martinez Garlic French fries • C. Matayoshi Baked with sour cream • R. Pascual-Kestner Hand-cut deep fried fries • T. Reed Air fried twice baked potato • R. Ries Potato leaked soup often served cold 			

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	<ul style="list-style-type: none"> S. Shimabukuro Crunchy hash browns 			
III. Plan for the Day	<p>K. Oliver reviewed the Retreat agenda.</p> <p>She confirmed Council members received their Retreat Box of materials and supplies.</p> <ul style="list-style-type: none"> Post-Retreat (Part 1) Facilitator Summary with four attachments Council Member Roles/Responsibilities Guidebook Interim Work: Strategic Plan Focus Areas – Ranked Results Draft Templates for Prioritized Focus Areas and Action Plans <p>She encouraged members to be creative with using supplies during the Retreat. Snacking is okay during the Retreat when not speaking.</p>			
IV. Summary of Feedback from November’s Retreat <ul style="list-style-type: none"> Post-Retreat (Part 1) Questionnaire Interim Work Updates Since November’s Retreat 	<p>K. Oliver summarized the feedback Council members shared about November’s Retreat experience.</p> <p>Council members were asked to fill out a post-Retreat questionnaire after November’s Retreat. The purpose of the post-Retreat questionnaire was to identify what parts of the Retreat members felt were positive and identify areas of improvement to consider for Part 2 of the Retreat.</p> <p>K. Oliver thanked Council members for their feedback and highlighted a few of the comments that were shared in the post-Retreat questionnaire.</p>			

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<ul style="list-style-type: none"> • Strategic Plan Focus Areas – Ranked Results • Council Member Guidebook • Discussion of Strategic Planning 	<div style="text-align: center; margin-bottom: 20px;">  <p>Feedback from November Retreat</p> </div> <ul style="list-style-type: none"> * Liked the discussion of roles and opportunities * Felt there was synergy developing * Liked discussion about engaging community stakeholders more, empowers the community * Appreciated Stacy’s administrative support * Some liked the facilitation style, others wanted Karen (and Rich) to be more assertive * Eager to move onto concrete action plans * Everyone be expected to have camera on <p>There has been a lot of work done to prepare to discuss the draft Strategic Plan and Action Plan templates including Council members providing their rank order responses which in turn allowed K. Oliver to draft content for the Strategic Plan and Action Plan. The drafts will be reviewed and updated during today’s Retreat.</p> <p>K. Oliver emphasized that strategic planning is a tool the Council can use to move from being less reactive to more active. Being able to form a plan that identifies the Council’s goals and objectives includes acknowledging where the Council is presently and where the Council wants to be in the future.</p> <p>E. Lau-James summarized the purpose of the guidebook noting that it is a memento for Council members to have that captures the spirit of the Council’s activities and goals. Having a concrete Strategic Plan and Action Plan will help the Council to build its momentum for this term and future terms. She hopes that the guidebook will be useful to members and that it is a fun way for members to remember their time.</p> <p>E. Lau-James explained that for today’s Retreat, Council members are asked to look at the focus areas and where their area of representation is as far as how they can contribute to addressing those focus areas. For</p>			

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Expectations	example, it could be that a Council member has a specialized skillset related to a focus area or perhaps a passion for another focus area. She encouraged all Council members to be thinking about their role and how they can contribute to addressing the focus areas that are identified in the draft Strategic Plan.			
<p>V. Outline of FY21 – FY23 Strategic Plan</p> <ul style="list-style-type: none"> Review Templates: Focus Areas (1-4) and Accompanying Action Plans 	<p>K. Oliver reviewed the elements of the Strategic Plan template including the focus area, objectives, and action plan.</p> <div data-bbox="564 529 1159 688" style="background-color: #4F81BD; color: white; padding: 10px; text-align: center; border-radius: 5px;"> <p>Goals and Objectives of Strategic Planning - Definitions</p> </div> <ul style="list-style-type: none"> * Focus Area (Goal): desired result, broad and long term * Objectives: includes date, specific and measureable, increase or decrease by % * Action Plan: specific tasks, steps, resources and strategies <p>She commended the Council members for their work in reviewing the focus areas identified in November and then prioritizing each area by rank order so that there was a clear identification of which focus areas were going to be a priority for the Council to work on.</p> <p>After the rank order was reviewed at the Council’s January 2021 meeting, she was able to take the top two ranked focus areas for each of the four categories to develop draft content for the Strategic Plan and Action Plan.</p>			

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	<p>Category #1: Public Policy and Legislation</p> <div data-bbox="571 256 1157 407" style="background-color: #0070C0; color: white; padding: 10px; text-align: center;"> <h3>Rank of Focus Areas: January, 2021 Council Meeting</h3> </div> <div data-bbox="571 354 1098 678" style="border: 1px solid black; padding: 5px;"> <p style="text-align: center; font-size: small;">Hawaii State Council on Mental Health Retreat Interim Work - Strategic Plan Focus Areas - Ranked Results</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2">Focus Area</th> <th colspan="14">Category #1: Public Policy and Legislation</th> <th rowspan="2">Rank</th> </tr> <tr> <th>Adeline</th> <th>Carl</th> <th>Chik</th> <th>Cliff</th> <th>Shir</th> <th>Ellen</th> <th>Hali</th> <th>John</th> <th>Katherine</th> <th>Karl</th> <th>Leif</th> <th>Nancy</th> <th>Richard</th> <th>Shir</th> <th>Scott</th> <th>Tara</th> </tr> </thead> <tbody> <tr> <td>Improve access to mental health (see meeting notes)</td> <td>5</td><td>3</td><td>2</td><td>1</td><td>1</td><td>3</td><td>3</td><td>1</td><td>1</td><td>1</td><td>2</td><td>8</td><td>5</td><td>5</td><td>2</td><td>1</td> </tr> <tr> <td>Address gaps within housing</td> <td>7</td><td>8</td><td>10</td><td>4</td><td>6</td><td>10</td><td>7</td><td>2</td><td>4</td><td>2</td><td>2</td><td>1</td><td>4</td><td>8</td><td>6</td><td>7</td> </tr> <tr> <td>Develop community re-entry programs with the Dept of Public Safety (DPS)</td> <td>8</td><td>4</td><td>5</td><td>2</td><td>7</td><td>8</td><td>5</td><td>3</td><td>10</td><td>4</td><td>4</td><td>4</td><td>9</td><td>6</td><td>7</td><td>3</td> </tr> <tr> <td>Develop integrated community behavioral health centers</td> <td>3</td><td>2</td><td>7</td><td>3</td><td>4</td><td>5</td><td>8</td><td>4</td><td>5</td><td>6</td><td>3</td><td>5</td><td>10</td><td>3</td><td>8</td><td>9</td> </tr> <tr> <td>Advocate for peer supported housing and employment</td> <td>9</td><td>9</td><td>8</td><td>7</td><td>8</td><td>6</td><td>9</td><td>6</td><td>9</td><td>8</td><td>5</td><td>3</td><td>3</td><td>9</td><td>4</td><td>6</td> </tr> <tr> <td>Consider the role of health insurance in accessing mental health resources</td> <td>10</td><td>5</td><td>4</td><td>10</td><td>5</td><td>4</td><td>10</td><td>7</td><td>3</td><td>10</td><td>7</td><td>7</td><td>6</td><td>4</td><td>1</td><td>10</td> </tr> <tr> <td>Advocate for mental health care for victims of sex trafficking</td> <td>6</td><td>6</td><td>6</td><td>5</td><td>9</td><td>9</td><td>6</td><td>8</td><td>8</td><td>5</td><td>9</td><td>8</td><td>2</td><td>7</td><td>2</td><td>4</td> </tr> <tr> <td>Identify priority legislative bills</td> <td>4</td><td>7</td><td>1</td><td>6</td><td>10</td><td>1</td><td>4</td><td>9</td><td>2</td><td>7</td><td>6</td><td>10</td><td>5</td><td>1</td><td>9</td><td>5</td> </tr> <tr> <td>Advocate for the documentation of individuals diagnosed with a mental illness and/or substance use disorder</td> <td>2</td><td>1</td><td>9</td><td>8</td><td>3</td><td>2</td><td>2</td><td>10</td><td>6</td><td>9</td><td>8</td><td>6</td><td>7</td><td>2</td><td>10</td><td>8</td> </tr> <tr> <td>Advocate for the emotional well being of those diagnosed with COVID-19 and pandemic mental health care</td> <td>1</td><td>10</td><td>3</td><td>9</td><td>2</td><td>7</td><td>1</td><td>5</td><td>7</td><td>3</td><td>10</td><td>9</td><td>1</td><td>10</td><td>3</td><td>1</td> </tr> </tbody> </table> <p style="font-size: x-small;">KEAO Consulting</p> </div> <p>Category #2: Knowledge, Skill Building, Education and Training</p> <div data-bbox="562 748 1163 899" style="background-color: #0070C0; 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K. Oliver explained the reason there were seven and not eight is because two of the prioritized focus areas were similar. This meant that they could be addressed as a single strategic plan item rather than two separately.</p>	Category #3: Communication/Dissemination of Mental Health Information														RANK	Focus Area	Adriana	Carl	Chris	Cliff	Ellen	Heidi	John	Katherine	Karl	Leif	Norm	Richard	Rob	Tara	MARK	Share information on the Council's website about existing mental health issues (local/state/national)	3	2	2	1	3	3	1	3	1	1	3	3	2	1	4	2 24	Engage with stakeholders by attending community meetings (i.e. Mental Health Task Force, NAMI Hawaii, etc.), share about the Council to increase community awareness, and tell the Council about community stakeholder feedback regarding mental health issues	2	1	3	4	1	2	3	3	2	2	3	1	2	1	3	3 36	Invite people to testify at Council meetings	4	4	4	2	4	4	4	4	4	4	4	4	3	2	3	4 58	Strengthen the Council's presence as advocates and advisors to DCM leadership, inclusion of input from Neighbor Island stakeholders and Service Area Board members	1	3	1	3	2	1	2	2	1	3	2	2	1	4	4	1 32	Category #4: Administrative Support for Council Functions														RANK	Focus Area	Adriana	Carl	Chris	Cliff	Ellen	Heidi	John	Katherine	Karl	Leif	Norm	Richard	Rob	Tara	MARK	Draft proposals for the Council's public advisory of mental health resources	3	4	2	1	6	2	1	2	1	2	3	4	4	1	3	5 24	Draft revised Council brochure and Service Area Board brochures	4	1	6	4	3	5	6	5	4	5	5	3	4	4	6	5 26	Draft descriptions and generalists for each area of representation on the Council	5	3	3	5	5	3	2	3	5	3	4	2	5	2	5	4 28	Draft general "job descriptions" of the Council's role and Service Area Board role	6	2	4	6	4	4	3	4	6	6	6	1	6	5	6	2 61	Draft a Council planning "toolkit" that includes activities and suggested activities and suggested activities complementary to mental health topics/events	2	6	5	3	2	6	4	1	3	4	2	3	2	6	1	3 33	Identify, track and share the status of DCM Behavioral Health Administration (BHA) bills (includes Adult Mental Health, Child Assessment, Mental Health, and Alcohol and Drug Abuse (Domestic))	1	5	1	2	1	1	5	6	2	1	1	6	1	3	2	1 26			
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Strengthen the Council's presence as advocates and advisors to DCM leadership, inclusion of input from Neighbor Island stakeholders and Service Area Board members	1	3	1	3	2	1	2	2	1	3	2	2	1	4	4	1 32																																																																																																																																																																																																																												
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Focus Area	Adriana	Carl	Chris	Cliff	Ellen	Heidi	John	Katherine	Karl	Leif	Norm	Richard	Rob	Tara	MARK																																																																																																																																																																																																																													
Draft proposals for the Council's public advisory of mental health resources	3	4	2	1	6	2	1	2	1	2	3	4	4	1	3	5 24																																																																																																																																																																																																																												
Draft revised Council brochure and Service Area Board brochures	4	1	6	4	3	5	6	5	4	5	5	3	4	4	6	5 26																																																																																																																																																																																																																												
Draft descriptions and generalists for each area of representation on the Council	5	3	3	5	5	3	2	3	5	3	4	2	5	2	5	4 28																																																																																																																																																																																																																												
Draft general "job descriptions" of the Council's role and Service Area Board role	6	2	4	6	4	4	3	4	6	6	6	1	6	5	6	2 61																																																																																																																																																																																																																												
Draft a Council planning "toolkit" that includes activities and suggested activities and suggested activities complementary to mental health topics/events	2	6	5	3	2	6	4	1	3	4	2	3	2	6	1	3 33																																																																																																																																																																																																																												
Identify, track and share the status of DCM Behavioral Health Administration (BHA) bills (includes Adult Mental Health, Child Assessment, Mental Health, and Alcohol and Drug Abuse (Domestic))	1	5	1	2	1	1	5	6	2	1	1	6	1	3	2	1 26																																																																																																																																																																																																																												

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	<p>K. Oliver summarized the seven focus areas that were included in the draft Strategic Plan and Action Plan.</p> <div data-bbox="564 289 1159 440" style="background-color: #0070C0; color: white; padding: 10px; text-align: center; border-radius: 5px;"> <p>Top 8 (7) Focus Areas: January, 2021 Council Meeting</p> </div> <ol style="list-style-type: none"> 1. Improve Access to Mental Health Services (existing/new) 2. Advocate for the Emotional Well-Being of the Community 3. Identify the Tools the Council is Empowered to Use 4. Outline an Onboarding and Annual Re-boarding Experience for Council Members <div data-bbox="564 721 1159 872" style="background-color: #0070C0; color: white; padding: 10px; text-align: center; border-radius: 5px;"> <p>Top 8 (7) Focus Areas (cont.):</p> </div> <ol style="list-style-type: none"> 5. Strengthen the Council's Presence as Advocates and Advisors to DOH Leadership, Inclusive of Input from Neighbor Island Stakeholders and Service Area Board Members 6. Share Information on the Council's Website About Existing Mental Health Services (Local/State/Federal) 7. Identify, Track and Share the Status of DOH Behavioral Health Administration (BHA) Legislative Bills <p>Council members shared the following comments about the Strategic Plan process thus far and ranked response process for identifying the Council's priority focus areas.</p> <ul style="list-style-type: none"> • E. Lau James stated that the focus areas were a good starting point and while these are not the only areas the Council identified, if we're able to address these areas initially then we can move on to address other areas. • C. Knightsbridge felt that these focus areas provided a good guide for the legislative (LEG) PIG. He felt that having the focus areas identified 			

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	<p>and the Council ranking them made the LEG PIG's work easier.</p> <ul style="list-style-type: none"> • C. Dang agreed with C. Knightsbridge that the focus areas were really helpful to the LEG PIG in identifying and narrowing down what the Council's priorities were and then looking for the bills that were related. For example, the LEG PIG inserted a statement that linked the Council's Strategic Plan with the Council's testimony. • R. Ries shared that ranking the focus areas was not always an easy process for him but also noted that he felt it was a healthy process. • C. Matayoshi felt that the process was well done and productive. <p>K. Oliver explained that the objectives are tangible outcomes. These could be things that the Council can look back at after a year to determine whether the goal was reached (measurable objective) such as:</p> <ul style="list-style-type: none"> • Implementing the new Council website • Conducting a training for Council members • Launching a public awareness campaign • Finalizing and submitting testimony • Establishing an onboarding process • Disseminating training materials to a percentage of providers • Responding to a percentage of bills <p>She next explained the action plan. These are specific steps that are located all in one place as a handy guide to refer to and a working document to be revised. These are action tasks and steps that include what will be done, who will do what, when will it be done, and what strategies/resources are available to assist such as:</p> <ul style="list-style-type: none"> • Who do we need to meet with? • Is a PIG needed? • What do we need to evaluate to determine what is happening now? • What are the things we need to know? • What strategies can we use to engage with the community? • What are ways we can obtain input – e.g., community meetings? 			

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	<p>K. Oliver walked Council members through each of the seven focus areas in the draft Strategic Plan and accompanying Action Plan. She acknowledged the Hawaii Opioid Plan as an excellent source and that she used the Hawaii Opioid Plan to develop the Council’s Strategic Plan template.</p> <p>She also noted that the content in the templates are completely in draft and should be updated where needed as much of the information is based on what is known as far as to deadlines and suggested action steps.</p> <p style="text-align: center;">DRAFT</p> <p style="text-align: center;">Hawaii State Council on Mental Health Strategic Plan FY 2020 – FY 2022 – Focus Areas</p> <p><u>Purpose:</u> In response to stakeholder feedback about areas of Hawaii’s mental health service system that need improvement, the State Council on Mental Health (SCMH) developed its Strategic Plan to prioritize (1) issues that directly affect more than one County service area (Statewide Comprehensive Integrated Service Area Plan; SCISAP); (2) opportunities for the Council to advocate for mental health services; and/or (3) specific ways the Council can be more effective in its advisory role to the Department of Health.</p> <p>Focus Area #1: Improve Access to Mental Health Services (existing/new)</p> <table border="1" data-bbox="564 824 1159 1273"> <thead> <tr> <th colspan="2" style="background-color: #6aa84f; 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Matayoshi, C. Knightsbridge, J. Fujii, N. Crozier • R. Ries recommended that all Service Area Board (SAB) representatives to the Council be involved in this focus area including T. Reid (Maui), C. Dang (Oahu), and C. Matayoshi (Hawaii Island). There is a vacancy for the Kauai representative. <p data-bbox="403 1308 1323 1341">Council members shared the following comments regarding Focus Area #1:</p> <ul data-bbox="441 1351 1323 1451" style="list-style-type: none"> • C. Matayoshi stated that the Statewide Comprehensive Integrated Service Area Plan (SCISP) is a compilation of the individual county level Comprehensive Integrated Service Area Plans (CISAP). 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	<p>CISAPs are shared with the Council. With that information and with the Council’s additional information, the Council submits the SCISP to the DOH. The DOH reviews the information and includes the Council’s feedback into the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant Application. The SCISP information is also referenced in the Council’s annual legislative report.</p> <ul style="list-style-type: none"> • R. Ries expressed a concern about the process and S. Haitsuka noted that the information including the feasibility of the proposed dates for the measurable objectives were inclusive of feedback she received from other staff. • R. Ries explained that he understands the CISAPs are county level and that the Council does not necessarily approve the CISAP information but does receive the information and determines what parts of the CISAP the Council will include in its SCISP. • C. Knightsbridge likes using online eligibility calculators to help people self-identify if they are eligible. • J. Fujii noted that Hawaii’s Medicaid application is online and the system checks information that is entered in the fully automated system. For example, the system is set up with a decision tree system that will triage between options based on responses. He noted that current Medicaid enrollment is approximately 70,000 members. • E. Lau-James shared that she felt that her telephonic eligibility experience was positive and that it was helpful for her to have this option to determine her eligibility status which navigated her to the marketplace to review options she was eligible for. • C. Knightsbridge noted legislation that supports telehealth access and prohibits denying claims for this service are bills to follow. • E. Lau-James empowered Council members who volunteered to work on this focus area to now make it their own by revising objectives. She recommends that PIG groups be formed for each focus area at the next Council meeting. • R. Ries suggested that E. Lau-James keep track of which Council members volunteer for which focus areas and it may be that some 			

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	<p>Council members need a little nudging to get involved.</p> <ul style="list-style-type: none"> E. Lau-James acknowledged that the draft Strategic Plan looks daunting and that Council members may be concerned about that knowing the Council only meets 12 times per year. She encouraged the Council members to look at their areas of expertise and consider how they can contribute. A goal of today’s meeting is to identify who is interested in working on which focus area so that PIGs can be formed to begin working on the objectives. E. Lau-James posed that the measurable objectives and action plan steps could be left to the Council members who are willing to work on the focus area. <p>Focus Area #2: Advocate for the Emotional Well-Being of the Community</p> <table border="1" data-bbox="564 691 1163 1133"> <thead> <tr> <th colspan="2" data-bbox="564 691 1163 748">Focus Area #2 Advocate for the Emotional Well-Being of the Community</th> </tr> </thead> <tbody> <tr> <td data-bbox="564 748 716 841">Strategic Planning: <i>Identified during the Council's Retreat</i></td> <td data-bbox="716 748 1163 841"> Category: <input checked="" type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions </td> </tr> <tr> <td data-bbox="564 841 716 1040">Area(s) of Need Addressed: <i>Council's purpose and responsibilities as required by Hawaii law</i></td> <td data-bbox="716 841 1163 1040"> Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council's advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input checked="" type="checkbox"/> Council's linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council's knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) </td> </tr> <tr> <td data-bbox="564 1040 716 1133">Outcome(s)/Product(s): <i>What the Council wants to see</i></td> <td data-bbox="716 1040 1163 1133"> <input checked="" type="checkbox"/> A professionally produced wellness brochure with content directed by Council that promotes and supports the emotional well-being of the community. <input checked="" type="checkbox"/> Distribute a public communiqué referencing the brochure and its availability on the Council's website. </td> </tr> </tbody> </table>	Focus Area #2 Advocate for the Emotional Well-Being of the Community		Strategic Planning: <i>Identified during the Council's Retreat</i>	Category: <input checked="" type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions	Area(s) of Need Addressed: <i>Council's purpose and responsibilities as required by Hawaii law</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council's advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input checked="" type="checkbox"/> Council's linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council's knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e)	Outcome(s)/Product(s): <i>What the Council wants to see</i>	<input checked="" type="checkbox"/> A professionally produced wellness brochure with content directed by Council that promotes and supports the emotional well-being of the community. <input checked="" type="checkbox"/> Distribute a public communiqué referencing the brochure and its availability on the Council's website.			
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Matayoshi, C. Knightsbridge, K. Aumer, R. Ries <p data-bbox="405 995 1318 1024">Council members shared the following comments regarding Focus Area #2:</p> <ul style="list-style-type: none"> <li data-bbox="443 1032 1318 1174">• C. Knightsbridge helped to develop the initial draft of the Council's brochure. He asked what a communiqué was. S. Haitzuka explained that a communiqué is the Council's communication and is developed by the PIG that is proposed in 2.3. <li data-bbox="443 1182 1318 1243">• C. Dang mentioned that a part of the communiqué could involve the media and possible a public service announcement (PSA). <li data-bbox="443 1252 1318 1357">• E. Lau-James shared that the Action Plan template can help provide a step-by-step guide with deadlines to keep track of activities and check them off as they are completed. 	Measurable Objective(s): <i>What the Council wants to accomplish and by when</i>	2.1 – By March 2021, identify ways the Council will advocate for the well-being of the community including references to evidence-based practices, peer reviewed publications and other widely recognized local/state/national references. 2.2 – By May 2021, (a) identify brochure content the Council would like to include and (b) form a PIG for brochure production. 2.3 – By July 2021, PIG presents a draft of the brochure for Council review. 2.4 – By August 2021, PIG (a) drafts the public communiqué that will accompany the brochure's debut and (b) finalizes the brochure. 2.5 – By September 2021, the Council reviews and approves the brochure and public communiqué. 2.6 – In time for the week of October 3-9, 2021 (Mental Health Awareness Week), publicly distribute the Council's brochure with its public communiqué.	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VI. Break	At 10:20 a.m., K. Oliver announced a 20 minute break. She encouraged Council members to stand up and stretch during the break.									
VII. Post-Break Group Exercise: BINGO!	<p>The Council reconvened Retreat activities at 10:30 a.m.</p> <p>E. Lau-James introduced the group break activity. She hosted a virtual BINGO! game. Council members who wanted to participate could do so by using the cards and markers provided in their Retreat Box.</p>									
<p>VIII. Questions from Morning Session</p> <ul style="list-style-type: none"> Outline of FY21 – FY23 Strategic Plan (continued) Review Templates: Focus Areas (5-7) and Accompanying Action Plans 	<p>K. Oliver moved the Council back to the Strategic Plan template to review the remaining four focus areas.</p> <p>Focus Area #4: Outline an Onboarding and Annual Reboarding Experience for Council Members</p> <table border="1" data-bbox="556 727 1171 1096"> <thead> <tr> <th colspan="2" data-bbox="556 727 1171 787">Focus Area #4 Outline an Onboarding and Annual Reboarding Experience for Council Members</th> </tr> </thead> <tbody> <tr> <td data-bbox="556 787 709 889"> Strategic Planning: <i>Identified during the Council's Retreat</i> </td> <td data-bbox="709 787 1171 889"> Category: <input type="checkbox"/> #1 Public Policy and Legislation <input checked="" type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions </td> </tr> <tr> <td data-bbox="556 889 709 1096"> Area(s) of Need Addressed: <i>Council's purpose and responsibilities as required by Hawaii law</i> <i>Includes a narrative statement describing the problem/issue.</i> </td> <td data-bbox="709 889 1171 1096"> Area(s) of Need (§334-10, Hawaii Revised Statutes): <input checked="" type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input checked="" type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council's advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input type="checkbox"/> Council's linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council's knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) XX </td> </tr> </tbody> </table>	Focus Area #4 Outline an Onboarding and Annual Reboarding Experience for Council Members		Strategic Planning: <i>Identified during the Council's Retreat</i>	Category: <input type="checkbox"/> #1 Public Policy and Legislation <input checked="" type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions	Area(s) of Need Addressed: <i>Council's purpose and responsibilities as required by Hawaii law</i> <i>Includes a narrative statement describing the problem/issue.</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input checked="" type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input checked="" type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council's advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input type="checkbox"/> Council's linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council's knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) XX			
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Lau-James, T. Reed, K. Martinez <p data-bbox="405 1170 1318 1200">Council members shared the following comments regarding Focus Area #4:</p> <ul data-bbox="443 1208 552 1237" style="list-style-type: none"> • None. 	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Measurable Objective(s): <i>What the Council wants to accomplish and by when</i>	4.1 – By April 2021, (a) identify features of the onboarding and reboarding experience the Council would like to include and (b) form a PIG for onboarding/reboarding. 4.2 – By May 2021, PIG members recommend an onboarding and reboarding draft checklist for Council review. 4.3 – By June 2021, the Council reviews and approves the onboarding and reboarding draft checklists. 4.4 – By July 2021, Council members receive the final onboard and reboarding checklists. 4.5 – By August 2021, the Council will facilitate onboarding and reboarding sessions with Council members during its August meeting (to re-occur annually) 4.6 – By October 2021, Council members (a) provide feedback on their onboarding and reboarding experience using the checklist and (b) recommend suggestions for checklist revisions. 4.6 - By November 2021, PIG members review suggestions and recommend revisions to the onboard and reboarding checklists. 4.7 – By December 2021, the Council reviews and approves the onboarding and reboarding revised checklists. 4.8 – By January 2022, Council members receive the final revised onboarding and reboarding checklists (to be used annually in August) and determine whether the checklists will be attached to the Council <u>By Laws</u> or referenced separately.											
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	<p>other meetings.</p> <ul style="list-style-type: none"> • R. Ries shared that he attends the Bereavement Network of Hawaii’s meetings and that could be a potential organization the Council could invite to present behavioral health related information related to the Council’s focus areas. • C. Dang noted that the Council agenda could increase opportunities for community input since the PIGs working behind the scenes, like the work horses, to address some of the Council’s action items. • E. Lau-James agreed with C. Dang about the PIGs doing more work behind the scenes. The Council can then review the PIGs work briefly and use the bulk of the meeting time to vote on the recommendations from the PIGs. There will be so many PIG recommendations that the Council will need to vote on and having the Council meetings heavily focus on voting is a gamechanger. • C. Matayoshi believes that this focus area and the objectives will definitely help strengthen the Council and make the Council more productive. • C. Dang mentioned that metrics are powerful; shows what the Council invested its time to work on. The Council can look at the measurable outcomes and can come up with metrics that are identifiable but concise, possibly two or three metric items initially. She stated measure creates the change. These metrics can help inform the conversation that occurs within the PIGs. • R. Ries agreed that tracking these tasks is important and the Council has not done this in the past as far as to measuring and tracking its activities. • R. Ries and C. Dang agreed that there is a need to include input from the DOH Child and Adolescent Mental Health Division (CAMHD) as well as Adult Mental Health Division (AMHD) at least twice per year. • C. Knightsbridge suggested that the Director of Health be invited to present at least once during the calendar year. • Regarding Outcome(s)/Product(s), “documentation” could be the meeting minutes and could be that Council members self-report their participation when they share their report at Council meetings. C. 			

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	<p>Dang related “documentation” to metrics in that the legislature may look at the metrics that shows how the Council is using its time and resources to engage with members in their area(s) of representation.</p> <ul style="list-style-type: none"> • Regarding metrics for measurable objectives, K. Oliver suggested that Council members should be able to identify metrics that could be useful such as increasing engagement options by x percentage or meetings. • K. Aumer mentioned that Council members can also make sure they are distributing the Council’s brochure and infographic and then asking how community members are receiving Council information. • C. Dang suggested removing specific meeting from measurable objective 5.1 because the Council has mentioned other meetings besides the Mental Health Task Force. R. Ries instead suggested adding another objective stating “other community mental health meetings” as a new 5.2. R. Ries acknowledge that he was thinking similarly about removing the DOH DD of BHA. <p>Focus Area #6: Share Information on the Council’s Website About Existing Mental Health Services (Local/State/Federal)</p> <table border="1" data-bbox="558 911 1167 1360"> <thead> <tr> <th colspan="2" data-bbox="558 911 1167 987">Focus Area #6 Share Information on the Council's Website About Existing Mental Health Services (Local/State/Federal)</th> </tr> </thead> <tbody> <tr> <td data-bbox="558 987 714 1084">Strategic Planning: <i>Identified during the Council's Retreat</i></td> <td data-bbox="714 987 1167 1084"> Category: <input checked="" type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input checked="" type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions </td> </tr> <tr> <td data-bbox="558 1084 714 1295">Area(s) of Need Addressed: <i>Council's purpose and responsibilities as required by Hawaii law</i></td> <td data-bbox="714 1084 1167 1295"> Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input checked="" type="checkbox"/> Council's advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input checked="" type="checkbox"/> Council's linkage to and advocacy for service recipients (d) <input type="checkbox"/> Council's knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) </td> </tr> <tr> <td data-bbox="558 1295 714 1360"><i>Includes a narrative statement describing the problem/issue.</i></td> <td data-bbox="714 1295 1167 1360">XX</td> </tr> <tr> <td data-bbox="558 1360 714 1453">Outcome(s)/Product(s): <i>What the Council wants to see</i></td> <td data-bbox="714 1360 1167 1453"> <input checked="" type="checkbox"/> A refreshed consumer-friendly Resources webpage within the Council's website that includes information about local/state/federal mental health/behavioral health resources. </td> </tr> </tbody> </table>	Focus Area #6 Share Information on the Council's Website About Existing Mental Health Services (Local/State/Federal)		Strategic Planning: <i>Identified during the Council's Retreat</i>	Category: <input checked="" type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input checked="" type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions	Area(s) of Need Addressed: <i>Council's purpose and responsibilities as required by Hawaii law</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input checked="" type="checkbox"/> Council's advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input checked="" type="checkbox"/> Council's linkage to and advocacy for service recipients (d) <input type="checkbox"/> Council's knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e)	<i>Includes a narrative statement describing the problem/issue.</i>	XX	Outcome(s)/Product(s): <i>What the Council wants to see</i>	<input checked="" type="checkbox"/> A refreshed consumer-friendly Resources webpage within the Council's website that includes information about local/state/federal mental health/behavioral health resources.			
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	<table border="1" data-bbox="558 207 1169 824"> <tr> <td data-bbox="558 207 711 461"> Measurable Objective(s): <i>What the Council wants to accomplish and by when</i> </td> <td data-bbox="711 207 1169 461"> 6.1 – In August/September 2021, Council members identify their top five local/state/federal mental health and behavioral health resources that are helpful for individuals within their area(s) of representation. 6.2 – In October 2021, (a) review the resources shared by Council members and (b) vote to approve resources to be listed on the Council’s Resource webpage. 6.3 – By January 2022, Council support staff will revise the Council’s Resource webpage inclusive of approved resources. 6.4 – By February 2022, Council members (a) review the Resource webpage and (b) identify any additional resources. 6.5 – As need arises but no less than annually in October-December, the Council (a) reviews the Resource webpage and (b) recommends updates/revisions. </td> </tr> <tr> <td data-bbox="558 461 711 626"> Internal/External Partners: <i>Internal: Council members per their area(s) of representation;</i> <i>External: Specific organizations, agencies and individuals</i> </td> <td data-bbox="711 461 1169 626"> Internal: <ul style="list-style-type: none"> ▪ Council members and stakeholders within their area(s) of representation ▪ Council support staff External: <ul style="list-style-type: none"> ▪ Community-based providers ▪ Organizations specializing in behavioral health support ▪ Community/Stakeholders </td> </tr> <tr> <td data-bbox="558 626 711 756"> Strategies: <i>Action steps the Council will take including PIGs (existing or new), requests for SABs and specialty areas, etc.</i> </td> <td data-bbox="711 626 1169 756"> <input checked="" type="checkbox"/> Seek input from individuals within Council members’ area(s) of representation to identify the top used/useful or needed resources. <input checked="" type="checkbox"/> Create a Resource webpage that includes searchable options such as topics/key words (i.e. crisis support, mental health, substance use, family member support, child/youth support, etc.), possibly incorporating information from SCISP and CISAP, Service Area Board members, etc. </td> </tr> <tr> <td data-bbox="558 756 711 824"> Status: <i>Updated quarterly (reviewed as a meeting agenda item; 3rd month each quarter)</i> </td> <td data-bbox="711 756 1169 824"> <input type="checkbox"/> Carried forward from (FY 2018 – FY 2020) <input type="checkbox"/> In progress (Month/Year) <input type="checkbox"/> Completed (Month/Year) </td> </tr> </table> <p data-bbox="405 850 1241 919">The following Council members expressed interest in working on the following measurable objectives:</p> <ul data-bbox="443 927 1304 992" style="list-style-type: none"> • All members of the Website, Social Media and Advocacy (WSA) PIG C. Matayoshi, H. Ilyavi, C. Dang, C. Knightsbridge, R. Pascual-Kestner <p data-bbox="405 1036 1318 1065">Council members shared the following comments regarding Focus Area #6:</p> <ul data-bbox="443 1073 1318 1469" style="list-style-type: none"> • K. Aumer mentioned that there are similar activities mentioned here and that it would be important to have a tie in to coordinate the activities of other focus areas. • C. Knightsbridge mentioned that there will need to be a way to coordinate the activities of the brochure PIG and the WSA PIG, etc. He suggested that the brochure mirrors the website; however, S. Haituka pointed out that there is a distinction between the focus areas one of which focuses on post-pandemic coping while the other focuses on general mental health. She mentioned that the content on the brochure would be added to the website as a handout. • C. Dang suggested the Council utilize focus groups periodically to ask 	Measurable Objective(s): <i>What the Council wants to accomplish and by when</i>	6.1 – In August/September 2021, Council members identify their top five local/state/federal mental health and behavioral health resources that are helpful for individuals within their area(s) of representation. 6.2 – In October 2021, (a) review the resources shared by Council members and (b) vote to approve resources to be listed on the Council’s Resource webpage. 6.3 – By January 2022, Council support staff will revise the Council’s Resource webpage inclusive of approved resources. 6.4 – By February 2022, Council members (a) review the Resource webpage and (b) identify any additional resources. 6.5 – As need arises but no less than annually in October-December, the Council (a) reviews the Resource webpage and (b) recommends updates/revisions.	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	<p>them to review the Council’s work. S. Haitsuka suggested that each Council members could take the information back to stakeholders within their area(s) of representation to receive feedback and bring the comments back to the Council for consideration.</p> <ul style="list-style-type: none"> • R. Ries noted that he feels comfortable talking to his colleagues and feels that it would be great if there was a support group for family members where input can also be sought. C. Dang suggested using the Mental Health Task Force, NAMI and others to generate feedback; ask them to review the Council’s information, possibly annually. • Regarding professional or contracted digital design services, K. Oliver asked whether it would be needed. <p>R. Ries encouraged all Council members to volunteer for at least one focus area. If any Council member is hesitant, he and other members can help.</p> <p>E. Lau-James shared that her experience on the current Legislative (LEG) PIG is that even though she wasn’t able to attend all meetings, she was included and was given all of the meeting notices and she attended when she could. She recognized that Council members have jobs and that the Council’s work is a volunteer position. She noted that this is an opportunity for Council members to work on an area of interest to them and she encouraged everyone to jump in and learn as you go.</p> <p>C. Dang suggested that E. Lau-James display the information during the meeting showing who volunteered for which focus areas. C. Knightsbridge suggested members go with their passion and sign up to participate and learn from other members. While not wanting to publicly shame Council members who did not sign up for a focus area, R. Ries again strongly encouraged Council members to sign up for at least one focus area.</p> <p>R. Ries noted that new Council members may be coming on board as well. He recalls how he felt as a new members and getting his sea legs comfortable. C. Knightsbridge suggested members e-mail S. Haitsuka after they have identified the focus areas they would like to work on.</p>			

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	<p>R. Ries noted that members can change their mind later on if they find that they do not like the PIG work or if it is not interesting work. C. Dang noted that the process for PIG work can be covered during the onboarding and reboarding orientation.</p> <div data-bbox="499 375 1226 902" style="border: 1px solid #ccc; padding: 10px; margin: 10px 0;"> <p>Focus Area #1 Carol, Cindi, Tara, Naomi, Jon</p> <p>Focus Area #2 Carol, Chris, Katherine, Richard</p> <p>Focus Area #3 Eileen, Heidi, Chris</p> <p>Focus Area #4 Eileen, Tara, <u>Kau'i</u></p> <p>Focus Area #5 Tara, Carol, Chris, Eileen, Katherine, Richard</p> <p>Focus Area #6 Carol, Cindi, Heidi, Chris, Rus</p> <p>Focus Area #7 Scott, Richard, Eileen, Tara, Cindi, Chris</p> </div> <p>D. Koyanagi stated that her area of interest is kids. She would be interested in helping with anything the Council is working that's kid focused.</p> <p>A. Beninato is interested in identifying what focus areas he would be useful to work on. He expressed interest legislation and being able to read the top six bills that were identified by the LEG PIG. C. Dang noted that each bill has a summary that describes the salient parts of each bill. This information is provided on the legislature website.</p> <p>C. Dang suggested reviewing the information about the bill relating to mobile health clinics. She suggested this information could be reviewed at the next meeting. C. Knightsbridge said that he agreed with A. Beninato's point about getting through the legalese jargon. C. Knightsbridge noted that the WSA PIG is working to address social media needs.</p>			

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	<p>A. Beninato also mentioned his interest in increasing accessibility using social media, such as Instagram, to connect with other people. He recalls an e-mail S. Haitsuka sent out about changing the law for open meetings to include virtual meetings so more people can connect on topics of interest in a way that they can understand and potentially share this information with the younger generation and others who are on social media and rely on social media for their real time information and updates. C. Dang noted that it is important to connect on social media and she, along with E. Lau-James, encouraged A. Beninato to join the WSA FIG.</p> <p>C. Knightsbridge brought up the concern about having information approved by the Council before it is distributed, including social media content. C. Dang mentioned that the Council may need to get the Attorneys General involved. T. Reed shared that she speaks only on her involvement and shares what she is doing when she interacts with others on Facebook.</p> <p>Focus Area #7: Identify, Track and Share the Status of DOH Behavioral Health Administration (BHA) Legislative Bills (includes: Adult Mental Health Division, Child Adolescent Mental Health, and Alcohol and Drug Abuse Division)</p> <div data-bbox="554 980 1173 1437" style="border: 1px solid black; padding: 5px;"> <p style="text-align: center; margin: 0;">Focus Area #7 Identify, Track and Share the Status of DOH Behavioral Health Administration (BHA) Legislative Bills (includes: Adult Mental Health, Child Adolescent Mental Health, and Alcohol and Drug Abuse Divisions)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 2px;">Strategic Planning: <i>Identified during the Council's Retreat</i></td> <td style="padding: 2px;">Category: <input type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input checked="" type="checkbox"/> #4 Administrative Support for Council Functions</td> </tr> <tr> <td style="padding: 2px;">Area(s) of Need Addressed: <i>Council's purpose and responsibilities as required by Hawaii law</i></td> <td style="padding: 2px;">Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council's advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input checked="" type="checkbox"/> Council's linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council's knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e)</td> </tr> <tr> <td style="padding: 2px;"><i>Includes a narrative statement describing the problem/issue.</i></td> <td style="padding: 2px; text-align: center;">XX</td> </tr> <tr> <td style="padding: 2px;">Outcome(s)/Product(s): <i>What the Council wants to see</i></td> <td style="padding: 2px;"><input checked="" type="checkbox"/> Post-pilot Participation Guidelines for Council Legislative Activities.</td> </tr> </table> </div>	Strategic Planning: <i>Identified during the Council's Retreat</i>	Category: <input type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input checked="" type="checkbox"/> #4 Administrative Support for Council Functions	Area(s) of Need Addressed: <i>Council's purpose and responsibilities as required by Hawaii law</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council's advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input checked="" type="checkbox"/> Council's linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council's knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e)	<i>Includes a narrative statement describing the problem/issue.</i>	XX	Outcome(s)/Product(s): <i>What the Council wants to see</i>	<input checked="" type="checkbox"/> Post-pilot Participation Guidelines for Council Legislative Activities.			
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	<p>participation guidelines, the current LEG PIG created a testimony template that was approved by the Council to submit testimony on.</p>			
<p>IX. Sustaining Your Work</p> <ul style="list-style-type: none"> • Finalize Strategic Plan • Next Steps 	<p>K. Oliver transitioned Council members to reviewing the accompanying Action Plan for the Strategic Plan template.</p> <p>She noted that the process for finalizing the Strategic Plan involves putting the measurable objectives into small action steps that include specific actions that Council members will take.</p> <p>The draft Action Plan includes suggested steps that can be taken to address each of the measurable objectives.</p> <p>C. Dang suggested that the report back feature is a good way to summarize the work that the PIGs did. She noted that the LEG PIG plans on doing this report back feature as part of its pilot of the Council's participation guidelines for legislation. She suggested that each of the focus areas could include a report back feature.</p> <p>K. Oliver pointed out that sustainability is an important part of keeping the focus on the Strategic Plan even when there is turnover in membership. She encouraged Council members to make the Action Plan template their own when working on each of the focus areas.</p> <p>She suggested that Council members could use the Strategic Plan and Action Plan templates as working documents and also as recruitment tools. It could be used for citations in other reports that the Council is involved in and to link the Council's activities to.</p> <p>Developing a timeline for focus areas is a good way to visually map out how the Council is doing.</p> <p>Sustaining the work that has been done over a period of time includes several parts.</p>			

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	<div data-bbox="562 217 1163 370" style="background-color: #4a90e2; color: white; padding: 10px; text-align: center; border-radius: 10px 10px 0 0;"> <h2 style="margin: 0;">Sustaining Your Work!</h2> </div> <p data-bbox="583 376 1104 418">The continuation of a program and the delivery of the intended benefits over an extended period of time <small>Shediac, Rizkallah MC, et al. Health Educ Res. 1998;13:87-108.</small></p> <p data-bbox="583 422 919 438">The indicators that something is sustained include:</p> <ul data-bbox="613 451 1104 600" style="list-style-type: none"> · maintenance or the ability to continuously deliver the benefits achieved when the intervention was first implemented, · institutionalization or the integration of the innovation within the organizational culture through policy and practice, and · capacity building activities that build the infrastructure and long-term resources that will support the continued delivery of the program. <p data-bbox="613 623 1104 639"><small>Rabin Baet, al. A glossary for dissemination and implementation research in health. J Public Health Manag Pract.</small></p> <div data-bbox="562 662 1163 815" style="background-color: #4a90e2; color: white; padding: 10px; text-align: center; border-radius: 10px 10px 0 0;"> <h2 style="margin: 0;">Why Sustainability?</h2> </div> <p data-bbox="588 815 1167 1075" style="text-align: center;"><i>“We have a responsibility to our program recipients; they’ve had so many losses in their lives and for us to come in for a year or two or three and give them hope, only to have the program go away, we’ve just caused another loss and a further loss of hope in their lives.” —Akerlund 2000</i></p> <p data-bbox="407 1117 1289 1182">She encouraged the Council to think about ways to share updates on the Council’s Strategic Plan and Action Plan steps as they are completed.</p> <p data-bbox="407 1224 1310 1364">She thanked the Council for spending their time to make the strategic planning process informative. She expressed her sincere gratitude for the opportunity to work with the Council to draft the Strategic Plan and Action Plan templates.</p>			

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X. Closing Remarks	<p>R. Ries thanked K. Oliver for facilitating the Council through four hours of strategic planning activities and discussions. He thanked Council members for their focus and their time. He recognized that four hours is a long time to focus and that the Council has done a great job with identifying the priority areas that we will work on.</p> <p>R. Ries stated the post-Retreat questionnaire link was shared in the Zoom chat. S. Haitsuka will also e-mail the link. He encouraged members to complete the questionnaire ASAP while it's fresh in their mind.</p> <p>R. Ries asked Council members to share feedback about today's Retreat.</p> <ul style="list-style-type: none"> • H. Ilyavi thanked K. Oliver, S. Haitsuka and E. Lau-James for planning a great retreat and for preparing excellent meeting materials and Retreat box supplies and snacks. • C. Matayoshi thanks K. Oliver for her facilitation of these two Retreat sessions. She thanked S. Haitsuka and E. Lau-James for helping to prepare the Retreat activities. She feels that there was great sharing and it feels like the Council is getting somewhere because we have a plan, a path and are focused and very productive. She feels this group has great energy! • C. Dang mentioned that she feels there is a stronger sense of direction and that the Council has a lot of talent now and we are at a point where we are using the talents of every Council member. She thanked everyone for a great Retreat experience. She feels that the Council has a sense of purpose and clarity which connects Council members to priority focus areas and where members can leave a legacy for future terms/members to use. • C. Knightsbridge expressed his satisfaction with getting stuff done and he is looking forward to meeting now compared to before. • N. Crozier shared that she feels honored to be elected to serve as a Council member and while she was floundering at the beginning of the term, she now feels she has a clear cut direction. • E. Lau-James shared that over the course of the last three months of the LEG PIG's work, she feels the LEG PIG did more in this time than 	Complete post-Retreat questionnaire	Council Members	2/12/21

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
	<p>what was done in the entire first year she has volunteered as a Council member. She thanked S. Haitsuka and R. Ries for leadership and culture change of the meetings and the Council overall. She is excited to do the Council’s work. She thanked everyone for a positive Retreat experience.</p> <ul style="list-style-type: none"> • R. Ries is excited about changing how people in the community know about the Council and its work so that the Council’s voice is heard. He is so happy to work with all Council members on the Strategic Plan. <p>R. Ries noted that K. Oliver will provide the Council with a post-Retreat summary to review at the March meeting.</p> <p>He thanked everyone for participating before adjourning at 12:37 p.m.</p>			
Retreat Materials and Supplies	<p>The following hard copy handouts were provided to Council members:</p> <ul style="list-style-type: none"> • Retreat cover letter and agenda • Retreat (Part 1) Post-Retreat Facilitator Summary with Appendix 1 (Pre-Retreat Questionnaire), Appendix 2 (Post-Retreat Questionnaire), Appendix 3 (Retreat (Part 1) Presentation Slides), Appendix 4 (Retreat (Part 1) Minutes) • Draft Council Member Guidebook • Post-Retreat (Part 1) Interim Work – Focus Area Ranked Results • Draft Strategic Plan Focus Area Template • Draft Strategic Plan Action Plan Template • Post-Retreat (Part 2) Questionnaire <p>The following supplies were provided to Council members to aide in their engagement and participation in Retreat activities:</p> <ul style="list-style-type: none"> • Pen, notebook, lip balm, hand lotion, BINGO cards/markers • Blank thank you card and individually packaged snacks 			
Reference Links to Resources Mentioned During the Retreat	<p>The following resources were shared during the Retreat.</p> <ul style="list-style-type: none"> • None. 			

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
March 9, 2021
9:00 a.m. – 11:30 a.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Crozier, Charleen “Naomi”; Dang, Cynthia “Cindi”; Fujii, John; Ilyavi, Heidi; Knightsbridge, Christopher; Koyanagi, Dina; Lau-James, Eileen; Martinez, Beatrice “Kau’i”; Matayoshi, Carol; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Ries, Richard; Shimabukuro, Scott**

Members Absent:

Members Excused:

Guests Present: **Lillibridge, Amanda; Lukens, Ashley; Reyno Yeomans, Raelyn; Shin, Doorae; Angela (no last name shared)**

DOH Staff Present: **Haitsuka, Stacy; Hiraga-Nuccio, Madeline; Nazareno, Jocelyn**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 9:00 a.m.</p> <p>Members and guests introduced themselves.</p> <p>The following definition of quorum was added to the agenda as of the November 10, 2020 agenda: Pursuant to Act 137-18 (SB 203), Chapter 92, Hawaii Revised Statutes: “(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes.”</p>	For information only.		

	<p>For example, if only 16 of the entitled 21 members are appointed, at least 9 must be present to establish a quorum. To validate a council action, of the 9 members present, an affirmative vote from at least 5 is required.”</p> <p>Quorum was established.</p>			
<p>II. Meeting Announcements</p>	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally get his attention during the meeting. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who take a break and step away from the meeting, please notify him before leaving as the Council needs to track of when Council members leave and return to verify quorum. • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. • If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear speaker. <p>R. Ries acknowledged that the Centers for Disease Control and</p>	<p>For information only.</p>		

	Prevention (CDC) announced a change in indoor gatherings and mask wearing; however, at this time, he noted that until the state has reassessed its interisland travel requirements and until the DOH has announced a change in its facility policies for resuming in-person meetings in DOH facilities, the Council will conduct its meeting virtually.			
III. Consideration and Approval of Minutes February 9, 2021 (Business Meeting and Retreat)	<p>The draft minutes for the February 9, 2021 business meeting were reviewed. Amendments as follows:</p> <ul style="list-style-type: none"> • Fix typo – “Tera” to “Tara” <p>C. Knightsbridge made a motion for the business meeting minutes from the February 9, 2021 meeting be approved. T. Reed seconded the motion.</p> <p>NOTE: Draft minutes for the February 9, 2021 Retreat were not reviewed.</p>	Finalize minutes as amended. Motion passed.	S. Haitzuka	03/29/21
IV. Community Input	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p> <p>[No community input was received.]</p>			
V. Permitted Interaction Group (PIG) Reports	<p>R. Ries explained that in this section of the agenda, PIG members may briefly summarize the PIG activities since the last Council meeting including meeting dates, discussions, and recommendations on topics approved at previous Council meetings.</p> <p>He asked that oral summaries be brief and if PIG members would like to share a longer report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <ul style="list-style-type: none"> • PIG for Website, Social Media, and Advocacy (WSA) <p>WSA-PIG members include C. Knightsbridge, C. Dang, C. Matayoshi, H. Ilyavi and R. Pascual-Kestner. C. Knightsbridge is the WSA-PIG lead.</p> <p>The WSA-PIG met twice since the last Council meeting. There are two recommendations for the Council to vote on today.</p>	For information only.		

Regarding resources to be listed on the Council’s website resource webpage, the WSA-PIG recommends Council members share resources, by category and by island by adding their resource items to the Google sheet that the WSA is currently using (see below for a sample).

The Council’s website needs Council members to assist with listing events (local, state, national) that the Council could include as a resource items.

WSA PIG members met on 2/23/21 and discussed the Council’s website - specifically the Council’s Resources page. WSA PIG members are asked to identify additional categories and suggested resources by Wednesday, 3/3/21.

NOTE: Categories and Resources, once vetted by the WSA PIG, will be listed/separated by Island (not County). The next WSA-PIG meeting is Thursday, 3/4/21 at 8:30am via Zoom.

WSA PIG members will present this list at the March Council meeting and Council members will be asked to identify additional categories and resources that meet the following criteria:

- Is it purposeful?
- Is it relevant?
- Is it behavioral health focused?

Category	Suggested Resource (Provide Name of Resource)	List each island the resource is for If you type "Statewide", you are saying the resource is available on Kauai, Ni'ihau, Maui, Molokai, Lana'i, Oahu, and Hawaii Island	Comment/Resource Description (Please share the website link if available)
1 Housing			
2 Employment			
3 Child Care			
4 Food/Nutrition			
5 Substance Abuse	West Hawaii Community Health Center (MAT & HI-RCORP)	Hawaii Island	1. https://www.westhawaiihc.org/
6 Mental Health			
7 Military/Veterans			
8 Clubhouses	A Clubhouse is a unique, voluntary, member-driven psycho-social rehabilitation	Statewide	https://health.hawaii.gov/amhd/consumerclubhouse/
9 Family Support Groups		Statewide/Online	https://namihawaii.org/2021/01/27/join-a-nami-hawaii-support-group/
10 Covid-19 Resources	Additional multilingual, 24/7 support is available to people experiencing emotional distress related to		1-800-985-5990
11 Adult Daycare			

Council members shared the following comments:

- C. Dang pointed out that the WSA-PIG wanted to make sure every area of representation on the Council was included in the Category column to ensure all Council members have a voice for their area(s) of representation.
- E. Lau-James noted that NAMI Hawaii has a very comprehensive resource list. She isn’t sure how to best share that with the Council. R. Ries suggested that the resource list be reviewed first. C. Knightsbridge mentioned the resources be those that Council members have found to be useful.
- R. Ries noted that the bereavement network of Hawaii may be one resource he would consider having shared.

Regarding calendar of event items for the Council’s website calendar, the WSA-PIG recommends Council members add their calendar items to the

Share the link to the Google sheet with Council members.

S. Haitzuka

3/15/21

same Google sheet but on the 2nd tab (see below for a sample).

WSA PIG members met on 2/23/21 and discussed the Council's website - specifically the Council's Calendar of Events page (proposing new page). WSA PIG members are asked to identify behavioral health related events - local/state/national by Wednesday, 3/3/21.

NOTE: Events, once vetted by WSA PIG members, will be listed by month. The next WSA-PIG meeting is Thursday, 3/4/21 at 8:30am via Zoom.

WSA PIG members will present this list at the March Council meeting and Council members will be asked to identify additional events that meet the following criteria:

- Is it purposeful?
- Is it relevant?
- Is it behavioral health focused?

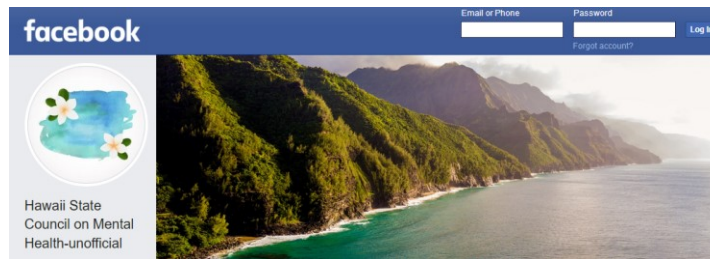
Month	Type of Event: - Local (type island name(s)) - Statewide - National	Organization/Host (Please Share the Event Name)	Comments/Event Description/Date Span (if not entire month) (Please share the event/host website link if available)
January	Statewide	HI State Legislature Opening Day	20th day of January
February			
March			
April			
May			

Council members shared the following comments:

- C. Dang

C. Knightsbridge shared that creating an unofficial Facebook page for the Council was the most practical way to manage the Facebook account. Here's the link to access the Facebook page.

<https://www.facebook.com/Hawaii-State-Council-on-Mental-Health-unofficial-112542660887805/>



About

CONTACT INFO

<https://scmh.hawaii.gov>

MORE INFO

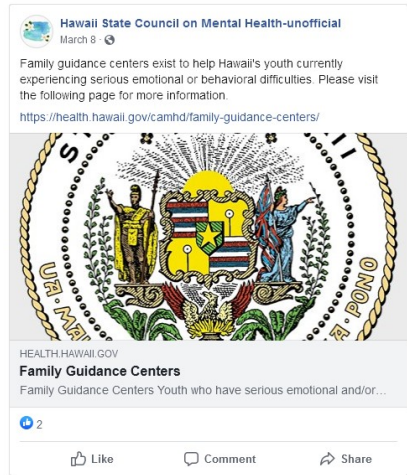
About

We are mental health professionals, family members, and members of the community who volunteer to advocate for Hawaii's citizens on mental health issues. This is our unofficial FB page.

Public & Government Service

There are currently two sample posts on the page: one for the Hawaii CARES 24/7 crisis line and the other for the Family Guidance Center.





Council members shared the following comments:

- H. Ilyavi noted that S. Haitsuka shared how other councils were sharing information on social media and advised on how this could be the done for our Council.
- R. Ries mentioned that he felt the unofficial Facebook page designed by C. Knightsbridge looks good.
- S. Shimabukuro asked who the moderator for the Facebook page would be. C. Knightsbridge clarified that right now he is the moderator but he emphasized that anyone can post to the page and the request would go to the moderators to check the guidelines for the post which include: non-political/non-opinionated, mental health focused content, and resources that are helpful to the community at large. He is happy to have other Council members be moderators as well. C. Dang concurred that there should always be a current Council member who is watching the page.
- S. Shimabukuro asked how often C. Knightsbridge would check for updates. He noted that on CAMHD’s social media, sometimes there are comments to posting that are needing to be responded to. C. Knightsbridge confirmed that he would check daily and that the page will alert him when there is a post request submitted.
- H. Ilyavi clarified that the thought process behind the postings was

<ul style="list-style-type: none"> • PIG for Legislation (LEG) 	<p>to have links to existing resources rather than the Council creating new things to post.</p> <ul style="list-style-type: none"> • K. Aumer wondered what the parameters would be for addressing comments to postings, especially those who are asking for help. C. Knightsbridge noted that this is an unofficial page but there will be information shared about accessing help via the Hawaii CARES 24/7 crisis line. H. Ilyavi noted that the page could mirror information already shared on the Council’s website and include 2-1-1 as an option for people to contact for additional help. • R. Ries suggested adding a disclaimer about content made by outside entities are not necessarily endorsed by Council members and is meant to be an informational resource. <p>LEG-PIG members include C. Knightsbridge, C. Dang, E. Lau-James, and T. Reed. C. Dang is the LEG-PIG lead.</p> <p>The LEG-PIG met twice since the last Council meeting. They provided a copy of their rank order results for bills they identified for the Council’s legislative bill tracking. As noted in the February business meeting minutes, the LEG-PIG identified 14 bills and rank ordered them to identify the top seven bills.</p> <p>The LEG-PIG also drafted four testimonies using the approved Council testimony template.</p> <p>Due to limited time during February’s business meeting the Council did not have time to vote on the LEG-PIG’s recommendations and instead we agreed to defer discussion to today’s meeting.</p> <p>C. Dang emphasized the time sensitivity during the legislative session. For future LEG-PIGs, she stressed that February is the month for the Council to receive the draft testimonies, review and approve them so they can be submitted when the hearings were scheduled.</p> <p>C. Dang noted that while the Council did not submit testimony, if the Council did submit, it may have changed the destiny of the bills the LEG-</p>			
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	<p>PIG recommended for the Council’s legislative bill tracking. For example, she noted:</p> <ul style="list-style-type: none"> • SB732 was originally a non-violent response pilot program; current status is bill was gutted and replaced with a study of the Hawaii CARES Program. The drafted testimony was for the non-violent response pilot program. • SB703 was for suicide prevention training; current status is this bill passed the Senate and crossed over to the House; pending hearing. • HB384 was for telehealth; current status is deferred. • HB692 was for sex trafficking prevention; current status is bill was referred but no hearing was scheduled; current status is deferred. • HB812 regarding trauma informed education was referred and it does not have an appropriation; current status is pending hearing. • SB199 regarding ; has a 48-hour notice and will get approved after the wait time; current status is pending hearing. • SB905 regarding the State Council; this bill directly involves the Council. SB899/HB628 were deferred; current status is bill crossed over to the House. SB905 received two Senate hearings. <p>C. Dang mentioned that the Council’s priority bill list was ranked ordered as noted in the handout; however, some of the bills have since died. She inquired about the Council’s preference for re-prioritizing those bills.</p> <p>E. Lau-James emphasized that the LEG-PIG and the Council is learning as we go and are piloting the participation guidelines that were drafted. In hindsight, the voting of the Council’s legislative bill tracking should have happened in February. She identified one of the big hold ups are having to wait a month for decisions to be made at the next Council meeting. She suggested the Council consider holding quick emergency Council meetings to vote on the bills that the LEG-PIG has prioritized and to vote to approve draft testimony.</p> <p>Regarding SB905, E. Lau-James noted drafted testimony includes the position of comments due to the educational requirements for this position that are not required for other Council positions.</p>			
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	<p>C. Knightsbridge supports the Council doing pre-meeting preparation including reading all the handouts that are sent a week prior to the meeting. For example, for today’s meeting, the LEG-PIG had several handouts including draft testimonies. It would be great for Council members to have read the legislative bills pertaining to the draft testimonies ahead of today’s meeting. That way, Council members would then have an idea whether their position on the bill is to support, oppose or share comments only, and whether they have edits for the draft testimonies. Reading the handouts prior to the meeting would help save time during Council meetings and move the discussion along.</p> <p>T. Reed wanted to clarify the role of the LEG-PIG. LEG-PIG members were selected by the Council and have done the work to research, read, prioritize and draft testimony for the Council to review, edit and approve. She expressed concern about the speed for obtaining approval from the Council as it’s very time sensitive work that needs Council approval. One thing she is frustrated about is that the LEG-PIG did meet and did the work but at today’s Council meeting, it feels like there is a re-hashing of the work that was done and that is being presented for Council approval. If Council members are unsure of their position or have not had time to read the bill and consider the draft testimony, she noted that members could abstain.</p> <p>The LEG-PIG will continue to pilot the participation guidelines that we received a draft of in our January 2021 meeting handouts and will revise the participation guidelines when they submit their final LEG-PIG report in June 2021.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries acknowledged the hard work of the LEG-PIG and noted that the work done so far has been amazing. • S. Shimabukuro noted that SB905 may currently have a far out date; however, the date was pushed out to allow for more discussion and can be changed in the final committee. • R. Ries noted that the Council may have an opportunity next year to revisit these bills if they are introduced again. 			
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	<ul style="list-style-type: none"> • R. Ries suggested that busy Council members may not read all the handouts that are sent a week prior to the meeting; however, a possible option, especially for time sensitive items that require thorough reading as opposed to skimming handouts, may be to have those handouts sent sooner and farther ahead of the meeting (i.e. more than a week prior). C. Knightsbridge suggested a monthly e-mail with updates. • S. Shimabukuro shared that the Child and Adolescent Mental Health Division (CAMHD) has a legislative group. In the early stages of the legislative session, the CAMHD legislative group meets twice a week. He’s not sure that the tempo of the LEG-PIG can keep up with that frequency for meetings. • R. Ries clarified that the LEG-PIG are permitted interaction groups that act as a think tank to work on tasks assigned by the Council and present their findings to the Council for official voting. • Regarding scheduling of emergency Council meetings, R. Ries noted that he supports these types of meetings so long as the Council does not violate the Sunshine Law. He also suggested that the Council could partner with community partners such as the National Association of Social Workers – Hawaii Chapter or the Hawaii Psychological Association, and CAMHD. C. Dang noted the Mental Health Task Force has a legislative process too. • C. Matayoshi commended the LEG-PIG for the work, time and all the effort that has been put into drafting the participation guidelines, researching bills, prioritizing bills for the Council, and drafting testimony. The LEG-PIG has done amazing work so far and she appreciates all of the efforts made. • Regarding re-prioritizing the Council’s priority bill list, he suggested that the LEG-PIG meet and re-order the list with the dead bills placed at the lower end of the list. • Regarding scheduling emergency Council meetings, S. Haitzuka noted that it is possible to schedule; however, it would be efficient if the LEG-PIG meet ahead of scheduling the emergency Council meeting to finalize the agenda and any handouts that need to be reviewed. For example, the LEG-PIG may want to meet to re-prioritize the Council’s priority bill list, update draft testimony 	<p>Look for the reference for emergency Council meetings and provide the citation.</p>	<p>S. Haitzuka</p>	<p>4/2/21</p>
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	<p>based on the most current draft of the bill, etc. C. Dang added that quorum must be achieved in order to vote. R. Ries noted that the public needs to be properly notified as well. C. Dang suggested that the LEG-PIG group meet in two weeks.</p> <p>The LEG-PIG requested the Council’s approval for two draft testimonies.</p> <ul style="list-style-type: none"> • HB812 – Relating to Trauma-Informed Education The recommendation is for the Council to approve the draft testimony in support of HB812. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ None. <p>C. Dang motioned to approve the draft testimony for HB812. C. Matayoshi seconded the motion.</p> <p>Council members voted to approve draft testimony.</p> <ul style="list-style-type: none"> • SB905 – Relating to the State Council on Mental Health The recommendation is for the Council to approve the draft testimony with comments for SB905. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ K. Aumer asked that the word “support” in the testimony be bolded. ○ R. Ries noted there are concerns about the educational requirement. While education is required, ho’oponopono is something that people are deeply knowledgeable about and those who are knowledgeable are not necessarily highly educated in terms of achieving a college degree. <p>C. Dang motioned to approve the draft testimony for SB905. C. Matayoshi seconded the motion.</p> <p>Council members voted to approve draft testimony for SB905.</p>	<p>Schedule next LEG-PIG meeting via e-mail to S. Haitzuka.</p> <p>Ayes (14); Noes (0); Abstentions (1)</p> <p>Motion passed.</p> <p>Ayes (12); Noes (0); Abstentions (2)</p> <p>Motion passed.</p>	<p>C. Dang</p>	<p>3/23/21</p>
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<ul style="list-style-type: none"> PIG for the SCMH Retreat 	<p>C. Dang stated that the LEG-PIG will monitor the status of these two bills and when they are scheduled for hearing, they will let S. Haitsuka know. S. Haitsuka stated that these two bills are also on the Behavioral Health Administration's (BHA) list of bills being watched.</p> <p>The Retreat PIG did not meet after February's Retreat; however, the Retreat Facilitator, K. Oliver has submitted a draft post-Retreat Facilitator Summary for February's Retreat and will be finalizing the post-Retreat Facilitator Summary and will submit the final draft later this week along with the approved Retreat minutes. She will work with S. Haitsuka to provide all required fiscal related documentation so that she is paid in full.</p> <p>Since the retreat is over, R. Ries asked for a motion to disband the Retreat PIG at this time.</p> <p>C. Knightsbridge motioned to disband the Retreat PIG. E. Lau James seconded the motion.</p> <p>Council members voted to approve the disbandment of the Retreat PIG.</p>	<p>Notify S. Haitsuka when bills are scheduled for hearing.</p> <p>Ayes (12); Noes (0); Abstentions (2)</p> <p>Motion passed.</p>	<p>LEG-PIG members</p>	
<p>VI. Island Representative Reports</p> <ul style="list-style-type: none"> Maui Service Area Board (MSAB) Oahu Service Area Board 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective Service Area Board may briefly summarize their board meetings and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer Service Area Board report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> MSAB did not meet. <p>The following updates were provided by C. Dang.</p> <ul style="list-style-type: none"> OSAB met and had quorum. The OSAB is discussing its CISAP and is discussing the use of telehealth and improving access and 			

<p>(OSAB)</p> <ul style="list-style-type: none"> Hawaii Service Area Board (HSAB) 	<p>response to 9-1-1 calls that involve mental health crises.</p> <p>The following updates were provided by C. Matayoshi.</p> <ul style="list-style-type: none"> HSAB had quorum. Currently the HSAB has three confirmed members and three pending members. Discussion was focused on finalizing the HSAB CISAP. When done, the HSAB CISAP will be shared with the Council. 			
<p>VII. Presentation/ Guest Speaker</p>	<p>R. Ries introduced Dr. Ashley Lukens. She is the co-founder of the Hawaii Clarity Project.</p> <p>The Hawaii Clarity Project is an initiative that aims to expand patient access to include psilocybin-assisted therapy modalities. Through community education, advocacy and legislative action, Hawaii Clarity Project staff have been working to create the necessary legal frameworks, regulatory bodies, and associated governmental mechanisms to help expand therapeutic access to psilocybin in Hawaii.</p> <p>The Council has not taken a position in support, against or neutrally on this topic. Doorae Shin, Project Manager for the Hawaii Clarity Project, reached out to request time on the Council’s agenda to present on this topic.</p> <p>Dr. Lukens shared the following points along with her PowerPoint presentation:</p> <ul style="list-style-type: none"> The Hawaii Clarity Project was co-founded by Robert Paterson and herself with a mission to expand legal, therapeutic medical psilocybin access in Hawaii. Psilocybin is safe and non-addictive. It has been effective in addressing mental health issues such as post-traumatic stress disorder and depression. The Hawaii Clarity Project belongs to a growing psychedelic renaissance. 			

GROUNDBREAKING RESEARCH

Cancer-related depression & anxiety

- 80% of cancer patients who received psilocybin showed significant reductions in anxiety and depression, lasting at least 6 months after a single session. (John Hopkins University)

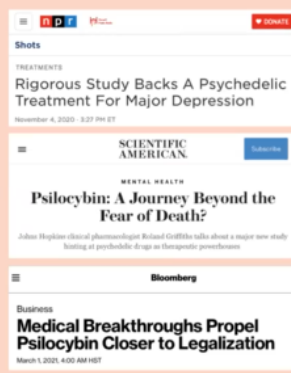
End-of-Life Anxiety

- "It is simply unprecedented in psychiatry that a single dose of a medicine produces these kinds of dramatic & enduring results"
-Dr. Stephen Ross, NYU Langone Center of Excellence on Addiction

Addiction

- A pilot study showed 80% of participants had quit smoking. After one year, it was 67%, making it more successful than current treatments. (John Hopkins University)

...and more!



- There are several research institutions that are conducting research, including research on the use of psilocybin to ease the effects of mental health symptoms (i.e. veteran population).

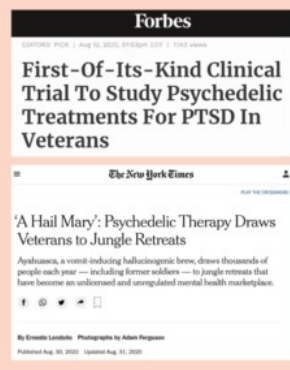
VETERANS & PSYCHEDELICS

Mental Health Crisis Among Veterans

- Between 10-20% of active duty veterans suffer from PTSD, much higher than the general population.
- Rate of drug and alcohol abuse is higher for veterans.
- Rate of suicide for veterans is 1.5x of the general population.
- Over 10% of Hawaii's population consists of veterans.

Promising Benefits

- Psychedelics are a life-saving therapy for many veterans suffering from PTSD and other mental illnesses.
- Heroic Hearts Project supports veterans seeking safe psychedelic therapy, with incredible results.



- The Hawaii Clarity Project is part a broad range of citizen-led initiatives to decriminalize and legalize psilocybin.
- The framework that allows for therapeutic access to psilocybin is important because it creates a designation for therapists to prescribe and administer psilocybin in treatment settings.
- The Hawaii Clarity Project is pushing for therapeutic access to psilocybin is because the setting is critical to the successful integration of the psychedelic experience. For example, where you're dosed, how you're dosed and how you're able to integrate

the insights from the psychedelic experience are critical in driving the critical long-term health benefits of psilocybin.

- There are three vehicles in the legislature that focus on psilocybin. One bill has died but two resolutions are set to be introduced (one in the House and one in the Senate) that require the DOH and the University of Hawaii to create a task force or advisory board to address the potential of therapeutic psilocybin in Hawaii.

OUR VISION

Psilocybin and other psychedelics are destigmatized, decriminalized, and accessible for those who need it.

Because we all know someone who stands to benefit from having access to these important therapies.



Council members shared the following comments:

- E. Lau-James asked about the difference between psilocybin and ketamine. Dr. Lukens noted that access to ketamine is already legal and can be addressed via existing options such as Beyond Mental Health (founded by Dr. Thomas Cook) and also the Ketamine Clinic of Hawaii. Dr. Lukens also noted that it's important for patients to have options that they can try to see what works best for them. She points out that micro-dosing may be popular, she is interested in macro-dosing with long-term integration of that dose with a booster macro-dose at various longer-term intervals (i.e. a year later). Her personal experience with being able to detach her ego from the narratives in her head and being able to grasp those thoughts tangibly was significant for her.
- R. Ries noted that this type of treatment model and regime likely will not make for popular pharmaceutical support but psilocybin is not something that is brand new.
- K. Aumer mentioned that the psilocybin did die but she was

	<p>interested to know what the challenges were and perhaps why the health department did not support the bill. Dr. Lukens noted that the bill may have been ill informed and the broader context in which the Hawaii Clarity Project was trying to introduce the issue was not clear. It was introduced by Senator Stanley Chang on his own volition and he is passionate about addressing mental health care. Hawaii Clarity Project aimed to introduce this bill to dispel the “party drug” image and to emphasize that there would be someone who is trained to provide guidance through the psilocybin treatment process.</p> <ul style="list-style-type: none">• K. Aumer inquired about how Oregon was able to get their psilocybin bill passed. Dr. Lukens noted that Oregon, unlike Hawaii, had a ballot measure that was voted for. Oregon now has a two year implementation period. For Hawaii’s psilocybin bill, the Hawaii Clarity Project used the language from the Oregon bill. Dr. Lukens clarified that there is a difference between medical access and therapeutic access to psilocybin. Medical access requires a diagnoses whereas therapeutic access can be used based on the recommendation of the therapist. This therapeutic access allows broader access for patients who are not diagnosed to have access to this therapeutic psilocybin access.• C. Knightsbridge asked how psilocybin is used to treat substance abuse relative to ayahuasca and ibogaine. Dr. Lukens stated that she does not have access to research that compares the efficacy of each of these substances alongside each other. Much of the research right now is anecdotal since most of the clinical trials are five or ten years in. She confirmed that access to ayahuasca is legal for access in ceremonial settings by a designated ayahuasca church. This setting may not be the most attractive setting for therapists to seek out access for patients. Ibogaine and iboga (the plant medicine ibogaine is derived from) are harder to access. She is unsure how psilocybin stacks up against these substances; however, based on her experience, a macro-dose of psilocybin is not the same of a “party” dose that someone would take before going to an event. Rather, this is a much heavier dose that is administered.			
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	<ul style="list-style-type: none"> • A. Beninato asked to clarify about the use of psilocybin relative to serotonin blocker. Dr. Luken stated that she believes the body reads psilocybin as serotonin. She clarified her Ph.D. is in political science and her mastery of the psilocybin literature is focused on shifting policy around psychedelics. She suggested that additional information can be reviewed in a white paper that is found on the Hawaii Clarity Project website under Resources. https://www.clarityproject.org/ She also suggested another resource, the Multidisciplinary Association for Psychedelic Studies (MAPS). https://maps.org/ • A. Beninato emphasized that he feels it's important for people to understand how psilocybin works, chemically which is the reason why someone can experience something beyond their usual experiences. Understanding how psilocybin can help connect places in the brain that are not usually connected with serotonin makes it a lot easier to understand why it is so effective in changing experiences. • R. Ries mentioned research in the 1950s didn't always result in certain experiences resulting from chemical action. Sometimes it was the result of chemical and receptor inaction which is a flip-around on the way most neurochemical research is oriented. • C. Dang inquired if the Hawaii Clarity Project has knowledge of who would be included as members of the psilocybin task force. Dr. Lukens stated there are recommendations for task force members and she would be happy to suggest an amendment to add a representative from the Council if the Council decides that this is something that they would like to support. <p>To get additional information and updates on the efforts of the Hawaii Clarity Project, please sign up for the alerts (scroll to the bottom of the homepage). https://www.clarityproject.org/</p> <p>D. Shin stated that an e-mail can be shared about upcoming legislation where the Council may decide whether they would like to submit testimony to support the Hawaii Clarity Project's three to five year strategy to move this issue along within the consciousness of the</p>			
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	<p>community and our legislators. Sample testimony can be found on the Hawaii Clarity Project's website under legislative updates. https://www.clarityproject.org/legislative-updates</p>			
<p>VII. State Agency Representative Reports</p> <ul style="list-style-type: none"> • Hawaii Public Housing Authority (HPHA) • Department of Health Child 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective state agency may briefly summarize agency data, agency information related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by K. Martinez:</p> <ul style="list-style-type: none"> • 750 Section 8 vouchers were issued by December 2020 to avoid lapsing funds. HPHA wishes it had more money to assist additional families. • The next initiative is to change some HPHA's Hawaii Administrative Rules (HAR) to accommodate these types of emergency types of programs and activities, including public housing. • HPHA hopes to open the waitlist for a short period of time for families to apply and likely use a lottery style system. • HPHA is working with private contractors to speed up the prep for available units. • Regarding moratoriums placed on public housing authorities nationwide by the U.S. Department of Housing and Urban Development (HUD), HPHA continues to allow for no minimum rent and only do evictions for health/safety issues (rarely evicted for this reason). HPHA is committed to helping families to pay their rent and encouraging families to pay what they can. • HPHA continues to assist families with personal protective equipment (PPE) and cleaning and sanitation supplies. <p>The following updates were provided by S. Shimabukuro and M. Hiraga-Nuccio :</p>			

<p>Adolescent Mental Health Division (DOH CAMHD)</p> <ul style="list-style-type: none"> Department of Human Services (DHS) MedQUEST (MQD) Division Medicaid Program 	<ul style="list-style-type: none"> Expanded access to services via telehealth has helped to connect remotely with families who need services and support. There are still reduced numbers of applicants. This is a concern and efforts are being made to address this reduction. There appears to be a need; however, due to schools not being in full face-to-face session, many referrals that would normally come thru the educational system have not been consistent throughout the pandemic. S. Shimabukuro met with education department staff to discuss options for remote screening and referrals. Educational outreach to other agencies such as the judiciary, child welfare services, and non-profit agencies for referrals is ongoing. <p>The following updates were provided by J. Fujii:</p> <ul style="list-style-type: none"> DHS MQD is in the middle of the QUEST Integration (QI) re-procurement. QUEST is the state’s Medicaid program run by the DHS MQD. Medicaid is a federal and state partnership program created to assist individuals with limited resources. The award announcement will be released on March 15th and the contract will be effective July 1st. DHS MQD awarded the Community Care Services (CCS) contract for severe mental illness (SMI)/severe and persistent mental illness (SPMI), a carve out health plan, to ‘Ohana Health Plan, the incumbent. The award announcement was released in February and the contract is effective July 1st. Funding is available to support DHS MQD program and to provide “federal match” dollars for qualified programs and services. The federal match is usually about 54%; For example, if Hawaii spends \$100 the federal match would be \$54 for every \$100 spent. DHS MQD is tracking legislative bills including those related to telehealth and various funding related bills that help to sustain existing services and help to strengthen our federal match. DHS MQD is currently working with the DOH Behavioral Health Administration’s (BHA) Child and Adolescent Mental Health Division (CAMHD) to stretch those federal match dollars to support CAMHD’s work. For example, Medicaid federal match dollars are being received for the CAMHD’s INSPIRE electronic medical records 			
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<ul style="list-style-type: none"> Department of Human Services (DHS) Child Welfare Services (CWS) Department of Human Services (DHS) Division of Vocational Rehabilitation (DVR) 	<p>system integration project. DHS MQD provides \$10 for every \$100 of system costs incurred by CAMHD.</p> <ul style="list-style-type: none"> DHS MQD is also working with DOE on programs that support disadvantaged children and assist with Medicaid federal match dollars for those services. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> A. Beninato inquired about whether Hawaii’s federal match is across the board or if it differs by type of program or service. J. Fujii noted that the federal match varies. Program related activities are usually based on a 54% match. Other states have a higher or lower match. He noted that most of the DHS MQD federal match has gone to technology but other services have different federal match criteria. For example, during the COVID-19 pandemic, the federal match has included COVID-19 testing and pandemic response activities. Also, salaries, personnel, and rent are around 50% federal match. Other Hawaii departments such as transportation have higher federal match dollars. <p>The following updates were provided by D. Koyanagi:</p> <ul style="list-style-type: none"> None shared. <p>The following updates were provided by R. Pascual-Kestner:</p> <ul style="list-style-type: none"> Update on the three priority categories for the DVR waitlist: Category 1: most significantly disabled has been resolved. Category 2: significantly disabled will soon be open. The opening of the waitlist means more participants on the waitlist can now enter and receive services. On February 22nd, there was a statewide leadership and staff meeting. There were two guest speakers – Kathleen Merriam, Windward Treatment Services Section Supervisor who spoke community mental health resources and about how to balance mental health during the pandemic. This is a topic that leadership 			
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	<p>has been addressing; specifically, how to re-engage with each other while being physically distanced and working remotely. The second speaker was Ka’ala Souza, author of the book Pono: A Hawaiian Style Approach to Balance and Wellbeing. He created a three-minute message online about resiliency in terms of technology and digital resiliency. This is important for DVR staff to understand in order for us to connect with our participants.</p> <p>https://3minutemessage.com/</p> <ul style="list-style-type: none"> • The DHS Ohana Nui initiative, “is based on national data and best practices that a multigenerational philosophy of service delivery is more effective than one that separately addresses individuals’ needs.” <p>https://humanservices.hawaii.gov/blog/ohana-nui-kicks-off/</p>			
<p>VIII. Specialty Area Representative Reports</p> <ul style="list-style-type: none"> • Hawaii Advisory Committee on Drug Abuse and Controlled (HACDACS) • Mental Health Providers 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective specialty area may briefly summarize specialty area activities related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by J. Fujii:</p> <ul style="list-style-type: none"> • HACDACS continues to monitor its priority bills. He will provide an update for the next Council meeting. <p>The following updates were provided by R. Ries:</p> <ul style="list-style-type: none"> • Providers are super overwhelmed due to patients experiencing heightened anxiety, depression and other pressures related to the pandemic. Providers are begging other providers to see patients who need help. He has been working very long hours to help 			

<ul style="list-style-type: none"> Parents and Family Members of Mental Health Service Recipients Consumer Advocates 	<p>patients including taking new patients.</p> <ul style="list-style-type: none"> The Hawaii Psychological Association is generating resiliency training and anti-burn out training for police, fire, ocean safety and emergency medical response staff. It is a voluntary training and a lot of interest has been expressed for this training. <p>The following updates were provided by H. Ilyavi:</p> <ul style="list-style-type: none"> She emphasized that kids are needing access to services. Every resource on the Big Island are waitlisted including educational support, childcare when returning to work, school-based programs with supervision, financial and other assistance are hard to access right now. She is working day and night to help families as much as possible. Thank goodness for telehealth options which has been a saving grace. <p>The following updates were provided by E. Lau-James:</p> <ul style="list-style-type: none"> Each month, the affect of isolation becomes more visible. There are “bubbles” that have been created where people are becoming more and more anxious because they do not have the community that they had prior to the pandemic. She is cautious about the number of individuals who are needing resources but have not reached out or connected with others yet. It will be interesting to see as the state opens up because there are likely people who have needed resources. <p>The following updates were provided by C. Knightsbridge:</p> <ul style="list-style-type: none"> There is a concern for the unemployment insurance delays and the additional requirements that at being put on the claimants to produce. It is so difficult to talk to someone in the office! On top of having to address mental health issues, the pressure of having to address unemployment insurance paperwork and documentation is going to be a big problem in the coming months. <p>The following updates were provided by N. Crozier:</p> <ul style="list-style-type: none"> She has recently been helping consumers who have no 			
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	<p>identification. Some are needing services such as a COVID-19 test. Without an ID of some kind, it is very difficult for case managers to assist with linking to services.</p> <p>The following updates were provided by T. Reed:</p> <ul style="list-style-type: none"> • Nobody is still taking into account the gap group of people who are on a fixed income and do not qualify for unemployment insurance. She has experienced increased expenses as a result of the pandemic. • She is one of two Maui Hawaii Certified Peer Specialists. She recently completed the youth mental health first aid course. Mental Health America-Hawaii is offering remote trainings that are lengthy but are really good trainings. https://mentalhealthhawaii.org/get-connected/ R. Ries commended T. Reed for her achievements in earning the Hawaii Certified peer specialist certification and for all of her dedication and hard work. He emphasized that the peer voice is critical and should be prioritized. 			
<p>IX. Old Business</p> <ul style="list-style-type: none"> • Post-Retreat Facilitator Summary 	<p>R. Ries noted that anytime the Council has a new business agenda item that needs to be continued to the next month’s meeting, the Council will have those agenda items listed the following month as Old Business agenda items.</p> <p>Post-Retreat Facilitator Summary</p> <ul style="list-style-type: none"> • R. Ries noted that the Council received two post-Retreat facilitator summaries from K. Oliver. She submitted the first post-Retreat summary with our December 2020 meeting handouts and the second post-Retreat summary with today’s meeting handouts. • The Council has not voted to accept these post-Retreat summaries formally but he would like the Council to do so at this time to formally acknowledge these documents being received. • He acknowledged the work that K. Oliver has done to help the Council with our Strategic Plan and Action Plan. <p>Council members shared the following comments regarding the Retreat experience:</p>			

	<ul style="list-style-type: none"> • C. Knightsbridge appreciated the snacks and felt that the Retreat (Part II) was far better than Part I. C. Matayoshi, E. Lau-James and H. Ilyavi agreed. • E. Lau-James felt that Part I meandered a little bit as the Council explored various topics and focus areas. • R. Ries acknowledged one of the potential reasons for the improved Part II experience is the honest feedback that was shared via the post-Retreat questionnaire. It is challenging to have a four-hour virtual retreat session each time. The honest feedback after Part I was significant to improving Part II. • C. Dang noted that the Retreat had been talked about for years. She wonders if there's a way to do a Retreat every second or third year. She feels that the results with participation and engagement is phenomenal. She hopes that there is an opportunity to continue to build upon the success in the future. R. Ries recognized that this Council group is a motivated group. He wondered whether there is a need to make a bylaw change. C. Dang suggested having a standing Retreat PIG get together to plan for a future Retreat. She noted that K. Oliver did stay in the background to allow the Council to take charge and run the retreat. The Council really took ownership of this retreat. T. Reed suggested perhaps a comradery style gathering to grow the Council and have time to continue to see gains, get to know each other, engage and become vested in the Council's plans. • C. Matayoshi asked whether the Council has a budget for activities. H. Ilyavi pointed out that due to no travel, there may be money allocated but not spent that the Council could use. E. Lau-James shared about the procurement request process that has been used to make specific requests for activities. • K. Martinez explained that anytime a state department wants to use money for a meeting or activity, S. Haitsuka would need to submit a request to the State Comptroller. She recalls that there were parameters for which meals could be purchased (i.e. light breakfast versus a full meal). There are also guidelines for nutrition choices for the meal items. It is possible to also include a speaker along with the meal. The justification would include all of the 			
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	<p>information to describe why the amount is being requested.</p> <ul style="list-style-type: none"> E. Lau-James felt that the amount of time it took to get all of the funding paperwork completed and approved was laborious. <p>C. Matayoshi made a motion to accept the two post-Retreat summaries submitted by K. Oliver. E. Lau-James seconded the motion.</p>	<p>Motion passed unanimously.</p>		
<p>X. New Business</p> <ul style="list-style-type: none"> Strategic Plan Review and Discussion of Focus Areas and Accompanying Action Plan Items 	<p>In the post-Retreat (Part II) summary submitted by K. Oliver, Appendix 2 and Appendix 3 identifies the current status of the draft Strategic Plan and Action Plan as we left it when the Retreat concluded.</p> <p>R. Ries noted that there is no voting on the Strategic Plan and Action Plan at this time. Rather, right now we are discussing any significant changes we want to make to these draft documents.</p> <p>Focus Area #1 Measurable Objectives Improving Access to Mental Health Services (existing and new)</p> <ul style="list-style-type: none"> 1.1 – R. Ries would like to push the start date back to July 2021 to align with the start of the new term. 1.2 – R. Ries would like to push the start date back to September 2021. If this date does not work for the block grant application timeframe, we may need to adjust the date again in July when we get an update from DOH staff about the block grant application. 1.3 – R. Ries would like to reserve this objective for the WSA-PIG as ad hoc support to coordinate with the Google sheet they are using to collect this information. While the Council does not have authority to approve or deny the Island Service Area Board CISAPs, R. Ries is hoping that all Island Service Area Board representatives could submit their island CISAP by June 2021 which is the close of this current term or if the CISAP cannot be completed by June 2021, provide a blurb to let the Council know why it wasn't completed and what the current status is. He would like to add this as an Action Plan item for this Focus Area. R. Ries acknowledged that C. Matayoshi, C. Knightsbridge, J. Fujii 			

	<p>and N. Crozier volunteered to work on this focus area; however, he wonders if Council members would support categorizing this focus area as an all-Council discussion rather than creating a PIG. He proposes that this focus area be kept on the agenda as new and old business until we complete the noted action steps.</p> <ul style="list-style-type: none"> • E. Lau-James asked whether each Focus Area should have its own PIG with assigned members. R. Ries commented that it may be that each Focus Area needs to be considered on a case by case basis for items that perhaps could be addressed as a whole Council and for the items that cannot be address in this way could then be assigned to a PIG for interim work. • C. Dang cautioned about the differences between a PIG and a standing committee. The PIG meets under special circumstances and has flexibility with the Sunshine Law. The standing committee can go on indefinitely compared to the PIG which is dissolved when the issue is addressed. <p>Focus Area #2 Measurable Objectives Advocate for the Emotional Well-Being of the Community</p> <ul style="list-style-type: none"> • 2.1 – R. Ries would like add a new 2.1 to state, “By April 2021, form a Wellness Brochure PIG” • 2.2 – R. Ries would like to remove (b) • R. Ries would like to combine the new 2.1 with 2.2 (a) • C. Matayoshi, C. Knightsbridge, K. Aumer and R. Ries volunteered to work on this Focus Area. <p>Focus Area #3 Measurable Objectives Identify Tools the Council is Empowered to Use</p> <ul style="list-style-type: none"> • R. Ries would like to push the dates out: <ul style="list-style-type: none"> ○ 3.1 – push the start date to April 2021 ○ 3.2 – push the start date to June 2021 ○ 3.3 – push the start date to August 2021 ○ 3.4 – push the start date to October 2021 • R. Ries noted that the Council has a lot more wiggle room in terms of prioritizing and the timeframes are within the Council’s control so that’s why he is suggested moving these dates. 			
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	<p>Focus Area #4 Measurable Objectives Outline an Onboarding and Annual Reboarding Experience for Council Members</p> <ul style="list-style-type: none"> • R. Ries would like to assign S. Haitzuka and J. Nazareno as the navigators for completing this Focus Area and making sure the Council completes the Action Plan items associated with the objectives. • R. Ries asked that S. Haitzuka and J. Nazareno check in with each other and with E. Lau-James, T. Reed and K. Martinez for their feedback as Council members who expressed interest in joining the Onboarding/Re-Boarding PIG. • R. Ries noted that this Focus Area will help get Council members refreshed and new Council members to “hit the ground running.” <p>Focus Area #5 Measurable Objectives Strengthen the Council’s Presence as Advocates and Advisors to DOH Leadership, Inclusive of Input from Neighbor Island Stakeholders and Service Area Board Members</p> <ul style="list-style-type: none"> • 5.1 – R. Ries would like to delete the current 5.1 and replace it with the current 5.2. He would like to push the start date back to April 2021. • R. Ries would like to clarify in the Action Plan for the new 5.1 (current 5.2) note that, “efforts to share/disseminate/distribute mental health information” is clarified as acceptable via written and oral reports from Council members when he/she shares their report at monthly Council meetings. • 5.3 – will become the new 5.2 • 5.4 – will become the new 5.3; R. Ries would like to clarify so that it says, “Schedule the Director of Health, DD BHA or their designee” to allow the department the opportunity to decide who they would like to have attend. He noted that it may not always be Eddie Mersereau, but that Eddie could designate someone on his staff and this would help the Council to meet its goal for this Focus Area by stating “or their designee.” • 5.5 – R. Ries would like to delete this objective. 			
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	<ul style="list-style-type: none"> • T. Reed, C. Matayoshi, C. Knightsbridge, E. Lau-James, K. Aumer and R. Ries volunteered to work on this focus area; however, R. Ries asked if Council members would support categorizing this focus area as an all-Council discussion, rather than creating a PIG. Allowing all Council members to share written or oral reports each month at Council meetings is already part of the standing Council agenda. • E. Lau-James expressed that she wants every Focus Area to have a PIG formed. She wants the Council to vote on her position at the next Council meeting. • E. Lau-James expressed that she wants every Council member to volunteer to work on at least one Focus Area. <p>Focus Area #6 Measurable Objectives Share Information on the Council’s Website About Existing Mental Health Services Including Local, State and Federal Services</p> <ul style="list-style-type: none"> • R. Ries commended the current WSA-PIG for doing awesome work. • 6.1 – R. Ries recommends disbanding the current WSA-PIG and creating a new Website and Social Media (WSM) PIG that will continue the current tasks and help coordinate efforts in Focus Area #1 as well as Focus Area #6. • R. Ries shared that he left the word “Advocacy” out of the new WSM-PIG’s name because every Council member is responsible for advocacy, not just this one PIG. • R. Ries noted that A. Beninato had shared he may be interested in joining the WSM-PIG when it is created, hopefully at the April 2021 meeting. <p>Focus Area #7 Measurable Objectives Identify, Track and Share the Status of DOH Behavioral Health Administration (BHA) Legislative Bills including Adult Mental Health, Child Adolescent Mental Health, and Alcohol and Drug Abuse Divisions.</p> <ul style="list-style-type: none"> • R. Ries recommends supporting the current LEG-PIG who are a ringer and the Council should be supportive of the LEG-PIGs efforts. • C. Knightsbridge was open to disbanding the current LEG-PIG and creating a new LEG-PIG; however, C. Dang opposed stating that the 			
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<ul style="list-style-type: none"> Council Officer Elections – Chair, 1st/2nd Vice Chair, Secretary 	<p>current LEG-PIG is busy and disbandment will occur in a couple months when the legislative session concludes. She recommends waiting to dissolve the current LEG-PIG as planned (see the draft Participation Guidelines for Council Legislative Activities).</p> <p>The officer positions for Chair and Secretary were unopposed at last month’s meeting. R. Ries re-affirmed his acceptance of the nomination for Chair and thanked Council members for their support and confidence. E. Lau-James re-affirmed her acceptance of the nomination for Secretary.</p> <p>For Vice-Chair, there were two nominees – C. Knightsbridge and C. Matayoshi. The Vice-Chair is responsible for facilitating Council meetings in the absence of the Chair.</p> <ul style="list-style-type: none"> Voting results are as follows: C. Knightsbridge received six votes; C. Matayoshi received three votes. <p>C. Knightsbridge was nominated, voted and accepted the nomination for Vice-Chair.</p> <p>For Second Vice-Chair, there were two nominees – T. Reed and K. Aumer. The Second Vice-Chair is responsible for facilitating Council meetings in the absence of the Chair.</p> <ul style="list-style-type: none"> Voting results are as follows: T. Reed received two votes; K. Aumer received seven votes. <p>K. Aumer was nominated, voted and accepted the nomination for Second Vice-Chair.</p>			
<p>XI. Closing Announcements</p>	<p>Council member shared the following announcements:</p> <ul style="list-style-type: none"> The 18th Annual Hawaii International Virtual Summit on Preventing, Treating and Assessing Trauma (IVAT) is scheduled for April 27-30, 2021. 			



Website: <https://www.ivatcenters.org/hawaii-summit>

The following chart identifies the cost for registration:

18 th Hawai'i Virtual Summit Registration Fees		
ADMISSION ITEMS	EARLY BIRD (Jan 25– Feb 28)	REGISTRATION FEE (Mar 1 – Apr 20)
Full Summit Registration <i>April 27-30, 2021</i>	\$350	\$385
3 Days Summit Registration <i>April 27-29, 2021 OR April 29-30, 2021</i>	\$300	\$335
2-Days Summit Registration <i>April 27-28, 2021 OR April 28-29, 2021 OR April 29-30, 2021</i>	\$220	\$255
1-Day Summit: Tuesday ONLY <i>April 27, 2021</i>	\$125	\$150
1-Day Summit: Wednesday ONLY <i>April 28, 2021</i>	\$125	\$150
1-Day Summit: Thursday ONLY <i>April 29, 2021</i>	\$125	\$150
1-Day Summit: Friday ONLY <i>April 30, 2021</i>	\$125	\$150

A request for funds was submitted; however, a response is pending. We hope to hear a response by our April meeting to confirm if funding is available and how many Council members will attend.

C. Dang hopes the Council will submit something for the next Hawaii IVAT summit. She noted that continuing education (CE) credits are available for this year's summit.

M. Hiraga-Nuccio mentioned that a reduced registration fee is available for people who volunteer to assist with the summit.

The next Council meeting is on Tuesday, April 13, 2021 from 9:00 a.m. to 11:30 a.m. via Zoom.

XII. Meeting Evaluation / Future Agenda Items

R. Ries encouraged members to share their feedback about how today's Council meeting went either by sharing them verbally or typing their feedback in the chat.

- C. Dang recognized that there is a big "hoopla" around the Senate

	confirmation process for incoming Council members. She would like to do something for outgoing Council members.			
VI. Adjournment	The meeting was adjourned at 11:50 a.m. R. Ries apologized for the extended meeting time and thanked Council members for attending past the 11:30 a.m. end time.	For information only.		
Electronic Mail Outs	The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list: E-mail (1 of 3) with handouts (total of 7 handouts) <ol style="list-style-type: none"> 1. March 2021 Meeting – Agenda 2. February 2021 Business Meeting – Draft Minutes 3. February 2021 Retreat Meeting – Draft Minutes 4. February 2021 Meeting – FY21 Attendance Log 5. March 2021 Meeting – PIG, Website/Social Media/Advocacy 2/23/21 Meeting Notes 6. March 2021 Meeting – PIG, Website/Social Media/Advocacy 3/4/21 Meeting Notes 7. March 2021 Meeting – PIG, Retreat Facilitator Post-Retreat Summary E-mail (2 of 3) with handouts (total of 8 handouts) <ol style="list-style-type: none"> 8. March 2021 Meeting – PIG, Legislation 2/8/21 Meeting Notes 9. March 2021 Meeting – PIG, Legislation 2/24/21 Meeting Notes 10. March 2021 Meeting – PIG, Legislation Proposed Council Priority Bill List 11. March 2021 Meeting – PIG, Legislation Rank Order List Results 12. March 2021 Meeting – PIG, Legislation Draft Testimony for HB912 13. March 2021 Meeting – PIG, Legislation Draft Testimony for SB703 14. March 2021 Meeting – PIG, Legislation Draft Testimony for SB732 15. March 2021 Meeting – PIG, Legislation Draft Testimony for SB905 E-mail (3 of 3) with handouts (total of 11 handouts) <ol style="list-style-type: none"> 16. March 2021 Meeting – Presentation Slides, Clarity Project 	For information only.		

	<ul style="list-style-type: none"> 17. March 2021 Meeting – CAHOOTS Program, Civil Beat Article 18. March 2021 Meeting – CISAP Template 19. March 2021 Meeting – National Association of Medicaid Directors (NAMD) Medicaid Report for Behavioral Health (February 2021) 20. Hawaii SAB Minutes – 1/26/21 21. Hawaii SAB Minutes – 11/24/20 22. Hawaii SAB Minutes – 10/27/20 23. Hawaii SAB Minutes – 9/22/20 24. Hawaii SAB Minutes – 8/25/20 25. Hawaii SAB Minutes – 7/28/20 26. Hawaii SAB Minutes – 5/26/20 			
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STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
April 13, 2021
9:00 a.m. – 11:30 a.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Dang, Cynthia “Cindi”; Ilyavi, Heidi; Knightsbridge, Christopher; Koyanagi, Dina; Lau-James, Eileen; Matayoshi, Carol; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Ries, Richard; Shimabukuro, Scott**

Members Absent: **Crozier, Charleen “Naomi”**

Members Excused: **Fujii, John; Martinez, Beatrice “Kau’i”**

Guests Present: **Kajimura, Trisha; Reyno Yeomans, Raelyn; Talisayan, Bryan**

DOH Staff Present: **Haitsuka, Stacy; Nazareno, Jocelyn**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 9:02 a.m.</p> <p>Members and guests introduced themselves.</p> <p>The following definition of quorum was added to the agenda as of the November 10, 2020 meeting: Pursuant to Act 137-18 (SB 203), Chapter 92, Hawaii Revised Statutes: “(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes.</p>	For information only.		

	<p>For example, if only 16 of the entitled 21 members are appointed, at least 9 must be present to establish a quorum. To validate a council action, of the 9 members present, an affirmative vote from at least 5 is required.”</p> <p>Quorum was established.</p>			
<p>II. Meeting Announcements</p>	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally get his attention during the meeting. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who take a break and step away from the meeting, please notify him before leaving as the Council needs to track of when Council members leave and return to verify quorum. • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. • If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear speaker. 	<p>For information only.</p>		

	<p>R. Ries acknowledged that the Centers for Disease Control and Prevention (CDC) announced a change in indoor gatherings and mask wearing; however, at this time, he noted that until the state has reassessed its interisland travel requirements and until the DOH has announced a change in its facility policies for resuming in-person meetings in DOH facilities, the Council will conduct its meeting virtually.</p>			
<p>III. Consideration and Approval of Minutes February 9, 2021 Retreat Minutes</p> <p>March 9, 2021 Minutes</p>	<p>The draft minutes for the February 9, 2021 Retreat were reviewed.</p> <p>C. Matayoshi made a motion for the February 9, 2021 meeting minutes to be approved. T. Reed seconded the motion.</p> <p>The draft minutes for the March 9, 2021 meeting were reviewed.</p> <p>T. Reed made a motion for the meeting minutes from the March 9, 2021 meeting be approved. E. Lau-James seconded the motion.</p>	<p>Motion passed unanimously.</p> <p>Motion passed unanimously.</p>		
<p>IV. Community Input</p>	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p> <p>E. Lau-James shared about an incident that occurred at her veterinary clinic where a police officer helped to address a situation with a homeless individual who defecated in the parking lot. The police officer spoke with her about how the Honolulu Police Department (HPD) could collaborate with social service providers. HPD officers know the community and they would like to address some of the issues they respond to in a forum where there are others who may be able to assist.</p> <p>R. Ries noted that HPD is currently undergoing a change in command leadership and it is possible to consider further discussion about how to address creating a new Council member position for law enforcement such as HPD and the Department of Public Safety (PSD) as was mentioned by R. Reyno Yeomans in a previous meeting.</p>			

	C. Knightsbridge suggested writing a letter. E. Lau-James supported writing a letter.			
<p>V. Permitted Interaction Group (PIG) Reports</p> <ul style="list-style-type: none"> PIG for Website, Social Media, and Advocacy (WSA) 	<p>R. Ries explained that in this section of the agenda, PIG members may briefly summarize the PIG activities since the last Council meeting including meeting dates, discussions, and recommendations on topics approved at previous Council meetings.</p> <p>He asked that oral summaries be brief and if PIG members would like to share a longer report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>WSA-PIG members include C. Knightsbridge, C. Dang, C. Matayoshi, H. Ilyavi and R. Pascual-Kestner. C. Knightsbridge is the WSA-PIG lead.</p> <p>The WSA-PIG did not meet last month; however, they did share two spreadsheets for Council member input. Additionally, S. Haitsuka forwarded Council members the link from C. Knightsbridge for the unofficial State Council on Mental Health Facebook page.</p> <p>Regarding metrics for the number of visits to the unofficial State Council on Mental Health Facebook page, C. Knightsbridge explained that it is too soon to be able to show metrics. The Facebook page is in the super infancy stage. The page needs more visitor traffic. Possibly, ads could be attached to the page in the future.</p> <p>Below is the link to access the unofficial State Council on Mental Health Facebook page. https://www.facebook.com/Hawaii-State-Council-on-Mental-Health-unofficial-112542660887805/</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> K. Aumer inquired about possibly advertising on other Facebook pages such as other agencies? C. Knightsbridge cautioned that due to this being an unofficial page, it may be best to avoid any 	For information only.		

<ul style="list-style-type: none"> • PIG for Legislation (LEG) 	<p>potential Sunshine Law issues.</p> <p>LEG-PIG members include C. Knightsbridge, C. Dang, E. Lau-James, and T. Reed. C. Dang is the LEG-PIG lead.</p> <p>The LEG-PIG did not meet last month. A copy of the Council’s testimony for HB812 HD1, Relating to Trauma Informed Education, was included in the meeting handouts. Testimony was submitted in support of the bill. C. Dang noted the last status of this bill was that it was pending a hearing with the Ways and Means (WAM) committee. CLICK HERE to view the current status of HB812.</p> <p>C. Dang reported that SB905, Relating to the State Council on Mental Health, made it to crossover but no hearing has been scheduled yet. CLICK HERE to view the current status of SB905.</p> <p>R. Ries acknowledged one handout for today’s meeting provided information from the Office of Information Practices (OIP) legal guidance on the Sunshine Law’s requirements to hold short-notice emergency or continued meetings as well as information about Chapter 92, Hawaii Revised Statutes (HRS) related to public agency meetings and recordings.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries commented that he believes next year, the Council will do a lot more because the Council’s legislative process will be refined as a result of lessons learned during this legislative session with the piloting of the Council’s participation guidelines for legislative participation. • C. Knightsbridge commented that he is interested in bills that relate to clinical psychologists with prescriptive authority. He believes more doctors will come to Hawaii if this is an option. <p>He suggested a speaker at a future Council meeting could be Judith Steinman from the John A. Burns School of Medicine (JABSOM) who is supports this issue.</p>			
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<ul style="list-style-type: none"> • PIG for the SCMH Retreat 	<p>C. Dang suggested that a good speaker could be Dr. Jeffrey Akaka who has opposed these bills in the past.</p> <p>Having speakers on both sides of the issue may increase opportunities for a well-rounded discussion.</p> <p>S. Shimabukuro suggested having a speaker from the military because the military already utilizes clinical psychologists in this manner.</p> <p>R. Ries noted that he is interested in hearing more, but is not particularly supportive.</p> <p>H. Ilyavi noted that there is limited access to doctors who can prescribe such is the case where the doctor sees the patient to prescribe, but passes the patient to another non-prescriber for treatment. R. Ries acknowledged that the skill is there for doctors to treat and prescribe and that psychologists have specialized training in providing treatment.</p> <p>Ries asked T. Kajimura if she was connected with Monica Kim from the pharmacy community. He recalls that she is a pharmacy science liaison. He will reach out to T. Kajimura to coordinate reaching out for additional information.</p> <ul style="list-style-type: none"> • C. Dang commented that once this legislative session is adjourned, the LEG-PIG will amend the draft participation guidelines and emergency meetings will not be necessary if the participation guidelines are followed. <p>Remove the Retreat PIG from the agenda.</p>	Remove from agenda	S. Haitzuka	4/29/21
VI. Island Representative Reports	R. Ries explained that in this section of the agenda, Council members who are representing their respective Service Area Board may briefly summarize their board meetings and when applicable, share updates on			

<ul style="list-style-type: none"> Maui Service Area Board (MSAB) 	<p>requested items identified at previous Council meetings. He asked that oral summaries be brief and if members would like to share a longer Service Area Board report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> A psychiatric nurse was invited to discuss the need for re-establishing a youth psychiatric facility. She noted that Maui has had a large increase in suicidal ideation and suicide attempts in youth. She wants to get hospital emergency department data on this; specifically, the number of youth ages 18 and younger who go to the emergency department and who should be referred to a facility for treatment. She noted that SB732 focuses on evaluating the Hawaii CARES program. A representative from the Maui CAMHD Family Guidance Center was invited to speak about concerns regarding the Hawaii CARES program. A principal at a Maui island school contacted Hawaii CARES to ask for crisis assistance to address a situation regarding a student. The principal waited and no assistance from Hawaii CARES was dispatched. The principal needed immediate help and luckily was resourceful enough to know to contact a DOH office to ask for help. Through the CAMHD Family Guidance Center, they were able to link the principal with Family Guidance Center staff who was teleworking from home that day and that staff was able to drive to the location to provide on-site assistance. Hawaii CARES has poor customer service and bad triage. They do not answer the phone (in comparison to ACCESS Line and the Crisis Line of Hawaii). The experience with Hawaii CARES is less than inviting and in need of quality review. Crisis calls need to be answered! Next month, the Hawaii Health and Harm Reduction Center (HHHRC) will present information to the MSAB about safe needle disposal options. May is mental health month. Mental Health America Hawaii is hosting an awards ceremony. T. Reid is being recognized. 			
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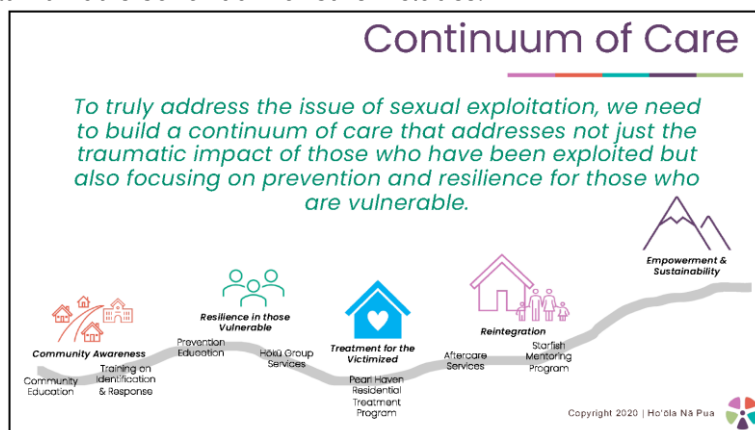
<ul style="list-style-type: none"> • Oahu Service Area Board (OSAB) • Hawaii Service Area Board (HSAB) 	<p>The following updates were provided by C. Dang.</p> <ul style="list-style-type: none"> • The OSAB is finalizing its Comprehensive Integrated Service Area Plan (CISAP). • One area that the OSAB is focused on is better partnerships with law enforcement in responding to community crises. <p>The following updates were provided by C. Matayoshi.</p> <ul style="list-style-type: none"> • Hearing frustration from providers/community about no one answering the Hawaii CARES phone line. Need to find out if Hawaii CARES has enough staff to answer calls and whether staff know that call needs to be answered and triaged in a timely manner. • C. Matayoshi is hoping that the Hawaii SAB CISAP will be recognized in the block grant application and in future annual legislative reports. • Community mental health clinics are struggling. Steven Pavao, the Hawaii Island Community Mental Health Center (CMHC) Branch Chief is also covering as the Acting Maui CMHC Branch Chief. • C. Matayoshi announced she will resign from the HSAB and the Council due to her appointment to the Hawaii Paroling Authority Board. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries thanked C. Matayoshi for submitting a copy of the Hawaii Island CISAP to the Council. • C. Dang supports having each county recognized in the state plan and the annual legislative report. S. Haitsuka recognized this request and stated she would look for opportunities to highlight County efforts. • T. Reed, C. Dang and R. Ries congratulated C. Matayoshi for her appointment to the parole board. • C. Knightsbridge encouraged each SAB representative to summarize their SAB information. 			
<p>VII. Presentation/ Guest Speaker</p>	<p>R. Ries introduced Jessica Muñoz and Joy Tanimura Winqvist. Jessica is the President of Ho‘ōla Nā Pua.</p>			

In addition to being a practicing nurse practitioner, she started Ho'ōla Nā Pua in 2009 as an all-volunteer operation that now employs approximately a dozen full-time staff. Some of Ho'ōla Nā Pua's community-based activities include school-based outreach, health care worker training, presentations and advocacy, 24-hour help line, youth mentoring, and more!

Council members received a copy of Ho'ōla Nā Pua's presentation on the Pearl Haven Residential Treatment Program and a copy of the referral packet.

J. Tanimura Winqvist presented on behalf of J. Muñoz and Ho'ōla Nā Pua. She shared that Ho'ōla Nā Pua means "new life for our children". Ho'ōla Nā Pua's Vision statement is, "A community where every child is safe and can embrace their bright future. Ho'ōla Nā Pua's Mission statement is, "We are committed to the prevention of sex trafficking and providing care for children who have been exploited."

Ho'ōla Nā Pua's Continuum of Care includes:



Features of Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program include:

- Specialized, long-term restorative residential treatment with

intensive therapeutic care for youth with complex trauma or who have been diagnosed with severe emotional disturbance as a result of sexual abuse, exploitation or trafficking.

The Pearl Haven Model

At Pearl Haven we believe that healing is not something a child does on their own, but that **it takes a community surrounding that child with aloha (love and compassion)**. That community includes the entire Pearl Haven team, the youth's 'ohana, and other members in their multidisciplinary team all working towards the same goal: healing and protecting traumatized and exploited youth. The community comes together to **nurture and connect** our youth with supportive, prosocial resources that **bolster growth, inspire progress, and empower** the youth towards **ho'ōia (health, wellbeing, renewal)**.

Healing from sexual trauma requires **consistency, structure, safe nurturing relationships, and corrective experiences**. At Pearl Haven, youth and their 'ohana are provided the space to **process** the hurt, **heal** the fractures in their relationships, and be surrounded with the support to **create newer healthier relationships**. Together, youth and their community work towards **healing, hope, and a bright future**.

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Some of the reasons for residential treatment include:

- Treatment needs not being met in lower level of care/settings.
- Acknowledging the level of trauma that has occurred, children who have been exploited suffer from severe post-traumatic stress disorder (PTSD) and complex trauma.
- Treatment provided in a residential setting is comprehensive and involves addressing the physical, relational, emotional and psychological needs of each youth resident.
- Symptoms usually interrupt their daily life or impact their level of functioning where remaining in their home, foster home, or other facility may not be safe.
- The residential setting provides the youth with additional benefits and supports including weekly therapeutic intervention sessions that focus on increasing their overall well-being.

She noted that the Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program was recently licensed by the DOH Office of Health Care Assurance (OHCA) as a Special Treatment Facility (STF) last week and she is currently assisting with completing the required insurance paperwork.

	<p>Right now, Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program accepts private insurance and will eventually accept Medicaid.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries mentioned practicum students getting involved. He recalls the wounded hero/Wounded Warrior program at the Tripler Army Medical Center (TAMC). Before it was deactivated in October 2020, the TAMC Wounded Transition Battalion cared for more than 5,500 wounded, ill and injured soldiers over its 13 year battalion. • R. Ries mentioned that youth who are appropriate for Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program are likely to lack warmth and have increased fear and an increased need for healthy warmth and strength. • D. Koyanagi asked whether youth living at the Hawaii Youth Correctional Facility will be transitioned to Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program. J. Tanimura Winquist stated that it is possible that youth will transition into Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program but the youth may also receive treatment from Kahi Mohala or other appropriate facilities. • C. Knightsbridge let J. Tanimura Winquist know that the Council is available to assist as a resource for Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program recruitment opportunities. • C. Dang noted there are some programs what are experiencing a reduction in funding for programs and services. • R. Ries asked to clarify the max age for the Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program. J. Tanimura Winquist stated that the program runs up until the youth's 17th birthday. At this time Ho'ōla Nā Pua is working with the insurance company to address this issue. Ho'ōla Nā Pua acknowledges that it is important to have every youth complete their treatment regardless of the age restriction. <p>R. Ries thanked J. Tanimura Winquist for sharing about the Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program.</p> <ul style="list-style-type: none"> • C. Dang expressed interest in the Council recognizing its level of effort by writing a thank you note to speakers and presenters. S. 	<p>Draft thank you letter.</p>	<p>S. Haitzuka</p>	<p>5/3/21</p>
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	Haitsuka stated a draft letter could be shared at the next meeting.			
<p>VII. State Agency Representative Reports</p> <ul style="list-style-type: none"> • Hawaii Public Housing Authority (HPHA) • Department of Health Child Adolescent Mental Health Division (DOH CAMHD) 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective state agency may briefly summarize agency data, agency information related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by K. Martinez:</p> <ul style="list-style-type: none"> • None provided. <p>The following updates were provided by S. Shimabukuro:</p> <ul style="list-style-type: none"> • There are more youth entering the hospital emergency departments for mental health and substance abuse reasons. They are waiting for a bed to open up in the community but not many providers currently have a specialist on-site. CAMHD is looking to have a telehealth program with doctors and others who can provide support to these youth. • National research is finding increased behavioral health issues, but our local survey is not. This may be because our local survey is of families who are receiving services and not the general public. <p>For example, responses and feedback regarding concerns for increased stress and anxiety may be from youth who may not speak up or participate in evaluations and may not engage or interact with other support service options.</p> <ul style="list-style-type: none"> • An informational campaign for youth is being developed to help them to know their rights to obtain mental health care without parent consent. This has been a law for a couple years but it was 			

<ul style="list-style-type: none"> • Department of Human Services (DHS) MedQUEST (MQD) Division Medicaid Program • Department of Human Services (DHS) Child Welfare Services (CWS) 	<p>recently refined last year to clarify some of the language.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries noted that he sees similar reports regarding youth who are “stuck in the middle” and who may be overparented by their parents. • C. Dang asked if CAMHD has peer specialists available to provide assistance and support to youth. S. Shimabukuro explained that in order for peer specialists to be able to bill for their services, they would need to be at least 18-19 years old and would need to be certified by the Adult Mental Health Division (AMHD) as well as receive supplemental training about the youth peer specialist role. Also, family support training has been identified but is not yet recognized by Medicaid. <p>The following updates were provided by J. Fujii:</p> <ul style="list-style-type: none"> • None provided. <p>The following updates were provided by D. Koyanagi:</p> <ul style="list-style-type: none"> • CWS has a big event called the Hawaii Family First Prevention Services Act (FFPSA). The goal of the FFPSA is to prevent children from going into foster care by strengthening families so more children remain in their family home with parents and relatives. CLICK HERE for more information about the Hawaii FFPSA. • She is the coordinator between CWS and the trafficking community. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • C. Knightsbridge expressed concern for children who are/have been stuck at home more due to the COVID-19 pandemic and a family abuser is also in the home. 			
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<ul style="list-style-type: none"> Department of Human Services (DHS) Division of Vocational Rehabilitation (DVR) 	<p>The following updates were provided by R. Pascual-Kestner:</p> <ul style="list-style-type: none"> He will have an update for next month's meeting with relevant information. 			
<p>VIII. Specialty Area Representative Reports</p> <ul style="list-style-type: none"> Hawaii Advisory Committee on Drug Abuse and Controlled (HACDACS) Mental Health Providers Parents and Family 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective specialty area may briefly summarize specialty area activities related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by J. Fujii:</p> <ul style="list-style-type: none"> None provided. <p>The following updates were provided by R. Ries:</p> <ul style="list-style-type: none"> More providers are needed. Expanding services to include interns and practicum students as well as peer support specialists is a good idea. Chaminade and Hawaii Pacific University are rolling out doctorate programs in psychology. <p>The following updates were provided by H. Ilyavi:</p> <ul style="list-style-type: none"> She has had a full load and parents are still experiencing lengthy 			

<p>Members of Mental Health Service Recipients</p>	<p>waitlist times to access resources.</p> <ul style="list-style-type: none"> • She feels many people in her area are reaching burnout level. For example, therapist are having to extend their hours to accommodate but still need more time to service those who need help. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • R. Ries mentioned compassion fatigue in relation to burnout at the provider level. • C. Dang asked whether support groups are an option. R. Ries shared that he is doing a resiliency training with the Honolulu Fire Department (HFD) and will also be providing training to HPD and to city lifeguards in the coming months. T. Kajimura shared that Mental Health America Hawaii is also providing similar support trainings. R. Ries is willing to share resiliency training information with H. Ilyavi and possible coordinate a training for Hawaii Island. <p>The following updates were provided by E. Lau-James:</p> <ul style="list-style-type: none"> • Regarding her husband, she has been impressed by how well telehealth visits have been going for him. He has not missed any monthly telehealth appointments with his psychiatrist. <p>The following updates were provided by K. Aumer:</p> <ul style="list-style-type: none"> • Telehealth has increased access to services by allowing patients to see their preferred clinician. • Extending licensure can help increase access to reach those who need it when they need it. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • H. Ilyavi and C. Knightsbridge concurred that it's important to have a choice so patients can decide which type of service works for them at the time they need to access the service – for example, face-to-face may work at times but telehealth may work better other times. 			
<ul style="list-style-type: none"> • Consumer 	<p>The following updates were provided by C. Knightsbridge:</p>			

<p>Advocates</p>	<ul style="list-style-type: none"> • Regarding HMSA’s QUEST telehealth services, he is able to go online and be seen by a doctor for a telehealth visit even if that person is not in Hawaii. This service allows him to obtain his medication refills in a timely manner. • He hopes that the post-pandemic/post-emergency proclamation will not result in regression. He would like to see telehealth and access to care continue to expand. • The LEG-PIG will be able to monitor telehealth related bills and the Council may be able to speak/advocate for telehealth. • PsyPACT, if licensed in Hawaii is a reciprocity agreement where all clinicians licensed by PsyPACT can treat patients in other states. CLICK HERE to view the PsyPACT website. <p>The following updates were provided by N. Crozier:</p> <ul style="list-style-type: none"> • None provided. <p>The following updates were provided by T. Reed:</p> <ul style="list-style-type: none"> • None provided. 			
<p>IX. Old Business</p> <ul style="list-style-type: none"> • The Clarity Project 	<p>R. Ries noted that anytime the Council has a new business agenda item that needs to be continued to the next month’s meeting, the Council will have those agenda items listed the following month as Old Business agenda items.</p> <p>During the March 9, 2021 meeting, Dr. Ashley Lukens and Doorae Shin shared information about The Clarity Project. R. Ries noted that the meeting minutes summarize her presentation. There has been some movement on addressing medicinal psilocybin access in Hawaii.</p> <p>First, the Senate Concurrent Resolution (SCR208 SD1) requests for the health department to convene a medicinal psilocybin and psilocin working group to examine the medicinal and therapeutic effects of psilocybin and psilocin or develop a long-term strategic plan to ensure the availability of medicinal psilocybin and psilocin or psilocybin-based and psilocin-based products that are safe, accessible, and affordable for eligible adult patients. SCR208 SD1 was heard by the Senate Health</p>			

<ul style="list-style-type: none"> Strategic Plan Review and Discussion of Focus Areas #1-7 and Accompanying 	<p>Committee on March 29th with the Clarity Project, Beyond Mental Health, Drug Policy Forum of Hawaii, and 31 individuals testifying in support. The Department of Health testified with comments and offered amendments. The Senate Health Committee recommended the resolution be adopted with the committee’s amendments. The resolution now sits in referral to the House Health and House Finance committees. CLICK HERE to view SCR208 SD1.</p> <p>Second, in addition to the information shared by Dr. Lukens at our last meeting, she also published an article in Civil Beat that reiterates many of the points she shared with us last month. CLICK HERE to view the article.</p> <p>The Council has not taken a position on this topic.</p> <p>Council members shared the following comments regarding the Clarity Project presentation:</p> <ul style="list-style-type: none"> C. Knightsbridge wanted to know if the Council will draft testimony to submit for a future SCR208 SD1 hearing. S. Haitsuka clarified that there are two different ways the Council could share their position – one way is to develop a position statement. This is a statement that the Council keeps internally that helps to guide drafting of future testimony. The other way is to submit testimony once a bill is scheduled for hearing. The position statement helps the Council and specifically the LEG-PIG members to know the Council’s position on the topic, generally, and be able to articulate it. R. Ries asked to table the discussion about this topic; however, he encouraged Council members to educate themselves about the topic. <p>R. Ries tabled this agenda item to the Council’s May 11th Council meeting.</p>	<p>Add to the May 2021 Council meeting agenda.</p>	<p>S. Haitsuka</p>	<p>5/3/21</p>
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Action Plan Items				
X. New Business <ul style="list-style-type: none"> Council Bylaw Review and Revisions 	R. Ries tabled this agenda item to the Council’s May 11 th Council meeting.	Add to the May 2021 Council meeting agenda.	S. Haitzuka	5/3/21
XI. Closing Announcements	<p>Council member shared the following announcements:</p> <ul style="list-style-type: none"> A request for funds for the Institute on Violence, Abuse and Trauma (IVAT) Summit from April 26-30, 2021 was submitted and approved. S. Haitzuka sent an e-mail requesting Council members reply if interested in attending the IVAT Summit. Council members interested and available to attend and who have not already registered or secured alternative funding should e-mail S. Haitzuka no later than 10:00 a.m. HST on Thursday, April 15th. CLICK HERE to view the IVAT Summit website. 			
XII. Meeting Evaluation / Future Agenda Items	<p>R. Ries encouraged members to share their feedback about how today’s Council meeting went either by sharing them verbally or typing their feedback in the chat.</p> <ul style="list-style-type: none"> None shared. <p>Future agenda items for the May Council meeting include:</p> <ul style="list-style-type: none"> Dr. Amy Curtis, AMHD Administrator 			
VI. Adjournment	The meeting was adjourned at 11:35 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMh members and individuals on the SCMh e-mail distribution list:</p> <p>E-mail (1 of 2) with handouts (total of 6 handouts)</p> <ol style="list-style-type: none"> April 2021 Meeting – Agenda March 2021 Meeting – Draft Minutes February 2021 Retreat Meeting – Draft Minutes March 2021 Meeting – FY21 Attendance Log March 2021 Meeting – Presentation Slides, Ho’ōla Nā Pua Pearl Haven 	For information only.		

	<p>6. March 2021 Meeting – Presentation Referral Packet, Ho‘ōla Nā Pua Pearl Haven E-mail (2 of 2) with handouts (total of 7 handouts)</p> <p>7. March 2021 Meeting – Hawaii SAB, CISAP 2021</p> <p>8. March 2021 Meeting – Old Business Retreat (Part II), Post-Retreat Facilitator Summary</p> <p>9. March 2021 Meeting – Information, Chapter 92 HRS, Emergency and Continued Meetings</p> <p>10. March 2021 Meeting – PIG, Legislation Final Testimony Submitted for HB812 HD1</p> <p>11. Maui SAB Minutes – 11/2/20</p> <p>12. Maui SAB Minutes – 6/1/20</p> <p>13. Hawaii SAB Minutes – 2/23/21</p>			
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STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
May 11, 2021
9:00 a.m. – 11:30 a.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Crozier, Charleen “Naomi”; Dang, Cynthia “Cindi”; Ilyavi, Heidi; Knightsbridge, Christopher; Koyanagi, Dina; Lau-James, Eileen; Martinez, Beatrice “Kau”i”; Ries, Richard; Shimabukuro, Scott**

Members Absent:

Members Excused: **Fujii, John; Pascual-Kestner, Rusnell “Rus”; Reed, Tara**

Guests Present: **Cole-Schwartz, Belinda; Guzikowski, Cheryl; Regidor, Debby; Reyno Yeomans, Raelyn; Rivera, Renee**

DOH Staff Present: **Haitsuka, Stacy; Hiraga-Nuccio, Madeleine; Nazareno, Jocelyn**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 9:01 a.m.</p> <p>Members and guests introduced themselves.</p> <p>The following definition of quorum was added to the agenda as of the November 10, 2020 meeting: Pursuant to Act 137-18 (SB 203), Chapter 92, Hawaii Revised Statutes: “(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes.</p> <p>For example, if only 16 of the entitled 21 members are appointed, at least</p>	For information only.		

	<p>9 must be present to establish a quorum. To validate a council action, of the 9 members present, an affirmative vote from at least 5 is required.”</p> <p>Quorum was not established by 9:09am; therefore, R. Ries skipped ahead to the Community Input agenda item noting that the Council would come back to review meeting minutes when quorum was established.</p>			
<p>II. Meeting Announcements</p>	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally get his attention during the meeting. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who take a break and step away from the meeting, please notify him before leaving as the Council needs to track of when Council members leave and return to verify quorum. • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. • If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear speaker. <p>R. Ries acknowledged that the Centers for Disease Control and Prevention</p>	<p>For information only.</p>		

	<p>(CDC) announced a change in indoor gatherings and mask wearing; however, at this time, he noted that until the state has reassessed its interisland travel requirements and until the DOH has announced a changed in its facility policies for resuming in-person meetings in DOH facilities, the Council will conduct its meeting virtually.</p> <p>R. Ries shared the following Council membership updates:</p> <ul style="list-style-type: none"> • Starting in July 2021, the Council will welcome a new member, Jennifer Renfro. She will join the Council as the Department of Education representative. Her term will end in June 2023. • D. Koyanagi, currently a member and confirmed for a term to end in June 2023. • A. Beninato, currently a member and confirmed for a term to end in June 2024. • K. Aumer, currently a member and our 2nd Vice Chair, was confirmed for a term to end June 2025. • C. Knightsbridge will end his term in June 2021. He did not submit his application for a second term. He indicated he would be willing to serve a second term and would submit his application. • C. Dang will end her term in June 2021. • S. Shimabukuro will be replaced by another DOH representative upon confirmation of interim appointment. We anticipate the new representative will be appointed as of July 2021. 			
<p>III. Consideration and Approval of Minutes April 13, 2021 Minutes</p>	<p>The draft minutes for the April 13, 2021 meeting were reviewed.</p> <p>C. Knightsbridge made a motion for the meeting minutes from the April 13, 2021 meeting be approved. E. Lau-James seconded the motion.</p>	<p>Motion passed unanimously.</p>		
<p>IV. Community Input</p>	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p> <p>B. Cole-Schwartz from National Alliance for Mental Illness (NAMI) Hawaii shared her concerns regarding obtaining a list of mental health resources. She did not know where to go to find a list.</p>			

	<p>In addition, she shared about a situation that occurred on Hawaii Island where help was needed, resources were requested, but services were denied due to criteria and alternative support was not available in a timely manner. She provided a handout explaining the details of the situation.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none">• R. Ries clarified that the issue isn't just about resources but also about coordination of responders and points of contact and knowing how to partner with each entity. Additionally, knowing about substance use history and options for treatment.• C. Dang suggested the Mental Health America (MHA) Hawaii Finding Help Resource Guide. CLICK HERE to visit the MHA website. Another resource could be to consult with Dr. Chad Koyanagi, a psychiatrist who has helped address Oahu's homeless crisis. The Institute for Human Services (IHS) could also share how they address the homeless population. She suggested B. Cole-Schwartz call IHS's main phone number and asking to speak with Dr. Koyanagi.• N. Crozier mentioned homeless outreach triage process that Mental Health Kokua (MHK) on Maui uses to build trust with individuals. MHK may be available on Hawaii Island too. Sometimes, offering water, clean clothes, blankets and "talking story" with the individual helps build trust and helps the individual to choose to receive psychiatric interventions including hospitalization or emergency department (ED) mental health evaluations.• H. Ilyavi suggested reaching out to Aloha United Way's 2-1-1 statewide call center for resource options.• E. Lau-James shared that she personally experienced the struggle with getting help for a family member and knows how challenging it can be to seek help to get individuals off the street. She noted that police have to determine if they can legally take someone against their will to a hospital ED for a psychiatric evaluation because doing so takes away the individual's rights. <p>The rules are very stringent and require the officer to consult with the policy psychologist. Even if the police are able to take the</p>			
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	<p>individual to a hospital ED, at most two to three days of observation is provided but many individuals are released from the hospital ED within 24 hours because they are not appropriate for inpatient psychiatric admission.</p> <ul style="list-style-type: none"> • C. Knightsbridge shared that there was a bill in 2020, HB2680 that helped to address these community concerns. • R. Ries commented that having a mental health professional alongside the officer may have made all the difference in handling the situation that was presented to them on scene. A confident and steady approach is extremely helpful. He clarified that the issue isn't just about resources but also about coordination of responders and points of contact and knowing how to partner with each entity. Additionally, knowing about substance use history and options for treatment. <p>R. Rivera shared that she is the new Hawaii Service Area Board (HSAB) Chair. She has not been nominated by the HSAB to be the HSAB representative to the State Council but wanted to share the following HSAB updates:</p> <ul style="list-style-type: none"> • Alyssa Lavoie from the Bay Clinic presented information to HSAB members about opioid response. • The HSAB Comprehensive Integrated Service Area Plan (CISAP) was completed and a copy was submitted to the State Council. • S. Pavao, Adult Mental Health Division (AMHD) Hawaii Community Mental Health Center (CMHC) Branch Program Manager, reported that there are staff vacancies at the Kona Clubhouse and the West Hawaii Clinic. Due to these staff vacancies, the Clubhouse is unable to accept new members and the clinic is unable to accept new referrals. He is looking into using nurses from Maui to cover nursing related service needs on Hawaii Island. • The HSAB was given information about the Crisis Assistance Helping Out on The Streets (CAHOOTS) Program in Eugene, Oregon. She is excited to learn about this program and how the team of crisis workers help without police intervention. • The HSAB current has three members. There are additional individuals who may be interested in joining the HSAB. 			
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	<ul style="list-style-type: none"> • The HSAB would like to set goals on how the HSAB can hear from the community and from families; hear their testimonies. • Personally, she shared that she is a student at the University of Hawaii earning her master’s degree in social work. She is a member of the Administrative Justice cohort. <p>She has moved on from her past openly shares that she served time in jail for crimes but since then, she has been receiving mental health services for over 15 years. It took being arrested for her to get help.</p> <p>R. Reyno Yeomans mentioned:</p> <ul style="list-style-type: none"> • Colorado diverts calls from police to the Denver Support Team Assisted Response (STAR) Program. Their budget is approximately \$1.4 million. In the first six (6) months, there were approximately 2,500 calls of which 748 were diverted to the STAR program which resulted in no arrests and no police required. • The Oregon CAHOOTS program received approximately 17% of calls diverted from the police. 			
<p>V. Permitted Interaction Group (PIG) Reports</p> <ul style="list-style-type: none"> • PIG for Website, Social Media, and Advocacy (WSA) 	<p>R. Ries explained that in this section of the agenda, PIG members may briefly summarize the PIG activities since the last Council meeting including meeting dates, discussions, and recommendations on topics approved at previous Council meetings.</p> <p>He asked that oral summaries be brief and if PIG members would like to share a longer report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>WSA-PIG members include C. Knightsbridge, C. Dang, C. Matayoshi, H. Ilyavi and R. Pascual-Kestner. C. Knightsbridge is the WSA-PIG lead.</p> <p>The WSA-PIG did not meet last month. In April 2021 the WSA-PIG shared a Google sheet with two tabs for Council members to share information for their respective areas of Council representation. One tab was for resources and the other was for behavioral health activities. S. Haitzuka</p>	<p>Send Google link to Council members.</p>	<p>S. Haitzuka</p>	<p>5/18/21</p>

	<p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • C. Dang affirmed the legislative session has concluded. She again mentioned the status of SB905 and HB812. She foresees these bills being reintroduced in a future legislative session. C. Knightsbridge shared that he felt the LEG-PIG was extremely productive this legislative session. • R. Ries noted that there will be no standing LEG-PIG committee. The participation guidelines provide a timeline of activities including the creating and dissolution of the LEG-PIG committee. 			
<p>VI. Island Representative Reports</p> <ul style="list-style-type: none"> • Maui Service Area Board (MSAB) • Oahu Service Area Board (OSAB) 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective Service Area Board may briefly summarize their board meetings and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer Service Area Board report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> • None provided. <p>The following updates were provided by C. Dang.</p> <ul style="list-style-type: none"> • The OSAB meet in April 2021 with quorum and members are working on the CISAP. • The OSAB is looking to create three PIGs to address its top three (3) focus areas. There was a concern about PIG members (not current Council member) but this is being clarified by T. Freitas, Oahu CMHC Branch Program Manager. • The OSAB needs to provide meeting minutes to the Council. 			
<p>VII. State Agency Representative Reports</p>	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective state agency may briefly summarize agency data, agency information related to behavioral health and when applicable, share updates on requested items identified at previous</p>			

<ul style="list-style-type: none"> • Hawaii Public Housing Authority (HPHA) • Department of Health Child Adolescent Mental Health Division (DOH CAMHD) • Department of Human Services (DHS) 	<p>Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by K. Martinez:</p> <ul style="list-style-type: none"> • With the Governor’s extension of the COVID-19 emergency proclamation, HPHA will open the waitlist for select areas on Oahu and Maui due to exhausting all waitlist applicants for those areas. The goal is to help families struggling with COVID-19 related housing issues. These units are vacant but could not be filled due to eligibility criteria, applicant preferences, etc. • Current renovations are being done to modernize old units so they are ADA compliant. Hopefully HPHA will be able to accept more vouchers and offer additional housing units to Section 8 applicants. • HPHA is looking to expand its housing inventory when it breaks ground on an approximate 800 studio and one bedroom units with ground floor commercial space on HPHA’s School Street property. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • C. Dang asked how many public housing residents are kupuna? K. Martinez estimated approximately 60% are kupuna age, noting many are challenged by availability of units and area of need/island location. <p>The following updates were provided by S. Shimabukuro:</p> <ul style="list-style-type: none"> • None provided. <p>The following updates were provided by J. Fujii:</p> <ul style="list-style-type: none"> • None provided. 			
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<p>MedQUEST (MQD) Division Medicaid Program</p> <ul style="list-style-type: none"> Department of Human Services (DHS) Child Welfare Services (CWS) Department of Human Services (DHS) Division of Vocational Rehabilitation (DVR) 	<p>The following updates were provided by D. Koyanagi:</p> <ul style="list-style-type: none"> CWS administrative staff will be transitioning back to the office full-time starting in May 2021 with some staff transitioning back into the office four of five days each week and teleworking on Mondays. CWS staff will continue to go out to homes, do investigations, etc. Court house staff will also be opening back up for hearings. <p>The following updates were provided by R. Pascual-Kestner:</p> <ul style="list-style-type: none"> None provided. 			
<p>VIII. Specialty Area Representative Reports</p> <ul style="list-style-type: none"> Hawaii Advisory Committee on Drug Abuse and Controlled 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective specialty area may briefly summarize specialty area activities related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by J. Fujii:</p> <ul style="list-style-type: none"> None provided. <p>NOTE: HACDACS meeting minutes were provided as a handout for today's Council meeting.</p>			

<p>(HACDACS)</p> <ul style="list-style-type: none"> • Mental Health Providers • Parents and Family Members of Mental Health Service Recipients 	<p>The following updates were provided by R. Ries:</p> <ul style="list-style-type: none"> • He continues to receive referrals; too many to accept. • More psychologists are returning to the office to see patients. • With COVID-19 vaccinations, perhaps there is less concern for the face-to-face transmission and interaction in the office setting. • He is also seeing more psychologists doing away with physical offices and doing 100% online telehealth appointments. • He is doing trauma treatment which is compassionate to do in a face-to-face setting but for things like tobacco dependence treatment, he can do online telehealth appointments for these. • He will be giving a resiliency training for police officers in May 2021. He used to be an Emergency Medical Specialist (EMS) in New York and understands the unique needs of mental health providers. • He estimates he is seeing patients 60% of the time via online telehealth appointments. <p>The following updates were provided by H. Ilyavi:</p> <ul style="list-style-type: none"> • Hawaii Island continues to see a lack of support services. She has had to tell parents in crisis that they are on the waitlist for services. • She and her colleagues are slowly moving back to in-office services with participants and offering a choice of face-to-face or virtual meetings. • She wants to know if a PIG for identifying/advocating for rural mental health services (access to care PIG) could be helpful. She expressed that it is hard to hear families in crisis and she cannot help them with any services in a timely manner. • She noted that Hawaii Island providers are booked out and are squeezing patients in as they can find space. <p>The following updates were provided by E. Lau-James:</p> <ul style="list-style-type: none"> • She is hearing more and more from family members about the stress and challenges of job loss, no health insurance, no income, kids being back home for school/all day/more often, etc. • She is unsure where the resources are and how to access them. 			
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<ul style="list-style-type: none"> Consumer Advocates 	<p>The following updates were provided by K. Aumer:</p> <ul style="list-style-type: none"> She is helping a younger individual/transgender with support from the Lavender Clinic. Unfortunately, there is a waitlist procedure and services are booked out. She is looking for alternative resources. <p>The following updates were provided by C. Knightsbridge:</p> <ul style="list-style-type: none"> He noted there are social issues unique to Hawaii. He mentioned needing police officers to be happy and need them to do their jobs; support the supporters! <p>The following updates were provided by N. Crozier:</p> <ul style="list-style-type: none"> She mentioned about police partnering on Maui with the Law Enforcement Assisted Diversion (LEAD) program to help with triage for addressing individuals who live with mental illness and who are involved in the criminal justice system. <p>The following updates were provided by T. Reed:</p> <ul style="list-style-type: none"> None provided. 			
<p>IX. Old Business</p> <ul style="list-style-type: none"> Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program 	<p>R. Ries noted that anytime the Council has a new business agenda item that needs to be continued to the next month's meeting, the Council will have those agenda items listed the following month as Old Business agenda items.</p> <p>During the April 13, 2021 meeting, Joy Tanimura Winquist shared information about Ho'ōla Nā Pua's Pearl Haven Residential Treatment Program. She gave an overview of the organization, the clinical program, and the referral process.</p> <p>The timing of her presentation to the Council was in line with a heavy media push for community outreach and awareness activities including KHON2's Shine the Light televised coverage of Ho'ōla Nā Pua's efforts to end sex-trafficking in Hawaii.</p> <p>Ho'ōla Nā Pua's Help and Referral Line is (808) 435-9555.</p>			

	<p>Department of Human Services (DHS) Child Trafficking phone numbers are: (808) 832-1999 on Oahu and 1 (888) 398-1188 for Neighbor Islands.</p> <p>D. Koyanagi mentioned she is the designated coordinator between DHS CWS and the trafficking community.</p> <p>The National Human Trafficking number is 1 (888) 373-7888.</p> <p>Council members shared the following comments regarding Ho‘ōla Nā Pua’s presentation:</p> <ul style="list-style-type: none"> • R. Ries stated that the Council has not taken a position on sex trafficking. The Council could discuss in a future Council meeting guidelines for Council positions and have a way to document these position statements as a living document. The Council can be informed prior to taking a position by inviting guests to share information with the Council. • C. Dang supports the Council writing an opinion letter and sending it to the Chair of the Senate and House Committees. She thinks the best time to send the letters is before the end of the summer break. <p>The Council asked S. Haitzuka to draft two (2) thank you letters. She included them as handouts for today’s meeting. One letter is for Ho‘ōla Nā Pua and the other letter is for The Clarity Project.</p> <p>Council members shared the following comments and edits:</p> <ul style="list-style-type: none"> • For Ho‘ōla Nā Pua’s Pearl Haven Residential Treatment Program letter: <ul style="list-style-type: none"> ○ Change the letter date to May 12, 2021 ○ Third paragraph, change the date to May 11, 2021 and fill in the blank with, “would like to continue partnering with your organization and stakeholders to support the treatment and healing of victims of sex trafficking, and educating community members about the signs and symptoms of sex trafficking. ○ Delete the “s” on align ○ Decrease font for the footer paragraph 	<p>Add to the June 2021 Council meeting agenda.</p>	<p>S. Haitzuka</p>	<p>5/31/21</p>
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<ul style="list-style-type: none"> Strategic Plan Review and Discussion of Focus Areas #1-7 and Accompanying Action Plan Items 	<ul style="list-style-type: none"> For The Clarity Project letter: <ul style="list-style-type: none"> Change the letter date to May 12, 2021 Fourth paragraph, delete “At this time” and “has not taken a position on this topic, and” Fourth paragraph, delete the “s” on align and add to the sentence, “...and other alternative forms of treatment.” Decrease font for the footer paragraph. <p>R. Ries tabled this agenda item to the Council’s June 8th Council meeting.</p>			
<p>X. New Business (Part 1 of 2)</p> <ul style="list-style-type: none"> Council Bylaw Review and Revisions 	<p>R. Ries tabled this agenda item to the Council’s June 8th Council meeting.</p>	<p>Add to the Juned 2021 Council meeting agenda.</p>	<p>S. Haituka</p>	<p>5/31/21</p>
<p>XI. Presentation/ Guest Speaker</p>	<p>R. Ries introduced Dr. Amy Curtis, Adult Mental Health Division (AMHD) Administrator. She is an experienced epidemiologist with a lot of national experience including her work with the Centers for Disease Control and Prevention. She last presented an AMHD update to the Council in the Fall of last year.</p> <p>Dr. Curtis shared the following AMHD updates:</p> <ul style="list-style-type: none"> The AMHD seeks public feedback on its Mission and Vision statements. The Council was provided with a letter she wrote that included the link to the online survey form as well as a hard copy form to mail. The due date for responses is Friday, May 14, 2021. All Council members are encouraged to submit feedback for consideration. An update will be shared in June 2021. 			

	<ul style="list-style-type: none"> • The AMHD, as well as other DOH Behavioral Health Administration (BHA) Divisions were negatively impacted by the COVID-19 pandemic for budgetary spending. For example, there are a number of AMHD positions that are vacant. AMHD intends to fill these positions; however, doing so with the current hiring freeze on most state jobs requires the Governor’s approval to hire. • BHA efforts in response to the COVID-19 pandemic continue with the Isolation and Quarantine (Iso-Q) hotels and behavioral health stabilization beds. • BHA has responded to COVID-19 outbreaks in shelters. • BHA staff coordinated the Windward COVID-19 vaccination clinic at the Windward Health Center and Windward Community College from December 2020 to May 2021. In total, this vaccination clinic was responsible for vaccinating approximately 50,000 residents with the Pfizer, Moderna, and Johnson and Johnson vaccines. • Now that the vaccine clinic closed, AMHD and other Division staff are returning full time to focus on individuals their Division serves and are looking to increase coordination of services across Divisions. • AMHD has been awarded federal funding through grant awards. Primarily grants were from the Substance Abuse and Mental Health Services Administration (SAMHSA) as well as funding for COVID-19 pandemic response. <p>Additional grants that AMHD is applying for include supplemental funding for psychiatric urgent care through the Community Mental Health Center clinics and funding for additional stabilization beds.</p> <ul style="list-style-type: none"> • AMHD wants to expand its services via telehealth and telepsychiatry. • AMHD’s newest residential and treatment programs include several Palekana locations which include short- and long-term stabilization beds to help individuals who need a place to stay and who are maybe decompensating but do not meet inpatient hospitalization criteria; others may need a place to go while they are transitioning from a hospital to a community placement. 			
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	<p>For example, Palekana Leahi has eight (8) beds and will increase to 16 beds this summer. The plan is to expand Palekana beds across all islands. AMHD sees these beds as a cost saving option that provides better outcomes for individuals to stabilize and then transitioned to their ideal community placement. Recently, a former Palekana resident needed to return to the Hawaii State Hospital. Even though they were re-hospitalized, they were able to articulate to staff that they were continuing to use the coping skills that they learned while residing at the Palekana program.</p> <ul style="list-style-type: none"> • AMHD is expanding the Hawaii Certified Peer Specialist (HCPS) program to include Hawaii Certified Forensic Peer Specialists. Peers have an important treatment team role. <p>For example, the Palekana stabilization bed program has a forensic peer specialist position built into the program.</p> <ul style="list-style-type: none"> • Dashboard with mental health data are available for public access at: www.hawaii.edu/aging/hbhd <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • There is a need to do more training around imminent risk and dangerousness. Community education and education for police officers and Mental Health Emergency Workers (MHEWs) is needed in addition to social workers and mental health providers. • Decriminalization of mental health is a priority. • Short-term stabilization beds are an important part of the overall service array. • There are constraints to getting therapy in an acute inpatient setting. There are cultural considerations. • Providers are burnt out and are focusing on stabilizing the patient and getting them back out into the community. There is a financial incentive to get the patients out of the inpatient beds even though they may not be ready or fully stabilized. • There is a huge disconnect between SAMHSA funding inpatient behavioral health therapy vs outpatient behavioral health therapy. • C. Knightsbridge expressed concern regarding the incentive for mental health professionals to stay in Hawaii after they have 			
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	<p>finished their professional training. There is currently no mandate for professionals to remain in Hawaii, for example, to practice for five (5) years post-training/licensure.</p> <p>C. Dang commented that incentives for licensed professionals to come to Hawaii to practice therapy should be considered.</p> <p>Dr. Curtis stated that AMHD is looking into building relationships with colleges to increase opportunities for students to get hands on experience. AMHD has worked with the University of Hawaii Myron B. Thompson School of Social Work for student internship opportunities. R. Ries mentioned that Hawaii Pacific University is another option for internships.</p> <p>She mentioned possibly better utilizing physician assistants.</p>			
<p>XII. New Business (Part 2 of 2) AMHD Request for Council Members' Comments on AMHD's Mission and Vision Statements</p>	<p>R. Ries asked Council members for their feedback regarding AMHD's request for Council member feedback on the AMHD Mission and Vision statements.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • C. Dang stated staff to patient ratio and improving outreach to homeless. R. Ries mentioned that homelessness is not illegal. • R. Ries suggested psychotherapy in inpatient settings. <p>S. Haitsuka encouraged Council members who have not submitted their feedback to do so online on or before Friday, May 14, 2021.</p>	<p>For information only.</p>		
<p>XIII. Closing Announcements</p>	<p>Council members shared the following announcements:</p> <ul style="list-style-type: none"> • R. Ries noted that a request for funds for the Institute on Violence, Abuse and Trauma (IVAT) Summit from April 26-30, 2021 was submitted and approved. There were several Council members who indicated they were available to attend. If you attended and would like to share any comments about the IVAT Summit and your experience, please share your feedback. 	<p>For information only.</p>		

XIV. Meeting Evaluation / Future Agenda Items	<p>R. Ries encouraged members to share their feedback about how today’s Council meeting went either by sharing them verbally or typing their feedback in the chat.</p> <ul style="list-style-type: none"> • None shared. 			
VI. Adjournment	The meeting was adjourned at 11:46 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <p>E-mail (1 of 2) with handouts (total of 7 handouts)</p> <ol style="list-style-type: none"> 1. May 2021 Meeting – Agenda 2. April 2021 Meeting – Draft Minutes 3. April 2021 Meeting – FY21 Attendance Log 4. May 2021 Meeting – Community Input, NAMI Hawaii – Hawaii ACT Pilot Program 5. May 2021 Meeting – Adult Mental Health Division Survey: Mission and Vision Statements 6. May 2021 Meeting – Draft Thank You Letter, Ho’ōla Nā Pua 7. May 2021 Meeting – Draft Thank You Letter, The Clarity Project <p>E-mail (2 of 2) with handouts (total of 7 handouts)</p> <ol style="list-style-type: none"> 8. May 2021 Meeting – Old Business Retreat (Part II), Post-Retreat Facilitator Summary 9. May 2021 Meeting – Old Business Retreat (Part II), Strategic Plan: Changes Noted from 3/9/21 Meeting 10. May 2021 Meeting – Announcement, C. Matayoshi Mahalo Letter 11. May 2021 Meeting – Announcement, Children’s Mental Health Awareness: CAMHD Info 12. HACDACS Minutes – 1/26/21 13. Maui SAB Minutes – 2/1/21 14. Hawaii SAB Minutes – 3/23/21 	For information only.		

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
June 8, 2021
9:00 a.m. – 11:30 a.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Dang, Cynthia “Cindi”; Ilyavi, Heidi; Knightsbridge, Christopher; Koyanagi, Dina; Lau-James, Eileen; Martinez, Beatrice “Kau’i”; Ries, Richard**

Members Absent:

Members Excused: **Crozier, Charleen “Naomi”; Fujii, John; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Shimabukuro, Scott**

Guests Present: **Guzikowski, Cheryl; Reyno Yeomans, Raelyn; Rivera, Renee**

DOH Staff Present: **Haitsuka, Stacy; Hiraga-Nuccio, Madeleine**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 9:02 a.m.</p> <p>Members and guests introduced themselves.</p> <p>The following definition of quorum was added to the agenda as of the November 10, 2020 meeting: Pursuant to Act 137-18 (SB 203), Chapter 92, Hawaii Revised Statutes: “(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes.</p> <p>For example, if only 16 of the entitled 21 members are appointed, at least 9 must be present to establish a quorum. To validate a council action, of</p>	For information only.		

	<p>the 9 members present, an affirmative vote from at least 5 is required.”</p> <p>Quorum was not established by 9:04am; therefore, R. Ries skipped ahead to the Community Input agenda item noting that the Council would come back to review meeting minutes when quorum was established.</p>			
<p>II. Meeting Announcements</p>	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • The SCMH continues to do its part to Stop the Spread of COVID-19 by holding its meetings virtually for the time being. Handouts are distributed electronically a week before the meeting. • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions during the meeting to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally get his attention during the meeting. ○ Please wait to be acknowledged before speaking. This will help to keep the meeting organized and the audio clear for minute taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who take a break and step away from the meeting, please notify him before leaving as the Council needs to track of when Council members leave and return to verify quorum. • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. • If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear speaker. <p>R. Ries acknowledged that the Centers for Disease Control and Prevention (CDC) announced a change in indoor gatherings and mask wearing;</p>	<p>For information only.</p>		

	<p>however, at this time, he noted that until the state has reassessed its interisland travel requirements and until the DOH has announced a changed in its facility policies for resuming in-person meetings in DOH facilities, the Council will conduct its meeting virtually.</p> <p>R. Ries shared the following Council membership updates:</p> <ul style="list-style-type: none"> • Starting in July 2021, the Council will welcome a new member, Jennifer Renfro. She will join the Council as the Department of Education representative. Her term will end in June 2023. • D. Koyanagi, currently a member and confirmed for a term to end in June 2023. • A. Beninato, currently a member and confirmed for a term to end in June 2024. • K. Aumer, currently a member and our 2nd Vice Chair, was confirmed for a term to end June 2025. • C. Knightsbridge will end his term in June 2021. He did not submit his application for a second term. He indicated he would be willing to serve a second term and would submit his application. • C. Dang will end her term in June 2021. • S. Shimabukuro will be replaced by another DOH representative upon confirmation of interim appointment. We anticipate the new representative will be appointed as of July 2021. 			
<p>III. Consideration and Approval of Minutes May 11, 2021 Minutes</p>	<p>The draft minutes for the May 11, 2021 meeting were reviewed.</p> <p>The following amendments were requested:</p> <ul style="list-style-type: none"> • Page 1 – S. Haitsuka will change the meeting date to May 11, 2021. <p>C. Knightsbridge made a motion for the meeting minutes from the April 13, 2021 meeting be approved as amended. K. Martinez seconded the motion.</p>	<p>Motion passed unanimously.</p>		
<p>IV. Community Input</p>	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p>			

	<p>R. Reyno Yeomans shared the following concerns:</p> <ul style="list-style-type: none"> • There is a lack of immediate care for people in crisis, especially immediate care for children/youth. For example, access to care for youth after a suicide attempt. The wait time for mental health appointments is several months. She would like to see data on services for youth and response to youth suicide attempts. She feels that this is an emergency. The Mental Health Task Force talked about long-term staffing but need to address this emergency situation now. She asked if this is our reality for youth to have to wait a week or more to see a psychiatrist. She is working to bring in funding for help in this area. <p>Council members responded to R. Reyno Yeomans with the following comments:</p> <ul style="list-style-type: none"> • C. Knightsbridge shared that it has been his experience that the wait time for a psychiatrist is historically long. He noted that one of out 10 people diagnosed with COVID-19 also had a mental health issue. He noted that with telehealth options, there should not be the same long wait time to see a mental health professional. • H. Ilyavi mentioned that she lives in Kona on the Hawaii Island. She works with parents whose children receive services via the Department of Health, Child and Adolescent Mental Health Division (CAMHD) via their Family Guidance Center. She advised that a 9-1-1 call is always preferred if in active crisis where an Emergency Department (ED) visit occurs and the individual is held there until they are seen by a doctor. In the ED and while in active crisis, the individual can be seen via telehealth and be spoken to in order to determine how to best assist with the immediate situation and if necessary, triage them to additional support services. • R. Ries encouraged R. Reyno Yeomans to keep attending Council meetings. He noted the Council may be able to support and advocate for her concerns. His experience with trauma and crisis therapy as well as with telehealth is that telehealth has been a godsend for some situations but other situations still need a face-to-face visit. • C. Knightsbridge noted that suicidal ideation (SI) vs. active suicide 			
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	<p>are both important areas of crisis to address. He emphasized that there is a need to focus on SI and be proactive before any suicide attempt is made.</p>			
<p>V. Old Business</p> <ul style="list-style-type: none"> • Adult Mental Health Division Update • Strategic Plan Review and Discussion of Focus Areas #1-7 and Accompanying Action Plan Items 	<p>R. Ries noted that anytime the Council has a new business agenda item that needs to be continued to the next month’s meeting, the Council will have those agenda items listed the following month as Old Business agenda items.</p> <p>During the May 11, 2021 meeting, Dr. Amy Curtis, Adult Mental Health Division (AMHD) Administrator, shared updates about the AMHD’s request for public input on its Mission and Vision statements, COVID-19 response efforts and impacts on budgetary planning/spending, federal funding/grant opportunities, expansion of telehealth and telepsychiatry services, and new residential and treatment programs.</p> <p>Council members shared the following comments regarding the Adult Mental Health Division presentation:</p> <ul style="list-style-type: none"> • No additional comments. <p>The Council asked S. Haitzuka to draft a thank you letter to Dr. Curtis. She included the draft as a handout for today’s meeting.</p> <p>Council members shared the following comments and edits:</p> <ul style="list-style-type: none"> • Delete the space holders “XXX” <p>R. Ries noted after two successful facilitated Retreat sessions (November 2020 and February 2021) that the Council began its review of the Strategic Plan in March 2021 with the intent of going through each of the draft Focus Areas, looking at our measurable goals, and editing the document so that we could finalize our draft and begin implementing portions of it using the accompanying action plan as our guide; however, we ran out of time to discuss the draft and edits.</p> <p>In our March 2021 Council meeting, R. Ries recalled making several comments that identified timely changes that aligned the Focus Areas</p>			

	<p>more strategically with other Council activities and timeframes. Council members also expressed comments for consideration which are shared as a handout for today’s meeting for easier reference.</p> <p>He also recalled and acknowledged E. Lau-James expressing strong support for creating a PIG for all seven of the Strategic Plan Focus Areas. He supports the spirit of this, but asked Council members to consider the time it takes to organize PIG meetings and staff support for these meetings. He noted that S. Haitsuka and J. Nazareno are support staff to the Council; however, they are not full-time Council support staff.</p> <p>Additionally, he offered that historically, seeing the challenges of scheduling meetings for the three PIGs we have had in the past year, scheduling PIG meetings in addition to the Council’s regular meeting has been extremely challenging for Council members to (1) reply to e-mail requests for scheduling PIG meetings and (2) attending PIG meetings when they are confirmed.</p> <p>Council members shared the following comments regarding the creation of PIGs for all seven Focus Areas:</p> <ul style="list-style-type: none"> • C. Dang noted that PIGs can be powerful. <p>A copy of the Retreat facilitator’s post-Retreat Summary was shared as a handout for today’s meeting. Using Appendix 3, R. Ries reviewed each Focus Area noting the following changes.</p> <p>Focus Area #1: Improving Access to Mental Health Services (existing and new)</p> <ul style="list-style-type: none"> • R. Ries noted this Focus Area could be addressed as a Council rather than a PIG. He expressed support for the Council having agenda items for future meetings as new and old business where it may address the measurable objectives as a group. • R. Ries noted that the Council may even be able to use a similar Google sheet for data collection like the one we are now using for the Website, Social Media and Advocacy (WSA) PIG. • R. Ries recalled that the Council drafted, edited and finalized the 			
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	<p>letter to E. Mersereau, DOH Deputy Director Behavioral Health Administration. Similarly, the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant application can be drafted, edited and finalized as a Council as well.</p> <ul style="list-style-type: none"> • C. Knightsbridge was supportive of the Council working together to complete these objectives. He noted that the accompanying Action Steps will help the Council to focus and show what has been accomplished. <p>Focus Area #2: Advocate for the Emotional Well-Being of the Community</p> <ul style="list-style-type: none"> • R. Ries recommended Objective 2.1 be revised to state, “By July 2021, form a Wellness Brochure PIG” • R. Ries anticipates a new PIG will be formed for brochure production as noted in Objective 2.2. He noted that S. Haitsuka recently assisted the Maui Service Area Board (SAB) to draft a brochure and she indicated she would be able to assist this new Council PIG with brochure production as well. When the draft brochure has been reviewed by the Maui SAB, a copy will be shared with the Council and with other SABs. • C. Knightsbridge advocates for Council members to attend Mental Health Task Force meetings and to participate in their discussions. • R. Ries is interested in creating a sub-category for first responders such as fire/policy/lifeguards/Emergency Medical Services (EMS) to prioritize support for their well-being. • C. Dang stated that the Council could better partner with the SABs to have them focus on local first responders at the Council level and have the SABs include this group in their Comprehensive Integrated Service Area Plans (CISAP). <p>Focus Area #3: Identify Tools the Council is Empowered to Use</p> <ul style="list-style-type: none"> • R. Ries recommended Objective 3.1 be revised by pushing the start date to August 2021. • R. Ries recommended Objective 3.2 be revised by pushing the start date to August 2021. • R. Ries anticipates a new PIG will be formed for infographic production as noted in Objective 3.1. He imagined that this 			
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	<p>infographic may be primarily for Council members to reference as an aid to empower members to use the resources and tools we identify to research our agenda topics, report back on our findings, and make recommendations for Council vote.</p> <ul style="list-style-type: none"> • R. Ries feels this Focus Area will be particularly helpful with orienting new members and could be a short-term PIG activity, possibly two or three PIG meetings. <p>Focus Area #4: Outline an Onboarding and Annual Reboarding Experience for Council Members</p> <ul style="list-style-type: none"> • R. Ries anticipates a new PIG will be formed for onboarding and reboarding as noted in Objective 4.1. • R. Ries suggested newer members think about their experience and help to outline the process for new members. • R. Ries thought that Focus Areas #3 and #4 could be combined. <p>Focus Area #5: Strengthen the Council’s Presence as Advocates to DOH Leadership, inclusive of input from Neighbor Island Stakeholders and Service Area Board Members</p> <ul style="list-style-type: none"> • R. Ries recommends Objective 5.1 be revised by pushing the state date to August 2021. • R. Ries hopes that Council members will consider using monthly Council report time to include our acknowledgement of “efforts” made to “share/disseminate/distribute mental health information.” • R. Ries noted this Focus Area could be addressed as a whole Council vs. as a PIG because all Council members are responsible for advocating and representing their respective areas of Council representation. Each Council member has dedicated time on the agenda to share about their mental health related activities. He feels it would be improper to have the responsibility of this Focus Area fall in the lap of a few Council members if a PIG were to be formed. <p>For example, the Council’s meeting minutes document our efforts to advocate. Perhaps a template may help prompt Council members by specifically reminding to mention updates and share how we participated in the last month relative to mental health activities.</p>			
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	<p>Focus Area #6: Share Information on the Council’s Website About Existing Mental Health Services (Local/State/Federal)</p> <ul style="list-style-type: none"> • R. Ries anticipates the current WSA PIG will be dissolved and a new website and social media PIG will be formed per Objective 6.1. • C. Knightsbridge stated his willingness to step up his efforts to help make forward progress with members of the new PIG. <p>Focus Area #7: Identify, Track, and Share the Status of DOH Behavioral Health Administration (BHA) Legislative Bills including Adult Mental Health, Child Adolescent Mental Health, and Alcohol and Drug Abuse Divisions.</p> <ul style="list-style-type: none"> • R. Ries anticipates a new legislative PIG will be formed in the fall of 2021 as noted in Objectives 7.3 and 7.4. • Based on Objective 7.3 and the draft participation guidelines for the Council’s legislative activities, R. Ries noted that the current legislative PIG is scheduled to be dissolved this month. • R. Ries suggested narrowing the focus of the Focus Area by retitling the Focus Area as, “Identify, track, and share the status of the Council’s legislative bills” rather than sharing the legislative bills from the DOH BHA Divisions. • R. Ries suggests for Objective 7.4, that 7.4b be included. That way, the Council forms a new legislative PIG first, and that new legislative PIG is responsible for finalizing the participation guidelines. Then, the existing Objective 7/4a becomes the new Objective 7.5 with a due date of November 2021. <p>In summary, Focus Areas with a recommendation for forming a new PIG:</p> <ul style="list-style-type: none"> - Focus Areas #2, 3, 4, 6 and 7 - No PIG is recommended for Focus Areas #1, 5 <p>Council members shared closing comments regarding this agenda item:</p> <ul style="list-style-type: none"> • C. Dang noted there are a lot of overlapping areas that these Focus Areas address. She emphasized that visuals are a powerful tool. • Council members agreed to review the revised draft of the Focus Areas with the recommended revisions noted in today’s discussion 			
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	<p>and vote to adopt the Strategic Plan with any final edits.</p> <p>R. Ries asked S. Haitzuka to prepare the revised draft for Council members to review. If possible, provide the revised draft by June 24th. That way, Council members will have more time to carefully consider the revisions in a fresh revised draft.</p>	<p>Revise draft and send to Council members for early review and consideration.</p>	<p>S. Haitzuka</p>	<p>6/25/21</p>
<p>VI. New Business</p> <ul style="list-style-type: none"> SAMHSA Auditor – Request Executive Meeting with State Council Members in July 2021 	<p>R. Ries asked Council members to refer to the meeting handout regarding the DOH BHA’s Mental Health Block Grant Program Monitoring Prep Team’s request for a Council Executive Meeting in July 2021. The handout explains the purpose of the meeting and preliminary agenda items.</p> <p>The Substance Abuse and Mental Health Services Administration (SAMHSA) is conducting an investigation of the DOH BHA as part of its routine program monitoring. The SAMHSA investigator would like to meet with the Council.</p> <p>The meeting will be held virtually via the same Zoom link we use for Council meetings. Executive meetings can be closed to the public but R. Ries explained the meeting will be kept open to the public.</p> <p>R. Ries explained the Executive meeting will be an information sharing meeting only. There will be no voting/decision making on official Council business that day so if we are unable to achieve quorum, it is okay to still meet. It would be great if all Council members could attend.</p> <p>The SAMHSA investigator will be joining on East Coast time which is six hours ahead of Hawaii time. R. Ries asked Council members to keep this in mind regarding scheduling.</p> <p>R. Ries noted the Council was asked to identify at least four two and one half hour blocks of time (2.5 hours) on Tuesday, July 27, 2021 and Thursday, July 29, 2021 that we would like to meet with the investigator. There is no need to vote on the days/times. The Council is just sharing our availability based on our schedules and if we are able to attend once the</p>			

<ul style="list-style-type: none"> Letters Encouraging Appointment of Agency Reps to the State Council – DHS, HACDACS, and Judiciary 	<p>day/time is confirmed, that's great.</p> <p>After reviewing schedule availability, Council members identified the following preferred days/times:</p> <ul style="list-style-type: none"> 1st choice: Tuesday, July 27th from 9:00 a.m. to 11:30 a.m. HST 2nd choice: Tuesday, July 27th from 8:00 a.m. to 10:30 a.m. HST 3rd choice: Tuesday, July 27th from 10:00 a.m. to 12:30 p.m. HST <p>S. Haituka will communicate the Council's preferred meeting days/times to the Prep Team and will get back to the Council as soon as possible to confirm the day/time.</p> <p>R. Ries stated that the Council discussed at the June Council meeting, the goal of achieving full Council membership. This was also an area identified as a priority during the Council's Strategic Planning Retreat.</p> <p>R. Ries explained the three draft letters in today's meeting handouts are to help the Council to fill membership positions with individuals who are willing and available to volunteer. Each letter is identical, other than the unique statement about the position that is applicable to the letter recipient: Dr. Judy Mohr Peterson for DHS, the Chair of HACDACS, and Chief Justice Mark Recktenwald for Judiciary.</p> <p>While there is currently a Council member, J. Fujii, filling the dual roles of DHS and HACDACS on the Council, his attendance and participation has been very minimal and most meetings he is unable to attend due to other job priorities. The Judiciary position has been vacant since June 30, 2019. He is not sure if there is another HACDACS member who is, like Jon, also a DHS employee where that person is able to dually fill these positions.</p> <p>Council members shared the following comments about the letters:</p> <ul style="list-style-type: none"> C. Dang commented that including the Council's Focus Areas and achievements may be a good idea to orient the letter recipients so they know who the Council is and what we do. C. Knightsbridge noted that if a representative is required by law, we should say so in the letter. However, C. Dang cautioned that a 	<p>Relay days/times to the Prep Team.</p>	<p>S. Haituka</p>	<p>6/8/21</p>
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<ul style="list-style-type: none"> • Council Bylaw Review and Revisions 	<p>punitive approach may be counter productive and a softer approach may be a better option to encourage the letter recipients to take action on their part.</p> <ul style="list-style-type: none"> • R. Ries offered that it may be okay to leave the draft letters as is and after a few months, wait for any non-action to mention achievements and the Hawaii Revised Statutes (HRS) requirements. • K. Martinez shared that her state agency recommended her to serve as she has experience working in the mental health field as well as with the public housing system. She recognized that applying for Council membership is voluntary, even for state employees in some cases, and it also could be a personal issue where the employee who is asked by their agency to apply may not feel that they are able to contribute meaningfully versus being told they have to represent their agency but are not able to really be an active and engaged participant. <p>R. Ries proposed that the letters be updated with the date and the title “Chairperson” under his signature and be distributed to the letter recipients. Council members were okay with this proposed plan and had no additional comments or edits.</p> <p>Looking at the bylaw handout, R. Ries asked Council members to suggest changes. The changes will be noted on a draft and will be reviewed, discussed further and voted on at the next Council meeting. He encouraged Council members to think about their experience as Council members and about how they would like to see the Council’s bylaws updated to reflect current activities.</p> <p>Council members identified the following recommendations for the header of the document:</p> <ul style="list-style-type: none"> • Update title by removing the hyphen in By-Laws so it reads Bylaws. • Update the date to reflect current draft. <p>Council members identified the following recommendations for Article I: Name:</p> <ul style="list-style-type: none"> • None shared. 	<p>Revise and distribute letters.</p>	<p>S. Haituka</p>	<p>6/24/21</p>
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	<p>Council members identified the following recommendations for Article II: Purpose:</p> <ul style="list-style-type: none"> • Change the purpose to read, "...to advise agencies and policy makers in their efforts to establish a comprehensive.... and private resources that aim to prevent, reduce, and heal mental disorders and substance abuse among children and adults and to represent recipients of mental health services in our communities." <p>Council members identified the following recommendations for Article III: Responsibilities:</p> <ul style="list-style-type: none"> • For 1, include "advisor to the Governor and Hawaii Legislature" if he is able to find the citation for this language from Hawaii law. • For 2b, add, "...statewide plan to address the individual needs of each County (i.e. SABs)." <p>Council members identified the following recommendations for Article IV: Membership:</p> <ul style="list-style-type: none"> • For 1b, vi., separate and create a vii. starting with "The Hawaii Advisory Commission..." • For 2, add a new b. that defines interim appointment. • For 3, add PIGs and add to the end of the sentence, "...by the Council to reflect the concerns and needs of our respective constituent groups." • For 5g, delete. It is exactly duplicative to 5b. • For 6a, consider changing three consecutive meetings to two. Noted is that this only applies to Council members who do not provide a reason for their absence ahead of the Council meeting or upon their ability to do so (i.e. an emergency prevented the member from communicating their absence prior to the meeting.) • For 6a, separate and create a new b by pulling out the second sentence to read, "The chairperson or acting chairperson of the board shall determine if the absence of the member is excusable." • For 6c, i, fix typo from "unexcused" to "excused" absence. • For 6c, ii, change "call" to "contact" and change "he or she" to "the" 			
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	<p>Council member” for inclusive language.</p> <p>Council members identified the following recommendations for Article V: Meetings:</p> <ul style="list-style-type: none"> • For 1, create a new f, stating, “Regular meetings shall be three hours in duration” and state that Council members are allowed to excuse themselves for brief breaks during the meeting so long as, for the purpose of quorum, the Council member notifies the Chair prior to excusing themselves. <p>R. Ries clarified that this suggestion is to change the meeting time from two and one half hours (2.5 hours) to three (3) hours where the meeting will be from 9:00 a.m. to 12:00 p.m. every 2nd Tuesday of the month. His feedback as the Chairperson is that he has had to rush the Council through its monthly agendas and feels that rushing has made the Council slightly less reflective in addressing agenda items. He noted that discussion about this recommendation will be done at the July Council meeting.</p> <ul style="list-style-type: none"> • For 3c, create a new i, for e-mail distribution and a new ii, stating if an e-mail address is not available, then U.S. postal mail is the second option. • For 5a, update the statement to clarify it is not 11 members. Rather, “A majority vote of the Council’s members in a meeting where quorum is established is required to make any action of the Council valid.” • For 5a, add the citation to recognize current Chapter 334-10, HRS, f and g, from the 2018 law change concerning the Council’s definition of quorum. <p>Council members identified the following recommendations for Article VI: Officers:</p> <ul style="list-style-type: none"> • For 3a, remove the current statement and replace it with, “At least one month before the election, the Chair will place nominations on the agenda as a New Business item.” 			
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	<p>Council members identified the following recommendations for Article VII: Committees:</p> <ul style="list-style-type: none"> • Change the title to include PIGs • Change the statement within this article to also include PIGs <p>Council members identified the following recommendations for Article VIII: Conflicts of Interest:</p> <ul style="list-style-type: none"> • Update this statement to clarify it is not 11 members. Rather, in the last sentence, align language with the changes suggested in Article V: Meetings. • The last sentence, change to read, “A majority vote of the Council’s members in a meeting where quorum is established is still required to make any action of the Council valid...” <p>Council members identified the following recommendations for Article IX: Amendment of By-Laws</p> <ul style="list-style-type: none"> • Update the article title by removing the hyphen in By-Laws so it reads Bylaws. • Update this statement to clarify it is not 11 members. Rather, in the last sentence, align language with the changes suggested in Article V: Meetings. • Delete “by the Council” at the end of the sentence. <p>Council members identified the following recommendations for Article X: Liabilities</p> <ul style="list-style-type: none"> • None shared. <p>R. Ries asked S. Haitzuka to prepare the revised draft for Council members to review. If possible, provide the revised draft by June 30th. That way, Council members will have more time to carefully consider the revisions in a fresh revised draft.</p>			
VII. Permitted Interaction Group (PIG) Reports	R. Ries explained that in this section of the agenda, PIG members may briefly summarize the PIG activities since the last Council meeting including meeting dates, discussions, and recommendations on topics approved at previous Council meetings.	Revised draft and send to Council members for early review and consideration.	S. Haitzuka	6/30/21

<ul style="list-style-type: none"> • PIG for Website, Social Media, and Advocacy (WSA) 	<p>He asked that oral summaries be brief and if PIG members would like to share a longer report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>WSA-PIG members include C. Knightsbridge, C. Dang, C. Matayoshi, H. Ilyavi and R. Pascual-Kestner. C. Knightsbridge is the WSA-PIG lead.</p> <p>The WSA-PIG did meet last month. They provided a copy of their meeting notes in today's meeting hangouts. In summary, they reviewed input from Council members for the two Google sheets. Members were asked to share information for their respective areas of Council representation by May 20, 2021. One tab is for resources and the other tab is for behavioral health activities.</p> <p>The WSA-PIG presented two recommendations for the Council to consider and vote on.</p> <ul style="list-style-type: none"> • #1: Posting the resources and behavioral health related activities by month to the Council's website. The recommendation is for the Council to approve the posting the resources and behavioral health related activities by month to the Council's website. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ None shared. <p>C. Knightsbridge motioned to approve the above recommendation. H. Ilyavi seconded the motion.</p> <p>Council members voted to approve the WSA-PIG recommendation #1: Posting the resources and behavioral health related activities by month to the Council's website.</p> <ul style="list-style-type: none"> • #2: Posting new/revised resources and behavioral health related activities by month automatically and without Council approval if 	<p>Ayes (9); Noes (0); Abstentions (0)</p>	<p>S. Haitzuka</p> <p>WSA-PIG members</p>	<p>5/18/21</p> <p>6/2/21</p>
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<ul style="list-style-type: none"> • PIG for Legislation 	<p>the primary purpose of the resource item or monthly activity is related to behavioral health/mental health/substance abuse.</p> <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ R. Ries clarified that his understanding is that the purpose of this recommendation is to allow the Council the ability to have a decision tree style process where there is an option for an automatic pass for resources and monthly activities that are established as being related to behavioral health or mental health or substance abuse. ○ R. Ries stated this was a good idea that would allow the Council to submit updates and new items via e-mail directly to Council support staff via our Council e-mail address or Council members could orally share during Council meetings. This also allows the Council more opportunity to be timely in posting updated information rather than having to wait to have every item reviewed and approved at Council meetings. <p>H. Ilyavi motioned to approve the above recommendation. C. Knightsbridge seconded the motion.</p> <p>Council members voted to approve the WSA-PIG recommendation #2: Posting new/revised resources and behavioral health related activities by month automatically and without Council approval if the primary purpose of the resource item or monthly activity is related to behavioral health/mental health/substance abuse.</p> <p>LEG-PIG members include C. Knightsbridge, C. Dang, E. Lau-James, and T. Reed. C. Dang is the LEG-PIG lead.</p> <p>The LEG-PIG did not meet last month. Due to not meeting, they were not able to revise the draft participation guidelines for the Council’s legislative activities. A copy of the unchanged draft participation guidelines was shared as a handout for today’s meeting.</p>	<p>Ayes (9); Noes (0); Abstentions (0)</p>		
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	<p>R. Ries recommended that the Council support the participation guidelines as drafted, including dissolving the LEG-PIG during this meeting. He noted that the next LEG-PIG will be formed later this year in preparation for the 2022 legislative session and at which time the new LEG-PIG may review the draft participation guidelines and make recommendations for revision.</p> <ul style="list-style-type: none"> • #1: Dissolve the current LEG-PIG. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> ○ R. Ries stated his understanding from the LEG-PIG’s previous meeting notes is that the participation guidelines for the Council’s legislative activities are meant to be a living document that can be updated when needed. ○ C. Dang shared that she felt the LEG-PIG did an exceptional job this legislative session and looks forward to future LEG-PIG work. She felt this LEG-PIG tapped into her skill area and it was a rewarding experience. ○ R. Ries noted that if anyone reports seeing anything posted that they feel is objectionable, the Council can review the information and discuss it at a future meeting. <p>C. Dang motioned to approve dissolving the current LEG-PIG. C. Knightsbridge seconded the motion.</p> <p>Council members voted to approve dissolving the current LEG-PIG as of today’s meeting.</p>	<p>Ayes (9); Noes (0); Abstentions (0)</p>		
<p>VIII. Island Representative Reports</p>	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective Service Area Board may briefly summarize their board meetings and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer Service Area Board report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p>	<p>For information only.</p>		

<ul style="list-style-type: none"> • Maui Service Area Board (MSAB) • Oahu Service Area Board (OSAB) 	<p>The following updates were provided by T. Reed.</p> <ul style="list-style-type: none"> • None provided. <p>The following updates were provided by C. Dang.</p> <ul style="list-style-type: none"> • The OSAB meet in May 2021 with quorum and members are working on the CISAP. • The OSAB is focused on improving access to mental health care. • The OSAB is looking to create three PIGs to address its top three (3) focus areas. There was a concern about PIG members (not current Council member) but this was clarified by T. Freitas, Oahu CMHC Branch Program Manager. • The OSAB will have new members. 			
<p>VII. State Agency Representative Reports</p> <ul style="list-style-type: none"> • Hawaii Public Housing Authority (HPHA) 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective state agency may briefly summarize agency data, agency information related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by K. Martinez:</p> <ul style="list-style-type: none"> • Opportunities for Section 8 housing are available in the Palolo Valley Homes Project area. These housing options do not include the full Section 8 community voucher but when families move into the Palolo Valley Homes Project, they are moving in with a subsidy. • All households with family members 18 years to 62 years with disability status may apply for this opportunity. The window to apply is from June 7, 2021 to June 9, 2021. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • K. Aumer asked if K. Martinez was aware of any HPHA activities for 	<p>For information only.</p>		

<ul style="list-style-type: none"> • Department of Health Child Adolescent Mental Health Division (DOH CAMHD) • Department of Human Services (DHS) MedQUEST (MQD) Division Medicaid Program • Department of Human Services (DHS) Child Welfare Services (CWS) • Department of 	<p>outreach where people live, possibly a partnership with The Queen’s Health Systems staff to post community outreach tents/tables within the housing project site and do door-to-door vaccination outreach. K. Martinez will double check and will share an update.</p> <p>The following updates were provided by S. Shimabukuro:</p> <ul style="list-style-type: none"> • None provided. <p>The following updates were provided by J. Fujii:</p> <ul style="list-style-type: none"> • None provided. <p>The following updates were provided by D. Koyanagi:</p> <ul style="list-style-type: none"> • CWS is busy with addressing mental health related issues between parents and children. There are a lot of funds available via the consolidated appropriations act. CWS must use the funds by September 2021. • At the age of 18 years, the youth is cut off from receiving CWS services but with COVID-19 response efforts, these funds are still available to use for these aged-out youth. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • E. Lau-James asked whether the funds are available for public access. D. Koyanagi stated she would double check on the criteria for eligibility and will share an update. <p>The following updates were provided by R. Pascual-Kestner:</p>			
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<p>Human Services (DHS) Division of Vocational Rehabilitation (DVR)</p>	<ul style="list-style-type: none"> • None provided. 			
<p>IX. Specialty Area Representative Reports</p> <ul style="list-style-type: none"> • Hawaii Advisory Committee on Drug Abuse and Controlled Substances (HACDACS) • Mental Health Providers 	<p>R. Ries explained that in this section of the agenda, Council members who are representing their respective specialty area may briefly summarize specialty area activities related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>He asked that oral summaries be brief and if members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next Council meeting.</p> <p>The following updates were provided by J. Fujii:</p> <ul style="list-style-type: none"> • None provided. <p>The following updates were provided by R. Ries:</p> <ul style="list-style-type: none"> • Mental health service providers continue to be overwhelmed with referrals for appointments. Some providers are having a challenging time with the overwhelming amount of requests. • He continues to see patients until 9pm-10pm in the evenings. • He is seeking a risk with the state economy, isolation and anxiety, and future shut down of services due to COVID-19 cases. • He recently did a trauma training for the Honolulu Police Department (HPD) and will do a training for the city lifeguards and ambulance workers. 	<p>For information only.</p>		

<ul style="list-style-type: none"> Parents and Family Members of Mental Health Service Recipients Student/ Youth and Consumer Advocates 	<p>The following updates were provided by H. Ilyavi:</p> <ul style="list-style-type: none"> Hawaii Island continues to see services delayed due to long waitlists for youth services. She noted that there are limited resources for summer youth activities. <p>The following updates were provided by E. Lau-James:</p> <ul style="list-style-type: none"> She attended two 2nd Tuesday NAMI Hawaii family support meetings and found that there is a lot of interest from the NAMI community. She likes hearing about resources and the Council’s work on topics that NAMI Hawaii members are also interested in. At NAMI Hawaii meetings, she shares Council updates and feels that having the Council’s website and social media resources available is helpful. She suggested the Council consider writing a letter to DOH expressing disappointment about SB1258, Relating to Telehealth, being deferred. <p>The following updates were provided by K. Aumer:</p> <ul style="list-style-type: none"> She feels that there is a need to increase education about COVID-19 vaccines and a need to continue spreading the work within the mental health community. She suggested that the Council could advocate for mental health community awareness by posting to the Council’s social media. C. Knightsbridge stated this is possible by reposting content from other social media accounts. <p>The following updates were provided by A. Beninato:</p> <ul style="list-style-type: none"> There are trust/mis-trust about how the government handles issues. On one side, there is mis-trust in government over the decisions and information that is shared. On the other hand, there are people who completely believe everything the government shares. For example, he pointed out President Nixon being caught lying which may have been a turning point in trusting government leaders. Medicine is being prescribed that can be unnecessary and detrimental. 			
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	<p>The following updates were provided by C. Knightsbridge:</p> <ul style="list-style-type: none"> • He shared information from a social worker. He will provide the information as a handout for next month’s meeting. • He feels there could be more language added to licensing laws for therapists, counselors, psychologists, advance practice registered nurses, and psychiatrists. • He feels the legislature should be held accountable for bill content. <p>The following updates were provided by N. Crozier:</p> <ul style="list-style-type: none"> • None provided. <p>The following updates were provided by T. Reed:</p> <ul style="list-style-type: none"> • None provided. 			
X. Presentation/ Guest Speaker	None scheduled.			
XI. Closing Announcements and Mahalo to Outgoing Members Whose Term Ends on June 30, 2021	<p>Council members shared the following announcements:</p> <ul style="list-style-type: none"> • R. Ries thanked C. Dang for her service as a Council member noting that she was amazing in her representation and attendance and her efforts making a position difference in the Council’s productivity. • C. Dang shared that this Council will leave a legacy and will improve access to care. She thanked Council members for informing the work she does. 	For information only.		
XII. Meeting Evaluation / Future Agenda Items	<p>R. Ries encouraged members to share their feedback about how today’s Council meeting went either by sharing them verbally or typing their feedback in the chat.</p> <ul style="list-style-type: none"> • R. Ries thanked Council members for their attention during the review of the Strategic Plan Focus Areas and the review of the Council’s bylaws. It was a lot of information to review and to make recommendations for edits. • R. Reyno Yeomans stated she feels the Council is headed in the right direction. She thanked Council members for their work. <p>The next Council meeting is scheduled for July 13, 2021 from 9:00 a.m. to</p>	For information only.		

	11:30 a.m. via Zoom.			
VI. Adjournment	The meeting was adjourned at 11:58 a.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <p>E-mail (1 of 2) with handouts (total of 7 handouts)</p> <ol style="list-style-type: none"> 1. June 2021 Meeting – Agenda 2. May 2021 Meeting – Draft Minutes 3. June 2021 Meeting – FY21 Attendance Log 4. June 2021 Meeting – Draft Thank You Letter, AMHD 5. June 2021 Meeting – Old Business Retreat (Part II), Post-Retreat Facilitator Summary 6. June 2021 Meeting – Old Business Retreat (Part II), Strategic Plan: Changes Noted from 3/9/21 Meeting 7. June 2021 Meeting – New Business SAMHSA MHBG Monitoring Request for SCMH Executive Meeting <p>E-mail (2 of 2) with handouts (total of 8 handouts)</p> <ol style="list-style-type: none"> 8. June 2021 Meeting – New Business Draft Council Membership Recruitment Letter, Judiciary 9. June 2021 Meeting – New Business Draft Council Membership Recruitment Letter, DHS MedQUEST Division 10. June 2021 Meeting – New Business Draft Council Membership Recruitment Letter, HACDACS 11. June 2021 Meeting – New Business SCMH Bylaws 12. June 2021 Meeting – PIG Reports, WSA-PIG Meeting Notes, 5/28/21 13. June 2021 Meeting – PIG Reports, LEG-PIG Draft Participation Guidelines for Council Legislative Activities 14. May 2021 Meeting – Final Thank You Letter, Ho’ōla Nā Pua 15. May 2021 Meeting – Final Thank You Letter, The Clarity Project 	For information only.		

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
July 13, 2021
9:00 a.m. – 11:30 a.m.

- Members Present: **Aumer, Katherine; Beninato, Antonino; Fujii, John; Ilyavi, Heidi; Knightsbridge, Christopher; Koyanagi, Dina; Lau-James, Eileen; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Renfro, Jennifer; Ries, Richard**
- Members Absent: **Crozier, Charleen “Naomi”**
- Members Excused: **Martinez, Beatrice “Kau’i”**
- Guests Present: **Botero, Adriana; Dang, Cynthia “Cindi”; Jackson, Richard “Rick”; McKinney, Lauren; Reyno Yeomans, Raelyn; Rivera, Renee**
- DOH Staff Present: **Haitsuka, Stacy; Nazareno, Jocelyn**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	<p>Chair R. Ries called the meeting to order at 9:01 a.m.</p> <p>Members and guests introduced themselves.</p> <p>The following definition of quorum was added to the agenda as of the November 10, 2020 meeting: Pursuant to Act 137-18 (SB 203), Chapter 92, Hawaii Revised Statutes: “(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes.</p> <p>For example, if only 15 of the entitled 21 members are appointed, at least 8 must be present to establish a quorum. To validate a council action, of</p>	For information only.		

	<p>the 9 members present, an affirmative vote from at least 5 is required.”</p> <p>Quorum was not established by 9:02am; therefore, R. Ries skipped ahead to the Community Input agenda item noting that the Council would come back to review meeting minutes when quorum was established.</p>			
<p>II. Meeting Announcements</p>	<p>R. Ries shared the following announcements:</p> <ul style="list-style-type: none"> • He thanked Council members for their understanding over the past 15 months as the Council continues to do its part to stop the spread of COVID-19 by holding its meetings virtually. Handouts are distributed electronically a week before the meeting. • He noted Governor Ige and the County Mayors have relaxed requirements for neighbor island travel and that S. Haituka and J. Nazareno will keep the Council posted of any travel related changes that affect Council meetings including any changes made by the Department of Health (DOH) for their facility use guidelines regarding resuming in-person meetings in DOH facilities as well as the lifting of the Governor’s suspension for state-funded travel. <p>For at least the next two month, for August and September, Council member should plan to participate in Council meetings virtually.</p> <ul style="list-style-type: none"> • To use our time efficiently during today’s meeting, he asked Council members and guests to follow the following basic virtual Council meeting courtesies: <ul style="list-style-type: none"> ○ Please address any comments or questions to him. ○ Members and guests may raise their “hand” virtually, type into the chat box, or orally get his attention during the meeting. ○ Waiting to be acknowledged before speaking will keep the meeting organized and audio clear for note taking purposes. • In general, only Council members are allowed to speak during the meeting, unless speaking as a presenter or sharing information during the Community Input section of the agenda. He will do his best to include and acknowledge guests when appropriate. • For Council members who take a break and step away from the meeting, please notify him before leaving as the Council needs to 	<p>For information only.</p>		

	<p>track of when Council members leave and return to verify quorum.</p> <ul style="list-style-type: none"> • If at any time a Council member has an issue with the meeting connection, please consider closing your Internet browser and rejoining the meeting by re-clicking on the Zoom link or joining by phone as an alternate option. • If not speaking, please place yourself on mute. This will help with the feedback noise and will allow for everyone to hear speaker. <ul style="list-style-type: none"> • As previously e-mailed to Council members, there was a recent change with the DOH Deputy Director (DD) for Behavioral Health Administration (BHA). Eddie Mersereau returned to his previous position as the Administrator for the Alcohol and Drug Abuse Division (ADAD). Dr. Libby Char, Director of the DOH, selected Marian Tsuji as the new DD BHA. Ms. Tsuji started her new job on June 28th. <ul style="list-style-type: none"> ○ Council members support writing a letter of appreciation to Mr. Mersereau to acknowledge the Council’s gratitude for his exceptional leadership. The Council noting that the leadership change was political and he was not punished for doing an amazing job even outside of behavioral health such as running the isolation and quarantine station. He was in the process of starting a new direction and leaders may disagreed. ○ Council members support writing a letter welcoming the new DD BHA and inviting her to a future Council meeting. <p>R. Ries shared the following Council membership updates:</p> <ul style="list-style-type: none"> • Starting this meeting, the Council welcomes new member, Jennifer Renfro. She will join the Council as the Department of Education representative. Her term will end in June 2023. • C. Knightsbridge has applied for a second term and is currently in a holdover position pending Governor Ige’s interim appointment and Senate hearing for a second term. • T. Reed has reapplied for the Maui Service Area Board representative position and her application is pending processing with the Governor’s office. • Two other Service Area Boards – Oahu and Hawaii Island – have 	<p>Draft letter for review and approval at the next meeting.</p> <p>Draft letter for review and approval at the next meeting.</p>	<p>R. Ries/ S. Haitzuka</p> <p>R. Ries/ S. Haitzuka</p>	<p>8/4/21</p> <p>8/4/21</p>
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	<p>representatives pending processing with the Governor’s office.</p> <ul style="list-style-type: none"> • Letts to the Judiciary, Human Services/MedQUEST Division and the Hawaii Advisory Committee on Drug Abuse and Controlled Substances (HACDACS) were drafted and finalized for their action. The Council will follow up in a couple months if no update is received. • To view the current Council membership, please refer to the Attendance Log for Fiscal Year (FY) 2022 in the meeting handouts. 			
<p>III. Consideration and Approval of Minutes June 8, 2021 Minutes</p>	<p>Quorum was established at 9:08 a.m.</p> <p>The draft minutes for the June 8, 2021 meeting were reviewed.</p> <p>The following amendments were requested:</p> <ul style="list-style-type: none"> • None. <p>C. Knightsbridge made a motion for the meeting minutes from the April 13, 2021 meeting be approved as amended. K. Aumer seconded the motion.</p>	<p>Motion passed unanimously.</p>		
<p>IV. Community Input</p>	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p> <p>R. Rivera shared the following Hawaii Service Area Board (HSAB) updates:</p> <ul style="list-style-type: none"> • The HSAB used information from its recently completed Comprehensive Integrated Service Area Plan (CISAP) to make a one page document sharing who the HSAB is, who they serve. • The HSAB discussed creating an unofficial HSAB Facebook page. • HSAB members identified every substance abuse and mental health service provider on Hawaii Island and plans to reach out to each provider to understand the services provided and to invite the provider to attend HSAB meetings. So far, responses have been great. A treatment center in Hakalau shared a presentation about their organization at a recent HSAB meeting. A presentation from Bay Clinic Ho’oponopono staff will be scheduled soon. • There are several individuals interested in applying for the HSAB. 			

	<p>L. McKinney shared the following concerns:</p> <ul style="list-style-type: none"> • She is a private practice licensed marriage and family therapist (LMFT) and a certified substance abuse counselor (CSAC) specializing in addiction treatment. She lives on Maui and sees patients statewide. • She is concerned about hospitalizations for mental health treatment. Emergency Department (ED) staff do not treat addiction when a patient presents in the ED with signs of addiction and overdose as well as mental illness. • She expressed frustration about the process, noting, “it’s like pulling teeth” to get ED staff to admit patients who need help. • She believes there is a need for more mental health education and training to ED staff. • She stated that calling the police or Hawaii CARES results in her, as a provider, not knowing the outcome of the referral. For example, if the patient she is referring meets criteria or acuity for acute care. She doesn’t know because she doesn’t receive a call back or update. • She has had to “coach” patients through the ED evaluation and screening process. • In one particular case, she provided crisis intervention and confirmed there was active suicidal ideation for a week and a suicide attempt. The patient was actively overdosing. She called 911 but the patient was not hospitalized. The patient voluntarily presented at the ED; however, ED staff said the patient was stable at the time of presentation. Therefore, no hospital admission. Unfortunately, the patient was not offered prescription medication. Instead, the patient was placed in a back hospital room for 14 hours and was released without appropriate care. The patient then hurt someone, is now facing criminal charges and has threatened suicide again. • Sadly, she has been hung up on by hospital staff because she has called multiple times to advocate for her patients. • She is appreciative of the clinicians she knows on Maui who provided assistance. • She wants to call attention to the failure of the system and the tremendous lack of education amongst ED staff. 			
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	<p>Council members responded to L. McKinney with the following comments:</p> <ul style="list-style-type: none"> • T. Reed asked whether L. McKinney has the information about the client to assist in reviewing the situation to identify where the breakdowns were. T. Reed invited L. McKinney to a future Maui Service Area Board meeting to discuss this topic further. • R. Ries sounds like a terrible failure of the system. Knowing we have a shortage of mental health clinicians, it would be great to have funding available to provide training. • R. Ries suggested the Council may want to explore this topic further possibly as a future Council agenda for further discussion to identify what is in place and determine whether the Council will want to take a formal position. <p>R. Reyno Yeomans shared the following concerns:</p> <ul style="list-style-type: none"> • She is attending Mental Health Task Force meetings in addition to State Council on Mental Health meetings. She attends Kailua Neighborhood Board meetings to make sure she is getting the word out about task force and Council discussions and ensuring that legislators know of these issues. • She also posts updates to social media. • She is aware that patients needing a mental health related appointment are experiencing long wait times. <p>R. Jackson shared the following Oahu Service Area Board (OSAB) updates:</p> <ul style="list-style-type: none"> • The OSAB met last month with quorum. • He observes that OSAB members work well together. • At the last meeting, there was discussion about Crisis Intervention Teams (CIT). The focus is on linking someone who is mentally ill with timely crisis intervention. There needs to be a streamlined way to call for help and for police to be dispatched to determine the person's status. The recommendation is to have at least one police officer available each shift to assist mental health professionals on that shift. There will be training scheduled for Honolulu Police Department (HPD) officers at the HPD Training Academy in Waipahu sometime in September 2021. NAMI Hawaii has the information for 	<p>Add to a future Council agenda.</p>	<p>R. Ries/ S. Haitzuka</p>	<p>8/2/21</p>
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	<p>the training. Years ago, he recalls assisting HPD with officer recruit training at the academy.</p> <ul style="list-style-type: none"> • R. Jackson stated he will be starting his seventh four-year term at 69 years young. He joined the OSAB to improve mental health services for all in Hawaii. • He thought Oprah and Prince Harry’s documentary “The Me You Can See” was well produced. He recommends Council members check it out. They were produced in five (5) one-hour segments. <p>Council members responded to R. Jackson with the following comments:</p> <ul style="list-style-type: none"> • E. Lau-James commented that there is a general agreement that police need a CIT program and public awareness is needed. Council members need to be a loudspeaker about this program as well. • T. Reed noted that she participates on Maui’s CIT via Mental Health America Hawaii. • R. Ries thought it was a good idea for Council members to advocate for CIT but also wants Council members to advocate for the resiliency of first responders. • C. Knightsbridge asked what are the current barriers to treatment? R. Jackson identified stigma, and some administrative processes can be barriers. <p>R. Reyno Yeomans added that:</p> <ul style="list-style-type: none"> • Anton Krucky, Executive Director of the Mayor’s Office of Housing (CLICK HERE for website) is working on a Crisis Outreach, Response and Engagement (CORE) Program that diverts 911 calls so HPD is not involved (CLICK HERE for Hawaii CORE article). Hawaii’s CORE Program is modeled after Denver’s Support Team Assistance Response (STAR) Program (CLICK HERE for Denver STAR webpage). <p>She noted that Denver’s STAR Program diverted 748 calls in the first six (6) months with no police involvement and no arrests. Oregon’s Crisis Assistance Helping Out On The Streets (CAHOOTS) Program responded to 24,000 calls in 2019 of which only 311 calls required police backup (CLICK HERE for Oregon CAHOOTS webpage).</p>			
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	<p>She believes the Hawaii CORE Program being rolled out in the downtown/Chinatown area on Oahu could be great to get people help without involving police.</p>			
<p>V. Old Business</p> <ul style="list-style-type: none"> • Strategic Plan Review and Discussion of Focus Areas #1-7 and Accompanying Action Plan Items 	<p>R. Ries noted that anytime the Council has a new business agenda item that needs to be continued to the next month’s meeting, the Council will have those agenda items listed the following month as Old Business agenda items.</p> <p>As a recap, R. Ries noted several main points regarding the Council’s Strategic Plan:</p> <ul style="list-style-type: none"> • The Council develops a Strategic Plan every two years. • This plan helps guide Council activities and is based on areas related to mental health in Hawaii that the Council feels it can address. • For our FY2020-2022 Strategic Plan, we got a late start due to the COVID-19 pandemic, but the Council was able to meet with Karen Oliver, Council Retreat facilitator for two sessions (November 2020 and February 2021). • At the Council’s March 2021 meeting, we started reviewing the initial draft to make revisions as needed. • At the Council’s June 2021 meeting, we made excellent headway by reviewing each of the seven Focus Areas and noting which ones needed updating and acknowledging potential Focus Areas that the Council will likely need to create a Permitted Interaction Group (PIG) to address. • In our meeting handouts for today, we have a revised draft of our Strategic Plan that incorporates the changes we identified as well as an accompanying draft Action Plan that will help us to accomplish each of the objectives we’ve listed on the Strategic Plan. • A third related handout is a one page sheet that identifies Council members who have expressed interest in joining a PIG. It is included in the meeting handouts for today’s meeting. • Our goal for today’s meeting is to share feedback and final edits. If possible, we would like to adopt our Strategic Plan and Action Plan as revised knowing we are using them as working documents that help guide our activities for the rest of FY2022. We will be able to 			

	<p>revise the document as we begin implementing our objectives.</p> <p>Focus Area #1: Improving Access to Mental Health Services (existing and new)</p> <ul style="list-style-type: none"> • R. Ries noted we had challenges completing our annual narrative reports in the past; however, we have articulated our preference for the Council’s section of the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature, including island/County-based highlights. • R. Ries recalled the Council has had practice composing a letter to the DD BHA and we look forward to being introduced to and talking story with Ms. Tsuji in future Council meetings. • R. Ries stated his feedback is that the two outcomes/products listed above the measurable objectives are very achievable in his opinion and the objectives clarify what we want to accomplish and by when. <p>Focus Area #2: Advocate for the Emotional Well-Being of the Community</p> <ul style="list-style-type: none"> • R. Ries noted the Council has a lot of opportunity with this Focus Area to promote mental health awareness in our communities and this Focus Area is a solid step for us to look at how we are connecting and sharing information. • R. Ries commented that forming a Wellness Brochure PIG sounds reasonable to help with researching and developing content for the brochure. • R. Ries mentioned the Council could address mental health of first responders and essential workers within this Focus Area. <p>Focus Area #3: Identify Tools the Council is Empowered to Use</p> <ul style="list-style-type: none"> • R. Ries stated that the Infographic PIG would focus their discussions around identifying tools and resources, prioritizing them and being creative with drafting a one-page infographic. • C. Knightsbridge asked how the Infographic PIGs information would be shared with others. R. Ries suggested it could be distributed when Council members interact with people in their communities. • A. Beninato noted that he is working on a personal project that involves field research and obtaining video footage for editing and 			
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	<p>sharing in future media posts.</p> <p>Focus Area #4: Outline an Onboarding and Annual Reboarding Experience for Council Members</p> <ul style="list-style-type: none"> • R. Ries looks forward to seeing what the onboarding and reboarding PIG comes up with. <p>Focus Area #5: Strengthen the Council’s Presence as Advocates to DOH Leadership, inclusive of input from Neighbor Island Stakeholders and Service Area Board Members</p> <ul style="list-style-type: none"> • R. Ries commented that the Council has identified the Mental Health Task Force in the outcomes/products for this Focus Area. The link in with Measurable Objective 5.2 describes how the Council knows if it has achieved this Objective by obtaining and distributing minutes to Council members. For the Mental Health Task Force meetings, copies of agendas and meeting notes can be requested through Bryan Talisayan, Executive Director for Mental Health America or Trish Kajimura, when she has transitioned to her new career role. • R. Ries noted that Council meeting minutes document our efforts to advocate through our monthly standing agenda items so each Council member may report their efforts and activities related to mental health. He suggested using a template to prompt Council members to mention mental health related updates when it is our turn on the agenda. That way, we would remember to share about how we have participated in the last month relative to mental health activities. He noted it is also okay, in lieu of an oral update, to submit a written report at least 10 days prior to the Council meeting so that it can be shared as a meeting handout when S. Haitsuka e-mails us with the agenda • C. Knightsbridge asked if Council members could be provided with a Council business card. R. Ries expressed openness to explore this request and to ask if funding is available. <p>Focus Area #6: Share Information on the Council’s Website About Existing Mental Health Services (Local/State/Federal)</p> <ul style="list-style-type: none"> • R. Ries noted for this Focus Area, the current Website, Social Media, 			
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	<p>and Advocacy PIG will be dissolved and a new website and social media PIG will be formed as noted in Objective 6.1. He also noted the scope of the new Website and Social Media PIG (WSM PIG) is narrower which could be an advantage to help the WSM PIG be successful in completing short-term achievable tasks assigned by the Council.</p> <p>Focus Area #7: Identify, Track, and Share the Status of DOH Behavioral Health Administration (BHA) Legislative Bills including Adult Mental Health, Child Adolescent Mental Health, and Alcohol and Drug Abuse Divisions</p> <ul style="list-style-type: none"> R. Ries noted the Council modified this Focus Area by re-focusing on the Council’s legislative priorities rather than specifically targeting the DOH BHA’s priorities. He feels this Focus Area is now more relatable and controllable for the Council to manage. Adding a second outcome/product stating the Council will produce its legislative priority bill list and have it shared with the DD BHA, the Mental Health Task Force and other mental health advocacy groups for whom Council members are affiliated would be a nice tie in. Related would be adding an Objective 7.5 that speaks to the Council receiving a copy of the DOH BHA’s legislative priority bills as well as a copy of the Mental Health Task Force’s legislative priority bills. <p>Council members shared closing comments regarding this agenda item:</p> <ul style="list-style-type: none"> E. Lau-James is excited about the Council’s Strategic Plan and wants to get members assigned to Focus Areas to start working on the Objectives. R. Ries noted that the Strategic Plan will be used as a working document that helps guide the Council’s activities for the rest of FY2022 and it can be updated when needed. <p>E. Lau-James made a motion to accept the Council’s FY2020 – 2022 Strategic Plan as revised. C. Knightsbridge seconded the motion.</p> <p>R. Ries asked S. Haitzuka to prepare the final version of the Strategic Plan documents for Council members to keep for their reference.</p>	<p>Motion passed unanimously.</p> <p>Create final versions of the Strategic Plan</p>	<p>S. Haitzuka</p>	<p>8/4/21</p>
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<ul style="list-style-type: none"> • Council Bylaw Review and Revisions 	<p>As a recap, R. Ries noted some main points regarding the Council Bylaws:</p> <ul style="list-style-type: none"> • The Council is responsible for periodically reviewing and revising its bylaws. • We put this item on the agenda for the last few meetings; however, it was only at the Council’s June 2021 meeting that we were able to devote the time and attention needed to systematically review our bylaws and propose edits. • In today’s meeting handouts, we have a draft of our bylaws with tracked changes in red noting the content we identified as possible revisions. • We agreed to discuss these changes at today’s meeting. • Our goal for today’s meeting is to share feedback and final edits. If possible, we would like to adopt a final version of our edited bylaws. <p>Bylaw header</p> <ul style="list-style-type: none"> • R. Ries noted that the hyphen in bylaws was removed in the header and throughout the document and the current date was added. <p>Article I: Name</p> <ul style="list-style-type: none"> • R. Ries noted that “Hawaii” was inserted into this Article and was reflected in our Council name at the top header of this document on every page. <p>Article II: Purpose</p> <ul style="list-style-type: none"> • R. Ries pointed out that the Council revised the purpose statement to include three sub-parts. The purpose statement now articulates our commitment to: <ul style="list-style-type: none"> ○ Advising agencies and policy makers; ○ Advocating for the mental health needs in each County and in partnership with the County Service Area Boards on Mental Health and Substance Abuse; and ○ Representing mental health service recipients in our communities. 	<p>documents and distribute.</p>		
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	<p>Article III: Responsibilities</p> <ul style="list-style-type: none"> • R. Ries noted some technical revisions were made to this Article. • T. Reed noted she wrote in her notes about adding “advisor to the Governor and Legislature”. This is noted in the minutes on page 14. This is not included in the draft. <ul style="list-style-type: none"> ○ S. Haitsuka stated this statement was not added due to not having the citation stating this language is in written in law. ○ C. Knightsbridge mentioned in the June meeting that he would send the citation to S. Haitsuka. He is currently still looking for the citation and will share it when he finds it. ○ S. Haitsuka stated administratively, the Council is attached to the DOH. In its advisory capacity, the Council advises the Governor through the DOH. <p>NOTE: The DOH, through its Behavioral Health Administration (BHA) is the state mental health authority and is statutorily mandated to assure a comprehensive statewide behavioral health care system by leveraging and coordinating public, private and community resources.</p> <ul style="list-style-type: none"> ○ K. Aumer offered §11-175-3, Hawaii Revised Statutes. She noted in b.1. it states, “advise the department” and in b.5. it states, “prepare and submit an annual report to the Governor.” ○ R. Ries noted historically, the Council has not had an audience directly with the Governor emphasizing that he has not tapped into the Council as an advisory body to him. Rather, the Council is meant to be a voice of the community. ○ C. Knightsbridge states he does not want the Council to be “just an advisory board to the DOH.” R. Ries and E. Lau-James affirmed the Council is not just a pawn for the DOH. ○ E. Lau-James emphasized that she doesn’t think a community member or legislator will look at the Council’s bylaws say it doesn’t include “the Governor”; the Council knows who we are and while the wording may be vague, it is sufficient. ○ C. Knightsbridge stated his agreement that the bylaws are for 			
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	<p>the Council’s self-governance.</p> <p>Article IV: Membership</p> <ul style="list-style-type: none"> • R. Ries noted several technical revisions were made to this Article. The membership description listed here now mirrors the areas of representation listed on our attendance log. • R. Ries noted that clarification for “holdover” and “interim” membership was added. • R. Ries pointed out that PIGs were added to recognize they are distinct from a committee. • R. Ries noted that statement 5.g under vacancies was deleted because it was redundant and exactly duplicative. • R. Ries mentioned that clarification under attendance was added. Immediately after the SECOND consecutive unattended and unexcused absence, a members’ term shall expire. • R. Ries suggested adding “contact” may be made in writing via e-mail to the Council’s e-mail address: DOH.SCMHChairperson@doh.hawaii.gov or via telephone to the designated Council support staff which could change in the future but for now, our support staff are AMHD employees – S. Haitsuka and J. Nazareno. <p>V: Meetings</p> <ul style="list-style-type: none"> • R. Ries explained that currently, Council meetings are two and one half (2.5) hours in duration; however, it is a fact that meetings almost always go past that time. This is why the suggestion is here in this section to change the meetings to three (3) hours instead. He mentioned last month that as the Council Chairperson, he has felt there were many times when he has had to rush the Council through agenda items and rushing has made the Council less reflective in addressing agenda items. • R. Ries noted this section clarifies how meeting agendas are distributed as e-mail (first preference) or postal mail (secondary option if the Council member or stakeholder does not have e-mail or requests physical copies be printed and mailed). • R. Ries noted this section clarifies passing of motions consistent 			
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	<p>with current Hawaii law and noted on page one of the minutes.</p> <p>Article VI: Officers</p> <ul style="list-style-type: none"> R. Ries noted that clarification was made for the nomination process as well as technical revisions. <p>Article VII: Committees</p> <ul style="list-style-type: none"> R. Ries noted technical revisions were made by revising the title of this Article to include PIGs and inserted PIGs throughout. <p>Article VIII: Conflicts of Interest</p> <ul style="list-style-type: none"> R. Ries noted there was one technical revision made on the last page to align the language with the language in previous Articles. <p>Article IX: Amendment of Bylaws</p> <ul style="list-style-type: none"> R. Ries noted technical revisions were made in this Article as well to align the language with language in previous Articles. <p>Article X: Liabilities</p> <ul style="list-style-type: none"> R. Ries noted there were no changes recommended for this Article. <p>E. Lau-James made a motion to accept the Council’s Bylaws as revised. T. Reed seconded the motion.</p> <p>R. Ries asked S. Haitzuka to prepare the final version of the bylaw document for Council members to keep for their reference.</p>	<p>Ayes (11); Noes (0); Abstentions (0)</p> <p>Motion passed unanimously.</p> <p>Create final version of the bylaws documents and distribute.</p>	<p>S. Haitzuka</p>	<p>8/4/21</p>
<p>VI. New Business</p> <ul style="list-style-type: none"> Action Steps for Strategic Plan Implementation 	<p>R. Ries asked Council members to review the Action Plan for the Council’s Strategic Plan implementation. A copy was included in today’s meeting handouts.</p> <ul style="list-style-type: none"> He noted the Action Plan is also a working document. It pulls out the 			

	<p>Objectives and strategies to help us focus on what parts of each Focus Area need attention and some form of action.</p> <ul style="list-style-type: none"> • He also noted, for the most part, he is okay with the revised version of the Action Plan and is okay with the action steps. <p>He stated S. Haitsuka and J. Nazareno could help to cross check the Action Plan one more time to make sure changes based on the Strategic Plan Focus Areas are reflected.</p> <p>R. Ries asked Council members to review the Strategic Plan handout with the chart showing the Focus Areas that Council members are interested in being appointed to. A copy was included in today’s meeting handouts.</p> <p>As a recap, R. Ries noted the following comments regarding forming PIGs:</p> <ul style="list-style-type: none"> • He acknowledged from the Council’s March 2021 meeting, E. Lau-James expressing strong support for creating a PIG for all seven of our Strategic Plan Focus Areas. • He noted that E. Lau-James, during our Council Retreat, encouraged each Council member to sign up for at least one (1) PIG of their choice. He reiterated his support for Council members signing up for at least one (1) PIG. • He noted it seems logical to want to create a PIG for each of the seven Focus Areas. On the one hand, creating a PIG for all seven Focus Areas could potentially allow for more time to discuss and work on the Objectives. On the other hand, it could be that we need to prioritize creating PIGs to work on Focus Areas that have specific, and short-term deliverables and defer other Focus Areas that can be addressed as a whole Council. • He asked the Council to take into consideration the time it takes to organize PIG meetings and staff support for these meetings. The Council has S. Haitsuka and J. Nazareno to assist but they are unfortunately not full-time staff to the Council. • Additionally, he noted historically, seeing the challenges of scheduling meetings for the three PIGs we have had in the past year, scheduling has been extremely challenging for Council members to (1) reply to e-mail requests for scheduling and (2) attend PIG 			
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meetings when scheduled.

In summary, Focus Areas with a recommendation for forming a new PIG:

- Focus Areas #2, 3, 4, 6 and 7
- No PIG is recommended for Focus Areas #1, 5

Below is the status of Council members who are interested in being appointed to the PIGs for Focus Area #2, 3, 4, 6, and 7.

State Council on Mental Health
Strategic Plan Focus Area - Preliminary Council Member Participation Tracking Sheet
(XX are as noted in the July 13, 2021 Council meeting)

Council Member Name	Focus Area #1	Focus Area #2	Focus Area #3	Focus Area #4	Focus Area #5	Focus Area #6	Focus Area #7	Total # of Focus Areas per Council Member
1 Aumer, Katherine		XX					XX	2
2 Beninato, Antonino		XX						1
3 Crozier, Charleen "Naomi"								0
4 Fujii, John		XX				XX		2
5 Ilyavi, Heidi			XX			XX		2
6 Knightsbridge, Christopher		XX	XX			XX	XX	4
7 Koyanagi, Dina			XX					1
8 Lau-James, Eileen			XX	XX			XX	3
9 Martinez, Beatrice "Kau'i"				XX				1
10 Pascual-Kestner, Rusnell "Rus"						XX	XX	2
11 Reed, Tara			XX	XX			XX	3
12 Renfro, Jennifer		XX					XX	2
13 Ries, Richard		XX					XX	2

Council members shared closing comments regarding this agenda item:

- E. Lau-James is excited about the Strategic Plan and to start working on the Objectives.

VII. Permitted Interaction Group (PIG) Reports

In this section of the agenda, PIG members may briefly summarize the PIG activities since the last Council meeting including meeting dates, discussions, and recommendations on topics approved at previous Council meetings.

If PIG members would like to share a longer report, please e-mail it to Stacy no less than 10 calendar days prior to the next meeting.

- PIG for Website,

WSA-PIG members include C. Knightsbridge, H. Ilyavi and R. Pascual-Kestner. C. Knightsbridge is the WSA-PIG lead.

<p>Social Media, and Advocacy (WSA)</p>	<p>The WSA-PIG did not meet last month but as a recap, they provided the Council with two recommendations which we voted and approved. The recommendations related to the posting of the resources and behavioral health related activities to the State Council website and being able to add resources and activities without Council approval if the primary purpose of the resource item or monthly activity is related to behavioral health/mental health/substance abuse.</p> <p>R. Ries noted that S. Haituka is coordinating the website changes and will update the Council when content has been added.</p> <p>At this time, R. Ries recommended that the Council support its Strategic Plan Focus Area #6, Measurable Objective 6.5 and dissolve the current WSA-PIG today and form a new Website and Social Media PIG (WSM PIG).</p> <p>C. Knightsbridge motioned to dissolve the WSA-PIG as of today. E. Lau-James seconded the motion.</p> <p>The new WSM PIG will be responsible for coordinating the sharing of information on the Council’s website about existing mental health services (local/state/federal).</p> <p>According to the Strategic Plan handout with the chart showing the Focus Areas that Council members are interested in being appointed to, there are four (4) Council members interested in joining the new WSA PIG.</p> <ul style="list-style-type: none"> • J. Fujii, R. Pascual-Kestner, H. Ilyavi and C. Knightsbridge <p>E. Lau-James made a motion to create a new WSA PIG and to appoint J. . Fujii, R. Pascual-Kestner, H. Ilyavi and C. Knightsbridge to the WSA PIG. T. Reed seconded the motion.</p> <p>R. Ries stated the Council can discuss short-term tasks that this new WSA PIG will work on at the next Council meeting.</p>	<p>Motion passed unanimously.</p> <p>Motion passed unanimously.</p>		
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<p>VIII. Island Representative Reports</p> <ul style="list-style-type: none"> Maui Service Area Board (MSAB) 	<p>In this section of the agenda, Council members who are representing their respective Service Area Board may briefly summarize their board meetings and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>If members would like to share a longer Service Area Board report, please e-mail it to Stacy no less than 10 calendar days prior to the next meeting.</p> <p>T. Reed shared the following updates:</p> <ul style="list-style-type: none"> Maui prosecutor’s office is creating a community court program. This program is a collaboration with the Hawaii State Judiciary and will offer amnesty for people that turn themselves in voluntarily. 	<p>For information only.</p>		
<p>VII. State Agency Representative Reports</p> <ul style="list-style-type: none"> Hawaii Public Housing Authority (HPHA) Department of Human Services (DHS) MedQUEST (MQD) Division Medicaid Program 	<p>In this section of the agenda, Council members who are representing their respective state agency may briefly summarize agency data, agency information related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>If members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next meeting.</p> <p>K. Martinez shared the following updates:</p> <ul style="list-style-type: none"> None provided. <p>J. Fujii shared the following updates:</p> <ul style="list-style-type: none"> DHS MQD has a 1.25% profit margin for their health insurers/contractors. Medicaid was a fee-for-service (FFS) plan until 1994. As a result, Medicaid is provided at no cost to members. If Hawaii were to go back to a Medicaid FFS model, services would be paid out-of-pocket (like paying to a veterinarian for animal care services) versus how payment are now spread out with a co-pay and health insurance coverage options. All policies for admission/non-admission criteria are set by Medical 	<p>For information only.</p>		

<ul style="list-style-type: none"> Department of Human Services (DHS) Child Welfare Services (CWS) 	<p>Directors and clinicians. For DHS MQD, Dr. Chad Koyanagi is the physician who reviews and approves the policy.</p> <ul style="list-style-type: none"> DHS MQD is making comparisons between physical and mental health care and services in a matrix for behavioral health parity. For example, if there is a 10 day limit on physical health, in the comparable service for mental health, is the day limit the same, more or less? Goal is to create a level playing field. Reports are submitted to federal regulators. Medicaid is the payor of last resort. The federal/state match is about 53-54% for federal and 46-47% for the Hawaii cost-share. There are issues around service delivery and quality. Looking at prior authorizations ensures services are available based on need. If the Medicaid fee is increased, there could be more funds available to pay for services. This could result in a boost in availability of services but it also means an increase in costs. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> R. Ries stated that he doesn't think the intent is to slice off or get rid of Medicaid as it exists now, but the interest is in prioritizing access to quality mental health services. R. Ries is interested in seeing the report showing parity comparison for various services. E. Lau-James asked how DHS MQD is addressing shortages of providers. J. Fujii noted that while flying members over to Oahu from Neighbor Islands to receive services is expensive it is not a long-term solution. Regarding shortage of providers and services, DHS MQD recognizes there is a shortage especially for mental health professionals on Neighbor Islands. <p>D. Koyanagi shared the following updates:</p> <ul style="list-style-type: none"> CWS is experiencing a shift in management due to staff retirements. She has observed adolescents with mental health challenges needing to access services. CWS has flown youth from Neighbor Islands to Oahu so they can access crisis services at the Waipahu crisis shelter facility. 			
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<ul style="list-style-type: none"> Department of Human Services (DHS) Division of Vocational Rehabilitation (DVR) 	<p>R. Pascual-Kestner shared the following updates:</p> <ul style="list-style-type: none"> He’s been asked by the DHS Administrator to look at creating a formal agreement with DOH for mutual service participants. He is looking to form a task force to partner with Neighbor Islands to assess gaps in resources. He has a concern about working on a contract and being a Council member. He is not sure if there is a conflict. 			
<ul style="list-style-type: none"> Department of Education (DOE) Student Services Branch (SSB) 	<p>J. Renfro shared the following updates:</p> <ul style="list-style-type: none"> She introduced herself and shared about her background. <ul style="list-style-type: none"> She is the Administrator in the Student Support Section (SSS) within the Office of Student Support Services (OSSS). The SSS coordinates the DOE’s services for school-based behavioral health, counseling, 13 federal programs mainly focusing on vulnerable populations such as homeless and English Language (ESL). The SSS works closely with the Exceptional Students Branch which coordinates special education and 504 services. She has been in Hawaii for five (5) years and is excited and honored to serve on the Council. She is from the Southeast area of Texas, about 30 miles from the Louisiana border. In the last five (5) years, the DOE OSSS has shifted, and the COVID-19 pandemic has fast forwarded, its prioritization of student whole wellbeing inclusive of mental health and social-emotional learning (SEL). HIDOE is not just about math, reading and writing. HIDOE used to provide services under a HNTSS support model focusing on prevention, intervention and postvention. In hindsight, in order to create a full array of support, they realized they need to promote mental health support as well. Regarding substance abuse and going into the Emergency Department (ED) for admission. Her understanding is that to be admitted with a high level of alcohol, the ED does not provide detox but, for admission, if patient indicates their alcohol abuse is paired with suicidal ideation, the ED will consider admission under risk criteria “hard to self.” She recognizes there is a huge discrepancy 			

	<p>regarding this advocacy and ED admission criteria. Unless the person indicates they are harming themselves in a lethal way, presenting with only substance use or alcohol abuse, it's difficult to get admitted for treatment.</p> <ul style="list-style-type: none"> • DOE is aware and is mindful of its responsibility to assist children and their 'ohana with trauma-informed practices and strategies. Trauma-informed grant funding via the Hawaii Department of Education (HI DOE) for \$5M will be used for students to get assessed for needing therapeutic services and referring students who need services to a provider. The DOE is in the process of contracting for this direct care service. • DOE recognizes there is a need to empower school staff to know how to help support students. This is being addressed via trauma-informed staff development through a statewide vendor list for trainers. This statewide vendor list may be helpful because the DOE will not need to go through the entire procurement process which is sometimes seen as a barrier to acquiring state contracted services. • DOE is working on integrating school counselors for behavioral health, SEL, and support for whole-child mental health. • The Hawaii Keiki Hotline is a partnership with the University of Hawaii and the DOH. Through the hotline, callers can be screened and if there is a need for mental health support, the hotline staff can contact the DOE complex school-based behavioral health staff. CLICK HERE for more information. • DOE expanded positions statewide to reach out to the Micronesian and Pacific Island populations to address trauma and mental health needs and concerns related to their transition to Hawaii. DOE will arrange for native language speakers to arrange for state-level interpreters to help with the DOE School Based Behavioral Health (SBBH) Program and homeless outreach coordinators. • She emphasizes that the DOE cannot do everything and doesn't have everything exactly perfect. DOE recognizes they need to partner with other agencies and it's important to not work in silos. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • C. Knightsbridge asked if there is a support program for teachers. 			
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	<p>J. Renfro acknowledged that all state employees have access to the REACH Program (CLICK HERE for more information). She noted with HI DOE Title IX services, HI DOE has had to provide information about teachers regarding harassment and arranged for direct intervention and support. Trauma-informed care is not limited to students or to a single episode. It has to do with the resiliency of the person and events can affect people differently. The HI DOE has had conversations about how to address trauma supports for faculty.</p> <ul style="list-style-type: none"> • R. Ries commented about the need to support educators as they may be experiencing trauma and stress related to the COVID-19 pandemic and school related changes. 			
<p>IX. Specialty Area Representative Reports</p> <ul style="list-style-type: none"> • Hawaii Advisory Committee on Drug Abuse and Controlled Substances (HACDACS) • Mental Health Providers 	<p>In this section of the agenda, Council members who are representing their respective specialty area may briefly summarize specialty area activities related to behavioral health and when applicable, share updates on requested items identified at previous Council meetings.</p> <p>If members would like to share a longer state agency report, please e-mail it to Stacy no less than 10 calendar days prior to the next meeting.</p> <p>J. Fujii shared the following updates:</p> <ul style="list-style-type: none"> • HACDACS heard from speakers advocating for legislation related to legalizing recreational cannabis. • One area that HACDACS is looking into is the Hawaii CARES program and access to substance abuse, mental health and crisis services. • Minutes from recent HACDACS meetings were shared in today’s meeting handouts. <p>R. Ries shared the following updates:</p> <ul style="list-style-type: none"> • He continues to see as many patients as he can, often working extra long day/evening and weekend hours to accommodate new patients who are in need of support and sometimes does not finish his workday until after 10:00 p.m. • He has had to decline referrals from insurance companies because 	<p>For information only.</p>		

<ul style="list-style-type: none"> Parents and Family Members of Mental Health Service Recipients 	<p>he is full but they consistently contact him to inquire about additional referrals.</p> <ul style="list-style-type: none"> He has heard from colleagues that they are feeling burnt out and he is also trying not to get burnt out. Mental health self-care is important for everyone! He is concerned about the impacts of opening Hawaii’s economy. There is good news for businesses but sometimes there’s negative health effects that are not always readily observed. <p>H. Ilyavi shared the following updates:</p> <ul style="list-style-type: none"> Hawaii Island continues to see services delayed due to long waitlists for youth services. There is a great need for immediate access to services. The response time is too long. She noted there are many parents who are still seeking services for their children. She is aware of children who are going to the hospital and are waiting for telepsychiatry services. Sometimes, they have to stay overnight and wait until services are available. <p>E. Lau-James shared the following updates:</p> <ul style="list-style-type: none"> She attended NAMI Hawaii meetings with other family members. She speak with L. McKinney who spoke to the Council today. Family members want to participate in the system and help their loved ones. She encourages family members to write letters and join meetings to advocate for loved ones. One soundbite she mentions to people is that she sees the Council and sees family members as part of government action as advisors to government. Hospitalizing someone with mental illness is challenging. It’s critical to emphasize in our advocacy that mental health care should be prioritized and heightened as there is a community risk if mental health is not treated in a timely and appropriate manner. She mentioned her son needing to go to the emergency room and he would not have received appropriate treatment if she did not push for further treatment prior to her son being sent home. 			
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<ul style="list-style-type: none"> • Student/ Youth and Consumer Advocates 	<ul style="list-style-type: none"> • She mentioned her family member has also had to wait to get services and he was having a medical emergency. • As a cat veterinarian, she is accountable to the payor (cat owner) just as the healthcare system is accountable to the insurance company/insurer (not the patient). She doesn't have to ask permission from an insurance company. She can order the necessary treatment and testing that she deems is appropriate for the cat's situation. It's horrific to know that the doctors' hands are bound by these rules that do not allow them to make decisions about what they can and cannot authorize and under what circumstances they can order treatment and testing. <p>Council members shared the following comments:</p> <ul style="list-style-type: none"> • J. Fujii acknowledge that regarding poor medical treatment, family members sometimes have to advocate for their loved one's care. He has had a family member recently need emergency medical care and he has had to advocate for their care with the clinicians. • J. Fujii noted that sometimes care is offered/provided inappropriately or sometimes people go without care. Both of these scenarios are unacceptable. <p>K. Aumer shared the following updates:</p> <ul style="list-style-type: none"> • She is concerned about people who are coming out of isolation. During the COVID-19 pandemic there has been an increase in isolation. People have been resourceful in obtaining information, sometimes going online or hearing information from various media sources. Sometimes, people were getting a lot of information that informed their decisions in ways that were not so positive. • There is a need to be aware of times of isolation. When looking to connect with other people or resources, there is a potential for negative health outcomes, such as misinformation. <p>A. Beninato shared the following updates:</p> <ul style="list-style-type: none"> • He sees a disconnect between what services say they will do and what services they actually provide. • He speaks to members in his community and specifically in the 			
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	<p>Native Hawaiian community. One person he spoke with expressed frustration that government is ineffective and there is a concern that there is a generalized lack of accountability.</p> <ul style="list-style-type: none"> • Important to recognize personal responsibility and choices. It is the person’s responsibility to make choices that are positive and it’s not up to the government to force the person to decide. <p>C. Knightsbridge shared the following updates:</p> <ul style="list-style-type: none"> • None provided. <p>N. Crozier shared the following updates:</p> <ul style="list-style-type: none"> • None provided. <p>T. Reed shared the following updates:</p> <ul style="list-style-type: none"> • None provided. 			
X. Presentation/ Guest Speaker	None scheduled.			
XI. Closing Announcements	<p>Council members shared the following announcements:</p> <ul style="list-style-type: none"> • R. Ries reminded Council members of the upcoming Council Executive Meeting scheduled for Tuesday, July 27, 2021 from 10:00 a.m. to 12:30 p.m. via Zoom. Meeting information can be found on page two (2) of today’s meeting agenda. 	For information only.		
XII. Meeting Evaluation / Future Agenda Items	<p>R. Ries encouraged members to share their feedback about how today’s Council meeting went either by sharing them verbally or typing their feedback in the chat.</p> <ul style="list-style-type: none"> • R. Ries thanked Council members for doing a final review and adopting the Council’s Strategic Plan Focus Areas and bylaws. <p>The next Council meeting is scheduled for August 10, 2021 from 9:00 a.m. to 12:00 p.m. via Zoom. Note the Council’s need meeting end time..</p>	For information only.		
VI. Adjournment	The meeting was adjourned at 11:28 a.m.	For information only.		

Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <p>E-mail (1 of 3) with handouts (total of 8 handouts)</p> <ol style="list-style-type: none"> 1. July 2021 Meeting – Agenda 2. June 2021 Meeting – Draft Minutes 3. July 2021 Meeting – Template FY22 Attendance Log 4. June 2021 Meeting – Final FY21 Attendance Log 5. July 2021 Meeting – Old Business Strategic Plan, Revised Draft Focus Areas 6. July 2021 Meeting – Old Business Bylaws, Revised Draft Bylaws 7. July 2021 Meeting – New Business Strategic Plan, Revised Draft Action Plan 8. July 2021 Meeting – New Business Strategic Plan, Volunteers by Focus Area as of 6/8/21 <p>E-mail (2 of 3) with handouts (total of 8 handouts)</p> <ol style="list-style-type: none"> 1. June 2021 Meeting – Final Thank you Letter, AMHD 2. June 2021 Meeting – Final Council Membership Recruitment Letter, Judiciary 3. June 2021 Meeting – Final Council Membership Recruitment Letter, DHS MQD 4. June 2021 Meeting – Final Council Membership Recruitment Letter, HACDACS 5. June 2021 Meeting – Mental Health Service Recipient/Consumer Advocate Report, Workforce Handout 6. July 2021 Meeting – HACDACS Minutes, 2/23/21 7. July 2021 Meeting – HACDACS Minutes, 3/23/21 8. July 2021 Meeting – HACDACS Minutes, 4/27/21 <p>E-mail (3 of 3) with handouts (total of 9 handouts)</p> <ol style="list-style-type: none"> 1. July 2021 Meeting – KSAB Minutes, 1/28/21 2. July 2021 Meeting – KSAB Minutes, 2/25/21 3. July 2021 Meeting – KSAB Minutes, 3/25/21 4. July 2021 Meeting – KSAB Minutes, 4/29/21 5. July 2021 Meeting – KSAB Minutes, 10/29/20 	For information only.		
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	<ul style="list-style-type: none">6. July 2021 Meeting – KSAB Minutes, 12/3/207. July 2021 Meeting – MSAB Minutes, 4/5/218. July 2021 Meeting – HSAB Minutes, 4/27/219. July 2021 Meeting – HSAB Minutes, 5/25/21			
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STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
July 27, 2021
10:00 a.m. – 12:30 p.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Fujii, John; Knightsbridge, Christopher; Lau-James, Eileen; Pascual-Kestner, Rusnell “Rus”; Reed, Tara; Renfro, Jennifer; Ries, Richard**


Members Absent: **Koyanagi, Dina**

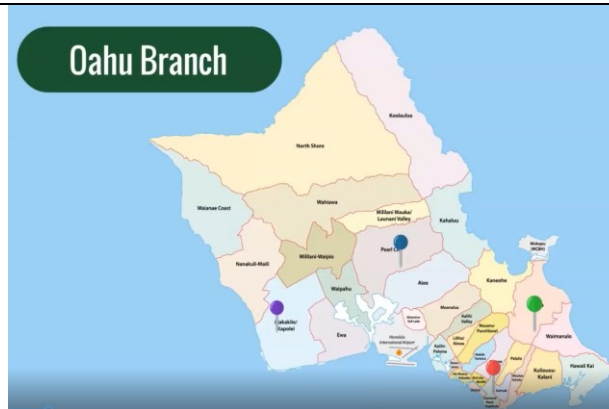
Members Excused: **Crozier, Charleen “Naomi”; Ilyavi, Heidi; Martinez, Beatrice “Kau’i”;**

Guests Present: **Allen, Kim; Dang, Cynthia “Cindi”; Gleason, Michelle; Jackson, Richard “Rick”; Sabree, Hassan; Talisayan, Bryan; Ulevich, Kate**

DOH Staff Present: **Curtis, Amy; Haitsuka, Stacy; Merriam, Kathleen; Nazareno, Jocelyn; Shimabukuro, Scott**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	Chair R. Ries called the meeting to order at 10:02 a.m.	For information only.		
II. Meeting Announcements	R. Ries shared the following announcements: <ul style="list-style-type: none"> • The purpose of today’s Executive Council meeting is to meet with the Substance Abuse and Mental Health Services Administration (SAMHSA) Program Monitor and Project Officer. • This Executive meeting is open to the public. • There should be time during the agenda for discussion; however, we will try to stay within the timeframes on the agenda out of respect for the SAMHSA representatives participating from the East Coast. • Due to our information sharing and discussion focused agenda, the Council will not be voting on any items today. If there are items that may need further discussion or a vote, the Council will follow up on those items at next month’s Council meeting. 	For information only.		

<p>III. Community Input</p>	<p>Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time.</p> <p>R. Jackson shared the following Oahu Service Area Board (OSAB) updates:</p> <ul style="list-style-type: none"> • Regarding the development of a Crisis Intervention Team (CIT) on Oahu, Oahu Service Area Board (OSAB) members are aware of tragic events on the mainland that have involved individuals with mental illness and hope that incidents like those do not occur in Hawaii. • His application for State Council membership is in progress per the Boards and Commissions office. 			
<p>IV. Hawaii Mental Health System – Service Area Overview</p> <ul style="list-style-type: none"> • Child and Adolescent Mental Health Division (CAMHD) • Adult Mental Health Division (AMHD) 	<p>Council members received presentations from the DOH CAMHD and AMHD that included information about activities, programs and services they coordinate.</p> <p>Scott Shimabukuro, Acting Administrator for the DOH CAMHD, shared the following information about the CAMHD.</p>  <p>CAMHD is organized across the state as identified by the colored pins.</p> <ul style="list-style-type: none"> • The CAMHD Central Division office is located in Honolulu on Oahu. • Family Guidance Centers (FGCs) are where community based services are accessed. There is at least one FGC in each County. • On Oahu, <ul style="list-style-type: none"> ○ Blue and green pins are known as the Central FGC, with locations in Windward Oahu and Central Oahu. ○ Red pin is where the Honolulu FGC is located. ○ Purple pin is where the Leeward FGC is located. 			



- There are Neighbor Islands,
 - Hawaii Island has three physical offices. Red pin is the East Hawaii FGC and green pin is the West Hawaii FGC location. There is also an office in Waimea.
 - Blue pin is where the Maui FGC is located.
 - Purple pin is where the Kauai FGC is located.

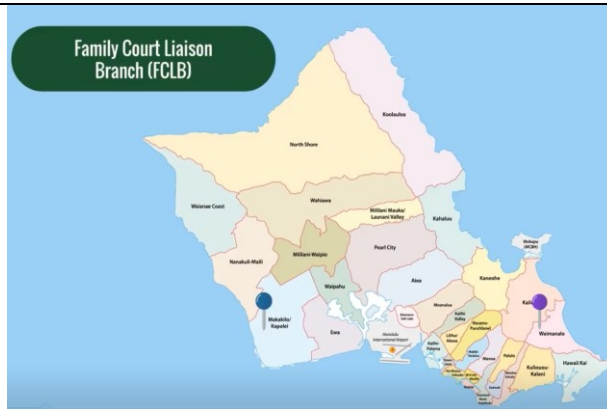


- There is a Family Court Liaison Branch (FCLB) serves all adolescents entering into the youth correctional system.
 - Purple pin is where the Youth Correctional Facility is.
 - Blue pin is where the federal youth detention facility is located.

Share a copy of the chart.

J. Fujii/
S. Haitzuka

8/4/21



A typical FGC includes the following types of staff.

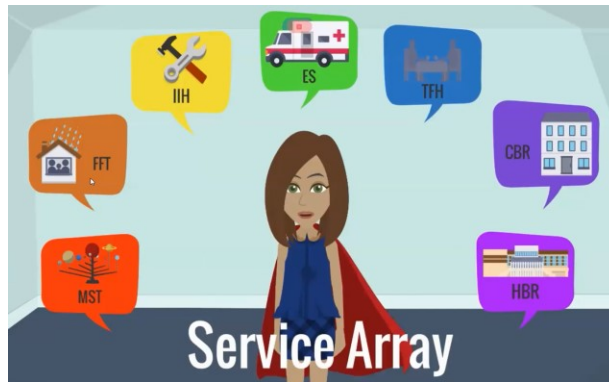
- Clinical Leads are a Psychiatrist and Psychologist
- Center Chief is responsible for the FGC operations
- There are usually several mental health supervisors who lead the care coordination team.
- Child and Family Services (CFS) Parent Partners provide peer support to parents with children receiving services through a FGC.
- Quality Assurance (QA) Specialist oversees compliance and program monitoring.

FGCs are Medicaid Fee-for-Service (FFS) providers. In order to obtain services, children need to have an order created by a clinical lead. The order is created after the clinician completes the assessment and meets with the family.



CAMHD's service array includes:

- Intensive in Home (IIH) services
- Functional Family Therapy (FFT) – proprietary evidence-based model
- Multisystemic Therapy (MST) – proprietary evidence-based model
- Emergency Services (ES) – available to all children in Hawaii regardless of their eligibility status and regardless if they are a resident of Hawaii.
- Transition Family Home (TFH) – family is licensed as a foster home but also provide therapeutic services.
- Community-Based Residential (CBR) – different levels within CBR provided in a community residential setting.
- Hospital-Based Residential (HBR) – services provided at Kahi Mohala



CAMHD has a current SAMHSA project to develop a more robust peer array of services. In addition to parent partners in FGCs, CAMHD also has a contract for youth partners. CAMHD is developing a program to certify more youth partners and expand youth partner services.

SCMH members shared the following comments regarding S. Shimabukuro's presentation:

- R. Ries asked about youth partners. When he was a family therapist (MST) with Parents and Children Together (PACT) and when he was with the Center for Cognitive Behavioral Therapy over 10 years ago, he recalls having a difficult time connecting parents to parent

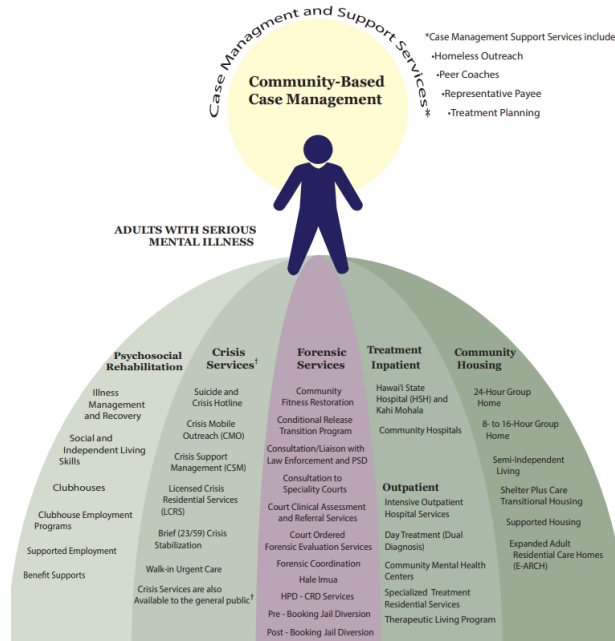
	<p>partners. He also recalls his childhood as an at risk youth and how he felt about efforts to rehabilitate him. He would like to know what the challenges are for recruiting parents and youth partners.</p> <p>S. Shimabukuro acknowledged there are multiple issues. Back then, CAMHD worked with a different parent partner agency. Right now, there are capacity issues. There's only one parent partner in each FGC. CAMHD's data-to-wisdom grant is looking at this issue to help address capacity, training, certification, etc.</p> <p>S. Shimabukuro noted that CAMHD has used youth in a very limited capacity and the intent is to expand youth partnerships statewide. CAMHD is working with the Department of Human Services, MedQUEST Division (DHS MQD) to make this a reimbursable service.</p> <ul style="list-style-type: none"> • K. Aumer asked about peer specialists. S. Shimabukuro explained that AMHD is able to bill for services performed by Hawaii Certified Peer Specialists (HCPS) but CAMHD cannot. DHS MQD is very supportive of CAMHD's efforts and recognizes the need for statutory changes to allow for billing to occur. • C. Knightsbridge mentioned his experience as a practicum student at Iola Lahui, a rural Hawaiian culturally based behavioral health program where he performed diagnostic assessments. Youth had to be flown to Oahu to get assessed. He pointed out how services could be provided on Molokai and Lanai by practicum students who live on those islands and provide supervision to them remotely. R. Ries suggested partnering with advanced level students who are willing to stay on island for a few days a week. S. Shimabukuro explained that CAMHD staff regularly fly to Molokai and Lanai to provide services and CAMHD is currently working with interns for various clinical responsibilities. • K. Aumer asked about reimbursement for telehealth services. S. Shimabukuro and J. Fujii explained that during the federal public health emergency period for the COVID-19 pandemic, telehealth services are covered as a reimbursed service. The emergency period will continue through the end of 2021; however, the state 			
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	<p>emergency period will likely end in August 2021. J. Fujii stated that the Hawaii Department of Human Services, MedQUEST Division (DHS MQD) is currently working on guidelines for telehealth beyond the public health emergency period.</p> <p>J. Fujii explained that the COVID-19 public health emergency has accelerated telehealth utilization. From a Medicaid perspective, we see the great use of telehealth and the hope is to continue telehealth access beyond the public health emergency period.</p> <p>J. Fujii referenced a telehealth utilization chart comparing utilization from 2019 to 2020. S. Shimabukuro and R. Ries stated they are interested in seeing this chart.</p> <p>To clarify, telephonic services are those provided over a telephone device without video (no eyes-on). Telehealth services include video as well as audio.</p> <p>K. Aumer clarified her concern for telehealth reimbursement is to ensure neighbor islands continue to have adequate telehealth access with the reimbursement to avoid interruption/delay in care.</p> <ul style="list-style-type: none"> • T. Reed mentioned Robin Lee, staff at the Wailuku, Maui CAMHD Family Guidance Center is a member of the Maui Service Area Board (SAB). It was mentioned that there is no place for youth to go on Maui for emergency hospitalization. <p>The Maui SAB included this service gap in their Comprehensive Integrated Service Area Plan (CISAP). She is interested in obtaining data on hospitalizations and utilization rates for hospital emergency departments (ED) by youth. S. Shimabukuro noted that due to the small numbers, there could be restrictions on sharing data due to potentially being able to identify the individuals.</p> <ul style="list-style-type: none"> • R. Ries referenced a Hawaii law stating that reimbursement rates for in-person services are to be the same as reimbursement rates for telehealth services. He is unsure of the law's effective date but has had his claims denied. He is aware there was a draft bill introduced 			
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	<p>that advocated for telephonic reimbursement being equal to in-person and telehealth rates but that bill died.</p> <ul style="list-style-type: none"> • K. Ulevich shared that during the emergency proclamation, her organization bills for telehealth at the same rate as in-person services but telephonic services have been billed at a lesser rate. <p>Amy Curtis, Administration for the DOH AMHD, shared the following information about the AMHD.</p> <ul style="list-style-type: none"> • Like CAMHD, AMHD has services that are state operated (i.e. Hawaii State Hospital (HSH) and the Community Mental Health Centers (CMHCs)) as well as contracted purchase-of-service (POS) providers. • AMHD wants services to be provided in an effective, person-centered environment with the overall goal of services being provided across all counties in a consistent way regardless of location. • “Umbrella person” infographic shows the services and programs offered by the AMHD. This infographic is under revision to add new services that AMHD has developed. <ul style="list-style-type: none"> ○ Case management services includes community-based case management (CBCM) and intensive case management (ICM). Programming for co-occurring mental illness and substance abuse (MISA) are included as well as the Palekana program. ○ Psychosocial Rehabilitation services include illness management and recovery (IMR), social and independent living skills, Clubhouses, and Clubhouse employment and supported employment programs. ○ Crisis services include Hawaii CARES, crisis mobile outreach (CMO) which is available to anyone in Hawaii who needs crisis assistance, crisis support management (CSM), Licensed Crisis Residential Services (LCRS), stabilization beds, and walk-in urgent care services. ○ Forensic services include community fitness restoration, conditional release transition program, law enforcement and public safety consultation, specialty court consultation, court-ordered forensic evaluation services, forensic coordination, police cellblock nursing services, and pre- and post-jail diversion. 			
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	<ul style="list-style-type: none"> ○ Treatment services include inpatient services at HSH and Kahi Mohala and in community hospitals, and outpatient services such as intensive outpatient hospital (IOH) services, co-occurring MISA services, CMHC services, specialized residential services program (SRSP) and therapeutic living program (TLP). ○ Community housing include 24-hour and 8-16 hour group homes, semi-independent living, transitional and supported housing and expanded adult residential care homes (E-ARCH). ● AMHD is trying to build peer supports. Currently, AMHD has peers employed but we want to also increase peers in our contracted programs. We have training for HCPS training (this week!) and in the fall, forensic peer specialist training. Looking into stipends and other ways to bring interest and awareness to peer employment. ● AMHD is trying to build its array of crisis stabilization services. While we have LCRS and CMO services, we've learned from the COVID-19 pandemic response, there are people needing stabilization services so AMHD will be looking to contract for expanding stabilization services across the state. ● AMHD staff have been doing many other COVID-19 pandemic response activities including isolation and quarantine (IsoQuar) services and vaccine clinic point of distribution. We are pivoting back to our primary work and looking to fill staff vacancies. ● There is a shared desire from the Hawaii State Judiciary, Public Safety Department, and law enforcement for decriminalizing individuals who live with a mental health condition. ● AMHD is in the process of revising its mission and vision statements. Requests for public input was requested and the final statements will be shared soon. She thanked the SCMh for their input. 			
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ADULT MENTAL HEALTH DIVISION: CORE SERVICES



SCMH members shared the following comments regarding A. Curtis’s presentation:

- K. Aumer expressed concern for sustainability for peer supports stating, “once established, is it sustainable?” A. Curtis explained that Hawaii Certified Peer Specialist (HCPS) training is done in-house. Additionally, by adding HCPS into AMHD’s array of services, peer supports are included in AMHD contracts which allows for reimbursement of their services.
- T. Reed shared that she is a HCPS and she is looking forward to attending the next forensic peer training. She also shared that Mental Health America Hawaii is considering a forensic peer specialist training too.

V. State Council on Mental Health

- Who We Are
- When and

R. Ries provided a detailed overview of the Council including historical information, membership composition, strategic planning and Focus Area priorities, and Statewide Comprehensive Integrated Service Plan (SCISP) and SAMHSA Mental Health Block Grant (MHBG) activities.

<p>How We Meet</p> <ul style="list-style-type: none"> • What We Do – Strategic Plan and Focus Area Goals • Our Involvement in the Development of Hawaii’s SAMHSA Mental Health Block Grant Application – Reviewing/ Drafting Content 	<p><u>Historical Information</u></p> <ul style="list-style-type: none"> • In 1981, Congress passed the Omnibus Budget Reconciliation Act eliminating federal funding for community mental health centers (CMHC) and other mental health and substance use services. Federal funding for mental health and substance use services was replaced with Block Grants to give states greater discretion in the allocation of federal funds and transferred responsibility for the persons living with mental illness back to the states. • In 1984, with Act 218, the Hawaii State Legislature, amended chapter 334, Hawaii Revised Statutes (HRS), establishing a 15 member State Council on Mental Health and Substance Abuse, and establishing 15-member service area boards to advise CMHCs in each county. The service area boards were called the Service Area Boards on Mental Health and Substance Abuse (SAB), and the law stated that the role of the Council and boards was advisory. • In 1985, Act 6 amended the law to change the membership of the SABs from 15 members to 9 members. The member’s role consisted of participating in the development of CMHC plans and budgets, and of providing advisement of service area needs. Members of the boards are service area residents and providers, with the majority being residents and non-providers. • In 1986, Congress passed the State Mental Health Planning Act, which authorized small grants to states to develop community-based programs and the institution of state planning councils. These state planning councils were comprised of citizens who advised, reviewed, monitored and evaluated all aspects of the development and implementation of the State Plan. • In 1993, with Act 210, the Hawaii Legislature amended the name of the State Council on Mental Health and Substance Abuse to the State Council on Mental Health (SCMH) and changed the composition of the Council from 15 members to 21 members. Meanwhile, the service area boards retained their name, the Service Area Board on Mental Health and Substance Abuse (SAB). • In 1989, Department of Justice’s lawsuit and resultant settlement agreement with the Adult Mental Health Division (AMHD) in 1989, the 			
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	<p>Community Plan for Mental Health Services was implemented as an order of the court on January 21, 2003. The Plan expanded Service Area Administrators' (SAA) oversight to County-level administrators and consolidated the SABs from 8 to 4 (one per County).</p> <ul style="list-style-type: none"> • In the Community Plan, the Service Area Administrator's responsibility in relation to the SABs was to write an annual Comprehensive Integrated Service Area Plan. This integrated plan addressed service needs identified in the seven service areas inclusive of County-specific analysis and solutions: <ul style="list-style-type: none"> ○ Crisis Services, ○ Treatment, ○ Case Management, ○ Community Housing, ○ Psychosocial Rehabilitation, ○ Co-Occurring Mental Illness and Substance Abuse, and ○ Forensics • In 2004, a minor change was made to the chapter 334-11, HRS regarding the SABs to reflect changes in the Community Plan. The only change made to the statute on SABs was clarification that the SABs advised each SAA, rather than each CMHC. <p><u>State Council on Mental Health (SCMH) Membership</u></p> <ul style="list-style-type: none"> • Currently, the SABs are guided by the Hawaii Administrative Rules (HAR), the HRS 334-3, 334-11, and the Sunshine Law under HRS 92-1. • Members serve on a voluntary basis, are appointed by the Governor and confirmed by the Senate. • A member is usually appointed to a four-year term, and thereafter, a maximum of another four-year term. • One member of each SAB has a dual role by also serving on the SCM. The purpose of this dual role is to bring county-level issues and concerns, including the county-based Comprehensive Integrated Service Area Plans (CISAP), to the SCM. • The SCM and SABs elect their own executive officers and create their own bylaws in compliance with federal/state statutes and administrative rules. • Meetings are open to the public. 			
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	<ul style="list-style-type: none"> • With the passing of Act 218 in 1984, the law stated that the SCMH’s role is advisory. That being the case, the SCMH advises the Governor through the DOH Behavioral Health Administration (BHA) in a few key ways including the allocation of mental health resources, statewide needs, and programs affecting two or more service areas. <p>NOTE: The DOH, through its Behavioral Health Administration (BHA) is the state mental health authority and is statutorily mandated to assure a comprehensive statewide behavioral health care system by leveraging and coordinating public, private and community resources.</p> <ul style="list-style-type: none"> • The SCMH reviews and comments on the Statewide Comprehensive Integrated Service Plan (SCISP), which is integrated into Hawaii’s MHBG application. • The SCMH serves as an advocate for adults with serious mental illness (SMI), children with serious emotional disturbances, other individuals living with mental illnesses or emotional problems, and individuals with co-occurring mental illness and substance use disorders. One SCMH member serves in a dual role membership on the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS). • The SCMH is made up of residents of the State of Hawaii, including mental health service recipients and mental health advocates, student and youth advocates, family members, individuals representing state agencies, specifically, mental health, education, vocational rehabilitation, criminal justice, housing, and social services; public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services; adults living with SMI who are receiving, or have received, mental health services, and family members of mental health service recipients and family members of children with serious emotional disturbances. • Currently, of the 21 membership positions, the SCMH has 13 members appointed. One member is in a holdover status waiting to be re-appointed, and we have three individuals waiting for the 			
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	<p>Governor’s approval for an interim appointment. These individuals will be scheduled for a confirmation hearing with the Senate Health Committee in the 2022 Legislative session.</p> <ul style="list-style-type: none"> • The SCMH has reached out to the human services and judiciary state agency representatives for help with filling vacancies. • The SABs are doing fairly well with their membership status. Hawaii Island has 4 members, Kauai has 2 members, Maui has 4 members, and Oahu has 8 members. Majority of vacancies are for mental health service recipients, student and youth representatives, and family members. • Lastly, the SCMH recently experienced a major change in its support staff with the retirement of the AMHD Planner who served as the SCMH’s primary administrative support. With this position vacant, the AMHD temporarily assigned Ms. Stacy Haitzuka, AMHD Communications and Training Specialist, and she has been helping Ms. Jocelyn Nazareno with administrative support for SCMH activities since June 2020. <p><u>SCMH Meetings</u></p> <ul style="list-style-type: none"> • SCMH meets monthly on the 2nd Tuesday from 9:00 a.m. to 12:00 p.m. HST • Due to the COVID-19 pandemic, the SCMH has been meeting virtually via Zoom. • Prior to the COVID-19 pandemic, the SCMH was meeting in person on Oahu with Neighbor Island members flying to Oahu. <p><u>SCMH Strategic Plan Focus Area Priorities</u></p> <ul style="list-style-type: none"> • In November 2020 and February 2021, the SCMH held its Strategic Planning Retreat in two parts. • At our June 2021 meeting, the members finalized and adopted the SCMH Strategic Plan for 2020-2022, acknowledging that some of our Strategic Plan goals are continuing from the previous plan and some goals have already had significant progress made as a result of Council members participating in Permitted Interaction Groups (PIGs), which are small groups of members who work between SCMH meetings on specific tasks and make recommendations to the 			
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	<p>for decision making.</p> <ul style="list-style-type: none"> • The SCMH has also made concerted efforts to raise awareness of the needs for County-level mental health services, especially services in rural areas and service availability issues where there have been issues with access to mental health services. • In summary, the Council’s Strategic Plan includes the following 7 Focus Areas: <ol style="list-style-type: none"> 1. Improving access to mental health services (existing and new) 2. Advocating for the emotional well-being of the community 3. Identifying the tools the Council is empowered to use 4. Outlining an onboarding and reboarding experience for Council members 5. Strengthening the Council’s presence as advocates and advisors to the Department of Health leadership, inclusive of neighbor island stakeholders and service area board members 6. Sharing information on the Council’s website about existing mental health services (local/state/federal) 7. Identifying, tracking, and sharing the status of the Council’s prioritized legislative bills <p><u>Statewide Comprehensive Integrated Service Plan (SCISP) and Mental Health Block Grant (MHBG) Activities</u></p> <p>Each year the SCMH reviews the Statewide Comprehensive Integrated Service Plan (SCISP) either as part of the full Hawaii MHBG application or as the mini-application during the 2nd year of the two-year block grant.</p> <p>The SCMH looks forward to reviewing this year’s MHBG application and to drafting our section of the MHBG application to provide more detail about SCMH activities and how members connect with their communities and with stakeholders in their area(s) of Council representation.</p> <p><u>SCMH is a Mental Health Advocate</u></p> <p>Lastly, I would like to comment that the SCMH has been building positive momentum in its role as mental health advocates in several ways.</p> <ul style="list-style-type: none"> • We have invited speakers from state agencies and from community organizations to share information and perspectives and with this 			
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	<p>information, we have been able to have more discussion and when appropriate take a position on the issue or mental health topic.</p> <ul style="list-style-type: none"> • We have submitted testimony for legislation related to mental health to voice our support, opposition or comments on drafted senate and house bills. • We have made significant improvement in the overall experience that members have when they serve and participate so that there is a welcoming atmosphere to meet and share updates during our respective standing agenda reports. • We have shared our concerns with the Governor and the legislature through our annual legislative report about Hawaii’s mental health service system and our recommendations for addressing areas we believe are service gaps. • We have expressed our feedback to the former DD BHA about the COVID-19 pandemic and mental health topics. We hope to continue to have an open dialogue with the newly appointed DD BHA. <p>R. Ries acknowledged there is much more that the SCMNH looks forward to being part of as it continues its work to advise, monitor, review and evaluate the provision of mental health services in Hawaii.</p> <p>He thanked each SCMNH member and each SAB member for volunteering to serve in these important roles. He emphasized that the SCMNH is very active and has taken its responsibilities very seriously.</p> <p>SCMNH members shared the following comments regarding the SCMNH presentation:</p> <ul style="list-style-type: none"> • A. Beninato mentioned his interest in public service announcements (PSA) and video production. He wonders what kinds of content would the SCMNH want to share. He is looking at sound bites for media circulation. T. Reed suggested inquiring with the cable television providers who may be able to offer free or low cost advertisements as part of its public service airtime. R. Ries mentioned KTUH as an option for media. • J. Renfro thanked everyone for sharing the information about the SCMNH. This is her 2nd meeting and she feels she has been warmly 	<p>Consider for a task assigned to the Website and Social Media Permitted Interaction Group (WSA PIG).</p>	<p>R. Ries/ S. Haitsuka</p>	<p>8/10/21</p>
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	<p>welcomed. She thanked all SCMH members for their commitment and dedication. R. Ries noted it has been over a year that the SCMH has been actively recruiting for a Department of Education (DOE) representative.</p>			
<p>VI. Presenter/Guest Speaker</p> <ul style="list-style-type: none"> • Questions to SCMH Members Regarding Hawaii’s Mental Health Block Grant (MHBG) Funding and Hawaii’s Mental Health Care System 	<p>R. Ries introduced Mr. Hassan Sabree, SAMHSA Project Monitor and Ms. Michelle Gleason, SAMHSA Project Officer.</p> <p>H. Sabree and M. Gleason participated in a dialogue, question and answer session with SCMH members about various Hawaii mental health and MHBG related topics.</p> <ul style="list-style-type: none"> • H. Sabree asked about the ratio of SCMH members in various non-state positions. Federal regulatory requirements include having over 50% of members being mental health service recipients, family members and youth/student advocates. <p>R. Ries shared about the recent changes to quorum that helped addressed both being able to conduct meetings and having members who show up at meetings. Changing this law was critical to helping address membership and meeting attendance.</p> <p>The SCMH has been very diligent with recruiting members from the various agencies and areas of representation.</p> <p>H. Sabree explained that the ratio, with respect to membership, (a) parents with children with serious emotional disturbance to other members of the SCMH is sufficient to promote adequate representation of such in the SCMH’s deliberation and (b) not less than 50% of SCMH members are mental health service recipients, non-state employees and not providers of mental health services.</p> <p>NOTE: M. Gleason, clarified that SAMHSA identifies “sufficient” number of parents with children with serious emotional disturbance (SED) to be “at least one member.” She encouraged the SCMH to verify that the parent has a child who is a child versus an adult son where the parent is now considered a relative.</p>	<p>For information only.</p>		
		<p>Check with H. Ilyavi to confirm the child is actually in the SED system.</p>	<p>R. Ries/ S. Haitzuka</p>	<p>8/10/21</p>

	<p>C. Knightsbridge emphasized the SCMH does meet the requirements H. Sabree stated.</p> <p>R. Ries noted there are at least six (6) members of the 13 filled seats who are not state employees and not a provider at all. E. Lau-James stated see counts that there are at least eight (8) of the 13 filled seats that meet the ratio requirement.</p> <p>M. Gleason stated she looks forward to reviewing Hawaii’s MHBG application in September and will watch for an update from the SCMH. She will consider efforts made by the state and by the SCMH to recruit members. She is very supportive of all efforts and will communicate the need for full member from the federal level to the state. She will ask her leadership about what can be done to advocate.</p> <p>C. Knightsbridge emphasized the SCMH has made efforts to reach out via written letters and inquiries to fill vacant agency positions. There is little the SCMH can do to enforce the requirement. R. Ries said that having a letter from the federal level could help.</p> <p>A. Curtis also stated she would help with recruitment efforts. She noted there are a lot of activities being worked on with Judiciary and she can help to advocate for membership. M. Gleason stated after September, she will be sure to send the letter that Hawaii can use to encourage compliance with the federal requirements. She forwarded the SCMH letter to the Judiciary to Marian Tsuji ,who stated she will assist with recruitment.</p> <p>If after reviewing the membership status in September and compared to the 2019 MHBG application, M. Gleason will work with the Hawaii MHBG planner to address the issue. She will ask for Hawaii to give an update and she will stay on top of receiving updates about filling those positions.</p>			
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	<ul style="list-style-type: none"> • H. Sabree pointed out that the SCMH has a “fascinating good problem” explaining that it is great news to hear the SCMH recognizes that recruitment is a challenge and it needs to be addressed. He plans on issuing a recommendation in his program monitoring report stating recruitment is a priority in order for Hawaii to be in compliance with federal requirements. • H. Sabree asked what the SCMH felt its role is in regard to reviewing Hawaii’s MHBG application. <p>R. Ries explained that the SCMH receives a draft copy of Hawaii’s MHBG application. We review and provide comments. For example, the last two MHBG applications were shared as handouts for today’s meeting. The SCMH has commented on both previously and generally supports the application. Comments include strengths and leading edges with what the SCMH sees as opportunities for improvement.</p> <p>Next month the SCMH will meet to review the new Hawaii MHBG application for the next two-year plan.</p> <ul style="list-style-type: none"> • H. Sabree asked if the SCMH reviews the fiscal allocation for MHBG funds. R. Ries acknowledged the SCMH does review the fiscal information and does its best to wrap its head around the numbers but without the scope of state staff who are versed in the number, it can be confusing. <p>For example, when money is allocated initially for an item but then it’s reallocated to something else and we do not really know the reasons or the balance amounts.</p> <p>M. Gleason mentioned about the December 1st report that includes information about spending in the previous federal fiscal year. It shows two expenditure tables and the SCMH should review it. R. Ries noted that J. Tanaka, the AMHD Planner at the time, did present that information to the SCMH.</p>			
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	<ul style="list-style-type: none"> • H. Sabree asked how the SCMH identifies a goal that either made its way into the MHBG application or if it was challenged. R. Ries mentioned the SCMH Strategic Plan Focus Area #1 which includes access to services for first responder mental health support. He also noted the importance of improving Neighbor Island crisis support for immediate response. R. Ries noted that he can share about services in the future as it's difficult to share about past opportunities. <p>For example, looking at someone on Maui who cannot access “boots on the ground” services on their island for whatever reason (i.e., capacity challenges), the SCMH have taken time to consider input from neighbor islands to hear about experiences and challenges.</p> <p>S. Haituka noted that the SCMH has discussed about peer support and advocacy for peer trainings. For example, N. Crozier is now helping with the Hawaii Certified Peer Specialist training that is happening today. T. Reed has mentioned being part of the forensic peer specialist training. Looking into warm lines for peer support has also been ways the SCMH has been an advocate for existing mental health services.</p> <p>E. Lau-James added that many SCMH members are new. With the Strategic Plan Retreat, SCMH members were able to hone our approach and plan in a structured and effective way.</p> <p>E. Lau-James stated SCMH Strategic Plan Focus Area #1, Objective 1.1 states, review the draft Hawaii MHBG application. We will work on this as a new membership group and we will develop our Comprehensive Statewide Integrated Service Plan (CSISP) which is part of the MHBG application.</p> <ul style="list-style-type: none"> • H. Sabree emphasized that the SCMH is in an advisory role however there is a need to establish that there is autonomy within the state; making sure the SCMH is not a “puppet” for the state stating the core purpose of the SCMH. 			
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	<p>C. Knightsbridge affirmed the SCMH takes its role seriously; seeing our SCMH role as a checks and balance system. Even if the SCMH is not in agreement with the DOH, the DOH doesn't have to agree; but is required to write back to explain.</p> <ul style="list-style-type: none"> • C. Knightsbridge asked H. Sabree what the SCMH can improve on? H. Sabree shared his preference for addressing areas for improvement. He likes to take a strengths-based approach. He recognizes the SCMH's brutal honesty, being transparent and its recognition of the delays involved in recruitment and in speeding up the appointment process for members. He encouraged the improvement of the onboarding experience for new members and encouraged SCMH members to engage with each other throughout their term. • R. Ries asked H. Sabree and M. Gleason about MHBG funds for SCMH business. For example, he asked whether MHBG funds could be used to purchase SCMH business cards. C. Knightsbridge noted the large amount of legalese that SCMH has to go through. Having a SCMH budget and options for spending would be helpful. <p>M. Gleason defers to the state for its decision making about funding but stated she would check with the SAMHSA Division of Grants Managements (DGM) for their input if it is an allowable cost.</p> <p>She noted as an example that a pamphlet placed in a doctor's office that explains what mental health services are available and who the SCMH is would be an appropriate use of MHBG funds. She emphasized that MHBG funds need to have a specific focus on the seriously mentally ill (SMI) population rather than broad non-specific SMI outreach.</p> <p>A. Curtis noted that there was money allocated for the SCMH however the COVID-19 pandemic has impacted the SCMH's spending (i.e., travel, rental car, lodging, Retreat costs, etc.).</p> <ul style="list-style-type: none"> • E. Lau-James mentioned the SCMH's efforts are documented in laborious meeting minutes It is excellent that the SCMH has 			
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	<p>maintained quorum for the entire fiscal year 2021. She credited the painstaking amount of time spent on strategic planning that brought about the opportunity to share so much introspection and reflection of how the SCMh operated before, how it currently operates and how it will operate in the future.</p> <p>For example, she pointed to the SCMh Strategic Plan Focus Area #4 which focuses on outlining the onboarding and reboarding experience for SCMh members. This has never been done before and will greatly improve the experience SCMh members have with being able to join the SCMh and get to work right away with the information they need. She mentioned the SCMh now has digital access to all SCMh files, not just orientation material in hard copy. The digital files are updated regularly and all SCMh members can access the information 24/7.</p> <ul style="list-style-type: none">• R. Jackson shared he has participated on the Oahu Service Area Board on Mental Health and Substance Abuse for many years. His focus is for humanitarian care for all. He supports human rights and equal employment opportunities (EEO), including senior citizens and people physical disabilities. He observes that these population groups appear to be underrepresented. <p>M. Gleason commented that there is a section in the MHBG application that allows for various categories of special population groups including lesbian, gay, bisexual, transgender and queer (LGBTQ) as well as Native American, and many other individuals including someone with substance abuse experience, even if these categories are not in statute, the MHBG application does ask whether these population groups are being represented.</p> <p>H. Sabree mentioned diversity and encouraged R. Jackson to address diversity issues within the SCMh.</p> <p>R. Ries noted that sometimes, diversity is not obvious to people and he recognized the SCMh is supportive of learning about each SCMh members' background. For example, he is a Spanish speaking individual but people may not automatically see this simply by</p>			
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	<p>looking at him.</p> <ul style="list-style-type: none"> • H. Sabree asked about training needs and how the SCMH goes about receiving training. R. Ries shared that SCMH members share knowledge during meeting discussions and speakers are arranged to come to meetings to present on specific topics. For example, SCMH members received legislative training and received a presentation about sex trafficking. <p>Many times, the SCMH identifies its training needs by hearing from community members or looking at feedback from other organizations.</p> <p>R. Ries stated the SCMH makes a concerted effort to get to know Neighbor Island community concerns and be inclusive of island-specific issues. R. Jackson noted that years ago, the SCMH would fly Neighbor Island residents to Oahu to attend SCMH meetings; however, those living in rural areas could not fly over because they did not have transportation. He feels the state has been accommodating.</p> <p>E. Lau-James noted with the creation of the legislative permitted interaction group (LEG PIG), the SCMH was able to create its first ever participation guidelines for SCMH legislative activities. The new onboarding process detailed in the Strategic Plan Focus Area #4 addresses the issue of creating a formal training and onboarding process. R. Ries noted that some of the newer SCMH members have signed up to be part of this group so that they can give feedback on their experience.</p> <p>R. Ries noted that previously documents were snail mailed. Expenses are saved and trees are saved. Time is also saved with digital access where before, the SCMH has endured significant delays in receiving the information. SCMH members can now access the materials 24/7 and the files are updated regularly.</p>			
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	<ul style="list-style-type: none"> • H. Sabree asked how SCMH members keep in touch with constituents in their area(s) of SCMH representation. R. Ries shared that sometimes, these could be natural contacts and natural connections. For example, he is a provider of mental health services and sees clients regularly. He also is connected to other service providers through other organizations he is a member of such as the Hawaii Psychological Association. He noted community members are invited to speak at each SCMH meeting. • H. Sabree asked if the SCMH meeting minutes contain documentation of service gaps. <p>R. Ries also noted the SCMH also discussed the lack of prescribers, not just psychologists, but also need for social workers and people who provide psychotherapy and are liaisons for support services. He is not a supporter of psychologists prescribing. He pointed out the need for police psychologists and retaining them on staff when other clinicians leave employment.</p> <p>R. Ries pointed out there are several instances where there is documentation about access to services, specifically about homelessness and the need for crisis response.</p> <p>There have been conversations about the need for a partnership program that helps pay for the cost of tuition with an agreement to stay in Hawaii to live and work. A. Curtis also shared that funding for this type of partnership has been on her mind as well.</p> <p>J. Renfro mentioned about the Hawaii Western Interstate Commission for Higher Education (WICHE) The Hawaii WICHE is actively addressing this issue. The University of Hawaii has a website with information about the Hawaii WICHE higher education partnership (CLICK HERE for handout).</p> <p>H. Sabree clarified that MHBG funds cannot be used for scholarships but he does encourage states in general to address work force issues. M. Gleason also clarified that the reason MHBG funds cannot</p>			
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	<p>be used for scholarships is because the funding must target the SMI population and community mental health services.</p> <p>M. Gleason mentioned the SAMHSA Minority Fellowship Program (CLICK HERE for website).</p> <ul style="list-style-type: none"> • R. Jackson asked about Hawaii law regarding eligibility for state funded services. If an individual has private insurance, does that make them ineligible for state funded insurance? Same for Clubhouse membership. If privately insured, they could not be a Clubhouse member. <p>A. Curtis stated that anyone can participate in Clubhouse regardless of their insurance status.</p> <p>A. Curtis stated that insurance is taken into consideration and looking at the policies for Medicaid and billing. AMHD funds uninsured and underinsured individuals for state services when appropriate. For example, on Neighbor Islands where there are challenges with access to care.</p> <p>A. Curtis stated the AMHD is interested in working with staff from the Housing and Urban Development (HUD) to address their definition of homelessness and how it excludes institutionalized individuals. M. Gleason noted that this would be something to discuss with the SAMHSA Projects for Assistance in Transition from Homelessness (PATH) grant staff (CLICK HERE). Changing legislation is not easy. The MHBG was developed by Congress and while we've come a long way, we've got a long way to go.</p>			
<p>VII. Wrap Up and Next Steps</p>	<p>R. Ries noted there will be time at the next meeting to debrief and consider next steps as a result of information shared during today's meeting.</p> <ul style="list-style-type: none"> • He expressed appreciation to H. Sabree and M. Gleason for their time. He also concluded by summarizing the mission and goal of the SCMH which involve being participatory and relevant in the 			

	<p>development of Hawaii’s mental health system.</p> <ul style="list-style-type: none"> • M. Gleason wrapped up the discussion stating as a result of today’s meeting, she has a better idea of who the SCMH is. She feels the SCMH is doing a great job. • H. Sabree wrapped up the discussion stating he was humbled and privileged to meet SCMH members today. He feels the SCMH is doing tremendous work. He can see things from a provider perspective as well as from his federal oversight role. He appreciates and respects the SCMH’s work. 			
VIII. Closing Announcements	<p>Council members shared the following announcements:</p> <ul style="list-style-type: none"> • None. <p>The next Council meeting is scheduled for August 10, 2021 from 9:00 a.m. to 12:00 p.m. via Zoom. Note the Council’s need meeting end time.</p>	For information only.		
IX. Adjournment	The meeting was adjourned at 12:38 p.m.	For information only.		
Electronic Mail Outs	<p>The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list:</p> <p>E-mail (1 of 3) with handouts (total of 8 handouts)</p> <ol style="list-style-type: none"> 1. July 2021 Executive Meeting – Agenda 2. Child Adolescent Mental Health Division (CAMHD) Service Brochure 3. Adult Mental Health Division (AMHD) Core Services Infographic 4. AMHD Mission, Vision and Guiding Principles 5. Hawaii CARES Contact Card <p>E-mail (2 of 3) with handouts (total of 8 handouts)</p> <ol style="list-style-type: none"> 1. Hawaii Mental Health Block Grant (MHBG) application for the full Federal Fiscal Year (2020-2021). 2. Hawaii MHBG Cycle 39 Fiscal Documents. 3. State Council’s Letter of Support for Hawaii’s MHBG Cycle 39 Application. 	For information only.		

	<p>Additional Resources:</p> <ul style="list-style-type: none">• CAMHD – Brochures (CLICK HERE)• CAMHD 101 – YouTube Video (CLICK HERE)• AMHD – Website (CLICK HERE)			
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State Council on Mental Health Attendance Log

FY2021 (July 1, 2020 - June 30, 2021)

Key: P = Present/In Attendance; E = Excused by Chairperson; A = Absent/Not In Attendance; R = Resigned; Gray Color = 1st Month for New Member

	Council Member's Name	Island	Term Expires	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL "P" Mtgs Attended
INDIVIDUALS IN RECOVERY and FAMILY MEMBERS																
1	Antonino Beninato Student/Youth Advocate	Oahu	6/30/21				P	P	P	P	P	P	P	P	P	9
2	Charlene "Naomi" Crozier Consumer Advocate	Maui	6/30/23	A	P	E	P	P	E	A	P	A	A	P	E	5
3	Christopher Knightsbridge Consumer Advocate 1st Vice Chair	Oahu	6/30/21	P	E	P	P	P	P	P	P	P	P	P	P	11
4	Eileen Lau-James Family Member Secretary	Oahu	6/30/23	P	P	P	P	P	P	P	P	P	P	P	P	12
5	Heidi Ilyavi Parent of SEBD Youth	Hawaii	6/30/22	P	P	P	P	P	P	P	P	P	P	P	P	12
6	Katherine Aumer Family Member 2nd Vice Chair	Oahu	6/30/21				P	P	P	P	P	P	P	P	P	9
	VACANT Student/Youth Advocate															
	VACANT Family Member															
	VACANT Family Member															
	Alexandra Macias Family Member	Oahu	6/30/22	P	P	R (as of 8/12/20)									2	
PROVIDER REPRESENTATIVE																
7	Richard Ries Provider Chair	Oahu	6/30/24	P	P	P	P	P	P	P	P	P	P	P	P	12

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Council Member's Name	Island	Term Expires	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL "P" Mtgs Attended
SERVICE AREA BOARD REPRESENTATIVES															
8 Tara Reed Consumer/Community Member	Maui	6/30/20	P	E	P	P	P	E	P	P	P	P	E	E	8
9 Cynthia "Cindi" Dang Community Member	Oahu	6/30/21	P	P	P	P	P	P	P	P	P	P	P	P	12
VACANT Community Member	Kauai														
VACANT Community Member	Hawaii														
Lani Nagao Community Member	Kauai	6/30/20	E	P	P	P	P	P	E	Term Completed					5
Carol Matayoshi Community Member	Hawaii	6/30/22	P	P	P	P	P	P	P	P	P	P	R (as of 4/13/21)		10
STATE AGENCY EMPLOYEES															
10 Beatrice "Kau'i" Martinez HI Public Housing Authority	Oahu	6/30/23	P	P	E	P	P	P	E	P	E	E	P	P	8
11 Dina Koyanagi DHS Child Welfare Svcs.	Oahu	6/30/21				P	P	E	P	E	P	P	P	P	7
12 Jon Fujii DHS Med-QUEST/HACDACS	Oahu	6/30/23	P	A	A	A	A	A	P	P	E	E	E	E	3
13 Rusnell Pacual-Kestner DHS Dept. of Vocational Rehab.	Oahu	6/30/23	P	P	P	P	P	A	P	P	P	P	E	E	9
14 Scott Shimabukuro DOH Child/Adolesc. Mental Hlth	Oahu	6/30/20	P	P	E	P	P	P	P	P	P	P	P	E	10
VACANT Education															

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VACANT Criminal Justice															
Timothy Lino Education	Oahu	6/30/23	E	R (August 3, 2020)										0	

State Council on Mental Health Attendance Log

FY2022 (July 1, 2021 - June 30, 2022)

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INDIVIDUALS IN RECOVERY and FAMILY MEMBERS																	
1	Antonino Beninato Student/Youth Advocate	Oahu	6/30/24	P	P												
2	Charlene "Naomi" Crozier Consumer Advocate	Maui	6/30/23	A	E												
3	Christopher Knightsbridge Consumer Advocate 1st Vice Chair	Oahu	6/30/21	P	P												
4	Eileen Lau-James Family Member Secretary	Oahu	6/30/23	P	P												
5	Heidi Ilyavi Parent of SEBD Youth	Hawaii	6/30/22	P	E												
6	Katherine Aumer Family Member 2nd Vice Chairperson	Oahu	6/30/25	P	P												
	VACANT Consumer Advocate <u>OR</u> Student/Youth Advocate <u>OR</u> Family Member																
	VACANT Consumer Advocate <u>OR</u> Student/Youth Advocate <u>OR</u> Family Member																
	VACANT Consumer Advocate <u>OR</u> Student/Youth Advocate <u>OR</u> Family Member																
PROVIDER REPRESENTATIVE																	
7	Richard Ries Provider Chairperson	Oahu	6/30/24	P	P												

State Council on Mental Health Attendance Log

FY2022 (July 1, 2021 - June 30, 2022)

Key: P = Present/In Attendance; E = Excused by Chairperson; A = Absent/Not In Attendance; R = Resigned; Gray Color = 1st Month for New Member

	Council Member's Name	Island	Term Expires	Jul	Jul Exec Mtg	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL "P" Mtgs Attended
SERVICE AREA BOARD REPRESENTATIVES																	
8	Tara Reed Consumer/Community Member	Maui	6/30/20	P	P												
9	Richard "Rick" Jacksom Community Member	Oahu	6/30/24	P	P												
	VACANT Community Member	Kauai															
10	Renee Rivera Community Member	Hawaii	6/30/22	/	/												
STATE AGENCY EMPLOYEES																	
11	Beatrice "Kau'i" Martinez Housing HI Public Housing Authority	Oahu	6/30/23	E	E												
12	Dina Koyanagi Human Services Child Welfare Svcs.	Oahu	6/30/23	P	A												
13	Jon Fujii Human Services Med-QUEST/HACDACS	Oahu	6/30/23	P	P												
14	Rusnell Pacual-Kestner Human Services Division of Vocational Rehab.	Oahu	6/30/23	P	P												
15	Jennifer Renfro Education	Oahu	6/30/23	P	P												
16	Kathleen Merriam Health	Oahu	6/30/24	/	P												
	VACANT Criminal Justice																

HAWAII STATE COUNCIL ON MENTAL HEALTH BYLAWS

ARTICLE I: NAME

The name of this organization shall be the Hawaii State Council on Mental Health as established in Chapter 334-10, Hawaii Revised Statutes (HRS). “Council”, “State Council” or “SCMH” may be used hereafter in place of the full name to refer to the organization.

ARTICLE II: PURPOSE

The purpose of the Council is (1) to advise agencies and policy makers in their efforts to establish a comprehensive community-based mental health system, utilizing public and private resources that aim to prevent, reduce, and heal mental disorders and substance abuse among children and adults; (2) to advocate for the mental health needs of each County in partnership with the County Service Area Boards on Mental Health and Substance Abuse (SABs); and (3) to represent recipients of mental health services in our communities.

ARTICLE III: RESPONSIBILITIES

1. The role of the Council is to serve as an advisory body to the Department of Health (DOH). “Department” or “DOH” may be used hereafter in place of the full name. The role of the Council shall not include any clinical, administrative or supervisory functions of the Department (Hawaii Administrative Rules (HAR) 11-175-3).
2. The functions of the Council (U.S. Code, Title 42, 300x-4, Public Law 102-321, ADAMHA Reorganization Amendments, Public Health Service Act 106, Stat. 382); HRS 334-10(c) are to:
 - a. advise the department on allocation of funds and resources, statewide needs, and programs affecting two or more service areas (HAR 11-175-03);
 - b. review and comment on the statewide comprehensive integrated service plan (SCISP) and report of the statewide plan that is included in Hawaii’s Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG) application, submitted by the DOH Adult Mental Health Division (AMHD);
 - c. serve as an advocate for adults with serious mental illness, children diagnosed with a serious emotional disturbance (SED), and other individuals with mental illness or substance use disorder, and in collaboration with the Hawaii Advisory Commission on Drugs and Controlled Substances (HACDACS); and
 - d. monitor, review and evaluate not less than once each year, the allocation and adequacy of mental health services within the State.
3. The Council shall, with the assistance of the Department, produce two documents annually:
 - a. A letter from the Chairperson of the Council to SAMHSA, of member comment and recommendation of their review of the Statewide Comprehensive Service Area Plan (September); and
 - b. An annual report to the Governor and Legislature on implementation of the Statewide Comprehensive Service Area Plan (October) and Council activities.
4. Meet at least quarterly and conduct all council meetings in accordance with HRS, Chapter 92 (Sunshine Law).

HAWAII STATE COUNCIL ON MENTAL HEALTH BYLAWS

ARTICLE IV: MEMBERSHIP

1. Council composition.

The Council shall be entitled to twenty-one members appointed by the Governor as provided in HRS 26-34. Of the twenty-one members:

- a. The majority of members shall be residents of the state; non-providers of mental health or other health services and a majority of the members shall be consumers and family members (not state employees or provider members.)¹
- b. The Council shall be composed of individuals representing (U.S. Code, Title 42, Section 300x-3(c)):
 - i. The principal state agencies with respect to mental health, education, vocational rehabilitation, housing, criminal justice, and social services (six (6) positions);
 - ii. The principal state agency with respect to human services, specifically oversight of the development of the plan submitted pursuant to title XIX of the Social Security Act (Medicaid) (one (1) position);
 - iii. A mental health provider representative (one (1) position);
 - iv. Public and private entities concerned with the need, planning, operations, funding, and use of mental health services and related support services;
 - v. Adults with serious mental illnesses who are receiving or have received mental health services;
 - vi. Student and youth mental health advocates;
 - vii. Family members of adults with serious mental illnesses;
 - viii. Family members of children requiring Support for Emotional and Behavioral Development (SEBD) and;
 - ix. The Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS), provided that the one HACDACS representative shall be knowledgeable about the community and the relationships among mental illness and substance abuse (one (1) position).
- c. Each of the four County Service Area Boards (SAB) on Mental Health and Substance Abuse shall be represented on the Council by one designated Council member who is also a Service Area Board member (HAR 11-175-04a).
- d. The Deputy Director of Behavioral Health Administration (BHA) or designee will serve as ex-officio (non-voting) member.

2. Terms of Membership

- a. Members of the Council shall be nominated with the advice and consent of the senate, appointed by the Governor (HRS 26-34).
- b. Terms of the members shall be for four years, provided that the Governor may reduce the terms of those initially appointed so as to provide, as nearly as can be, for the expiration of an equal number of terms at intervals of one year.

¹ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Service Administration (SAMHSA), Center for Mental Health Services (CMHS), Community Mental Health Services Block Grant Application Guidance and Instructions, 2008-2101 CDFA No. 93.958.

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- c. No member shall be appointed consecutively to more than two terms; provided that membership does not exceed eight consecutive years inclusive of terms served in completing the term of a member unable to serve her or his full term.
 - d. Terms shall expire at the end of the State fiscal year.
 - e. Members of the Council may be considered as “interim” members when they have been appointed by the Governor to officially serve for a period of time prior to the Senate Health Committee hearing or advise and consent.
 - f. Members of the Council may be considered as “holdover” members when they are an existing member and have either submitted their application (re-applied) and are pending confirmation to a continuing term or have served the maximum period but a new member has not yet applied/been selected.
3. Privileges of Membership.
All members of the Council shall be eligible to vote, hold office, serve on the committees and Permitted Interaction Groups (PIGs), and participate in activities as established by the Council.
4. General Conditions of Membership.
All members shall agree to abide by these bylaws as adopted by the Council.
5. Vacancies.
- a. Vacancies shall exist on the death, resignation, or removal of any member.
 - b. Resignation of members will take effect upon receipt notification of resignation by the Governor.
 - c. Members must submit a copy of a resignation letter to the Council to be forwarded to the Adult Mental Health Division Planning Office and to the Governor.
 - d. A member appointed to fill a vacancy shall hold office for the remainder of the unexpired term of his or her predecessor in accordance with HRS 26-34, subject to Article V, Section 6 of the Constitution of the State.
 - e. In accordance with Article V, Section 6 of the Constitution of the State, when the Senate is not in session and a vacancy occurs, the Governor may fill the vacancy, which shall, unless confirmed by the Senate, expire at the end of the next session of the Senate.
 - f. A person receiving an interim appointment such as this paragraph provides shall not be eligible for another interim appointment to such a vacancy if the appointment shall have failed to receive confirmation by the Senate.
 - g. The Governor may remove or suspend for cause any member after due notice and public hearing in accordance with HRS 26-34.
6. Attendance.
Compliance with HRS 92-15.5 Nonattendance of board member; expiration of term.
- a. Notwithstanding any law to the contrary, the term of a board member shall expire upon the failure of the member, without valid excuse, to attend two consecutive meetings duly noticed to all members of the board and where the board failed to constitute quorum necessary to transact board business.
 - b. The Chairperson or acting Chairperson of the board shall determine if the absence of the member is excusable. The expiration of the member's term shall be effective immediately

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- after the second consecutive unattended meeting and unexcused absence. The vacancy shall be filled in the same manner as the original appointment.
- c. This section shall not apply to ex-officio members of a board.
 - d. Notwithstanding the definition of "board" in section 92-2, this section shall apply only to a state board and shall not apply to a board of any political subdivision of the State or whose authority is strictly advisory. [L 2004, c 234, §1]
 - i. If a member does not attend meetings for a certain amount of time without providing an excuse that counts as an excused absence, the Chairperson should contact the member by phone or e-mail to inquire about their attendance. If no contact is established by phone or e-mail, the Chairperson should send a letter to the member suggesting that they resign.
 - ii. Valid Excuse and Notification of Chairperson. It is incumbent on each Council member to contact the Chairperson if they will not attend a meeting (in absence of the Chairperson, member shall contact the Vice-Chairperson). Illnesses, being out of State or urgent conflicting meetings are valid reasons to be excused if the Chairperson is notified ahead of time. An absence for which the Chairperson has not been contacted with valid reasons will be an unexcused absence.
 - iii. Contacting the Chairperson or Vice Chairperson to Request Excused Absence. Whenever possible, Council members should request excused absences in writing via e-mail correspondence to DOH.SCMHChairperson@doh.hawaii.gov prior to the start time of the meeting. If e-mail is not possible, Council members should contact the assigned Council support staff by phone to request excused absences.
 - iv. Recording of all SCMH Meeting Excused/Unexcused Absences and Quorums. A record will be kept of each Council meeting in which the attendance of all 21 members is noted, including those with excused absences and unexcused absences and those in which a quorum was present. This record will be provided to each Council member on a monthly basis.
7. Compensation.
Members shall serve without compensation, but shall be reimbursed for expenses, including travel expenses, necessary for attending meetings of the Council and for performance of their duties.

ARTICLE V: MEETINGS

- 1. General
 - a. All meetings of the Council shall be open to the public and all persons shall be permitted to attend any meeting unless otherwise provided in the constitution or as closed pursuant to sections HRS 92-4 and HRS 92-5, except to those who willfully disrupt a meeting (HRS 92-3; Attorney General, Dec. 1985).
 - b. All meetings shall be held through video teleconferencing facilities on each island.
 - c. Notification and conduct of meetings shall be in compliance with HRS 92 (Sunshine Law).
 - d. Conduct of meetings will be in accordance with Roberts' Rules of Order except as precluded by Hawaii laws and as dispensed with by the Chairperson for efficient conduct of meetings.
 - e. A regular meeting date will be established according to the votes of a majority of the membership.

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- f. Regular meetings shall be three hours in duration. Council members are allowed to excuse themselves for brief breaks during the meeting so long as, for the purpose of quorum, the Council member notifies the Chairperson prior to briefly excusing themselves.
2. Emergency.
 - a. Meetings shall be conducted at least quarterly but shall generally be held monthly unless cancelled for particular reasons or inability to attain a quorum. Indication from the Council Secretary or Behavioral Health [Services] Administration staff that a quorum will not be achieved is sufficient reason for the Chairperson to cancel, postpone or reschedule a meeting.
 - b. A regular meeting date will be established according to the votes of a majority of the membership.
 3. Agenda.
 - a. The Chairperson or designee will provide the agenda to the staff 10 days prior to the meeting to allow staff time to meet the requirement of getting meeting notices posted, sent to the Governor, and posted on the State online public meetings calendar at least six calendar days prior to the meeting date.
 - b. The agenda cannot be changed without the approval of two-thirds of the Council's membership via a recorded vote (HRS 92-7, and Attorney General, December 1995).
 - c. The agenda shall be deemed that proper notice is given by:
 - i. E-mail distribution (preferred) to the e-mail address indicated by those who have registered their name and e-mail address with the DOH BHA or, if no e-mail address is available or upon request,
 - ii. U.S. postal mail to the address indicated by those who have registered their name and address with the BHA for receipt of notices.
 4. Quorum.
 - a. A quorum for the purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins.
 - b. If a quorum is present when a vote is taken, the affirmative vote of a majority of the members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, or the articles of incorporation, or the bylaws require a greater number of affirmative votes.
 5. Passing Motions.

Pursuant to [Act 137-18 \(SB 203\)](#), Chapter 92, Hawaii Revised Statutes:
“(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes.

 - a. A majority vote of the Council's members in a meeting where quorum is established is required to make any action of the Council valid (HRS 92-15, and Attorney General, September 28, 1975, and December 1985).

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- b. The Law does not allow absentee balloting (Attorney General, September 1990).
- 6. Confidentiality.
The Chairperson determines when confidential matters will exclude public hearing pursuant to HRS 92-5.
- 7. Conflict of Interest.
Members of the Council will not vote on any question in which they have a conflict of interest (HAR 11-175-09).
- 8. Testimony.
The Council shall accept all written testimony and may not limit oral testimony to less than three minutes per person for each agenda item (HAR 11-175-03c).
- 9. Minutes.
 - a. Written minutes will be maintained of the date, time, and place of each meeting;
 - b. The members present or absent;
 - c. The substance of the matters proposed, discussed, or decided;
 - d. A record by individual member of any vote taken; and,
 - e. Any other information that any member of the Council requests be included in the minutes (HRS 92-9).

ARTICLE VI: OFFICERS

- 1. Eligibility.
 - a. The officers of the Council shall be the Chairperson, First Vice Chairperson, Second Vice Chairperson, and Secretary.
 - b. All shall be elected from among its members [of the Council].
- 2. Term.
 - a. Officers will normally be elected for a term of one year to coincide with the appointment of a new member (normally in conjunction with the calendar year, i.e. January).
 - b. If an officer vacancy should occur for any reason, such as loss of an officer (death, vacancy), the Council may vote to initiate an election to fill the officer vacancy or to elect a new slate. The duration will normally be to the end of the calendar year, but other circumstances may call for other terms to be decided by the Council.
- 3. Nomination.
 - a. At least one month before the election, the Chairperson will place nominations on the agenda as a New Business item.
 - b. Nominations will be made at least 15 days prior to the meeting at which the vote for officers is taken.
 - c. At any of these meetings in which voting for officers are an agenda item, any member may make a nomination, including a self-nomination.

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4. Election. Officers shall be elected by ballot, usually at the first meeting of the calendar year. The Law does not allow absentee voting (Attorney General, September 1990).
5. Removal of Officers. Officers may be removed for non-performance of duties or misconduct, as voted upon by a majority of Council members.
6. Duties of Officers.
Chairperson. The Chairperson shall:
 - (a) Represent the Council as its official spokesperson.
 - (b) Sign all legal documents/correspondence for the Council.
 - (c) Preside at meetings of the Council.
 - (d) Prepare agenda items for Council meetings.
 - (e) Assign members and chairpersons to committees.
 - (f) Request the resignation of members not in compliance with the By-laws.

First Vice Chairperson. The First Vice Chairperson shall:

- (a) Assume all the Chairpersons' responsibilities when the Chairperson is absent or unable to represent the Council.
- (b) Perform other duties as requested by the Chairperson.

Second Vice Chairperson. The Second Vice Chairperson shall:

- (a) Assume all of the Chairperson's responsibilities when the Chairperson and First Vice Chairperson are absent or unable to represent the Council.
- (b) Ensure minutes of meetings are being recorded, review minutes for accuracy and relevance, and have the minutes for the last twelve months available at Council meetings.
- (c) Add names to and delete names from the mailing a list as indicated by the Chairperson.

Secretary. The Secretary shall:

- (a) Ensure all attendees at the Council meetings have signed the attendance sheet and Neighbor Island guests are accounted for.
- (b) Ensure quorum is achieved at the beginning of each Council meeting.
- (c) Check the accuracy of the Attendance Log for each Council meeting.
- (d) Ensure that the Council meeting is held in accordance with Part I of Chapter 92, Hawaii Revised Statutes (Sunshine Law).
- (e) Repeat verbally each motion made during the Council meeting indicating the names of who made the motion and who seconded it; provide the number of "yeas," "nays," and abstentions.

ARTICLE VII: COMMITTEES AND PERMITTED INTERACTION GROUPS

Committees and Permitted Interaction Groups (PIGs) may be composed of Council members and members of the community. Chairpersons of committees and PIGs shall be members appointed to the Council. The Council Chairperson shall assign Council members to committees and PIGs. Council members will decide via majority vote the standing committees and PIGs that will exist. Members of standing committees and PIGs will decide, under the guidance of committee and PIG chairpersons,

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the issues that they will address, keeping in mind the tasking of the Council under law. The Council Chairperson shall create ad hoc committees as special needs arise or as the Council requests.

ARTICLE VIII: CONFLICTS OF INTEREST

Members of the Council shall not vote on questions in which such members have a financial interest pursuant to HRS 84-3: "an interest held by an individual, the individual's spouse, or dependent children, which is:

- (1) An ownership interest in a business.
- (2) A creditor interest in an insolvent business.
- (3) An employment or prospective employment for which negotiations have begun.
- (4) An ownership interest in real or personal property.
- (5) A loan or other interest.
- (6) A directorship or officership in a business.

Nor shall members participate in discussions or decisions that directly affect their financial interests or its direct competitors. The criteria for conflict of interest as established by the State Ethics Commission shall be followed pursuant to HRS 84-14 and 84-15 and as clarified by written communication from the State Ethics Commission dated April 2, 1986. A majority vote of the Council's members in a meeting where quorum is established is still necessary to make any action of the Council valid pursuant to HRS 92-15 and as clarified by written communication from the Attorney General dated September 28, 1979 and December, 1985.

ARTICLE IX: AMENDMENT OF BYLAWS

These bylaws may be revised or amended by a majority vote of the Council's members in a meeting where quorum is established, if notice of intent to revise or amend is given to Council members at a preceding Council meeting, or by U.S. postal mail fifteen days before the meeting at which the revision or amendment is to be considered. A revision or amendment shall take effect immediately upon its adoption.

ARTICLE X: LIABILITIES

Nothing herein shall constitute members of the Council as partners for any purpose. No member or officer shall be liable for the acts or failure to act, of any other member or officer of the Council (HRS 26-35.5).

REPORT TO THE THIRTY-FIRST LEGISLATURE
STATE OF HAWAII
2021

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

PREPARED BY:
STATE OF HAWAII
DEPARTMENT OF HEALTH
DECEMBER 2020

HAWAII STATE COUNCIL ON MENTAL HEALTH (SCMH) ANNUAL REPORT TO THE GOVERNOR AND LEGISLATURE

The State Council on Mental Health (“Council”) is an active, advocacy group comprised of twenty-one dedicated volunteers committed to providing a voice for children, youth, adults, and their families about Hawaii’s behavioral health system. Council members are service recipients, family members, providers, community members, and state employees who share their time, energy, expertise, and experience to advocate for a system of care that provides quality behavioral health services to all people of Hawaii when, where, and how they need it.

The Council’s mission is to advocate for a Hawaii where all persons affected by mental illness can access treatment and support necessary to live a full life in the community of their choice.

The Council’s vision is for a Hawaii where people of all ages with mental health challenges can enjoy recovery in the community of their choice.

Further, as defined by both state and federal law, the purpose of the Council is to:

- Serve as an advocate for adults diagnosed with a severe mental illness, for children and youth diagnosed with serious emotional disturbance, and individuals who live with mental illness or emotional support needs, and individuals who live with co-occurring mental illness and substance use disorders.
- Advise the Department of Health (DOH), the state mental health authority, on statewide needs, allocation of resources, and programs affecting two or more service areas;
- Provide guidance to the DOH through its review and comment on the implementation of the statewide comprehensive integrated service plan; and
- Monitor, review, and evaluate the allocations and adequacy of behavioral health services within the state on an ongoing basis.

The Council’s activities focus on assessing, evaluating, monitoring existing behavioral health services, identifying service gaps, and advising the DOH of its findings. The Council receives information about community behavioral health needs through:

- Council members’ community engagement, stakeholder advocacy, and personal/professional experiences;
- Feedback submitted by the four Service Area Boards on Mental Health and Substance Abuse regarding County-based comprehensive integrated service area planning;
- Informational presentations shared by representatives of community organizations;
- State agency reports, including those shared by representatives of the DOH Behavioral Health Administration, the Child and Adolescent Mental Health Division (CAMHD), and the Adult Mental Health Division (AMHD); and
- Collateral information reviewed from local, state, and national/federal behavioral health resources.

The Council is legislatively mandated to submit an annual report to the Governor and the Legislature on the implementation of the statewide comprehensive integrated services plan (“Plan”). Section 334-10(3), Hawaii Revised Statutes (HRS) states that, “The Council shall prepare and submit an annual report to the governor and the legislature on implementation of the statewide comprehensive integrated service plan. The report presented to the legislature shall be submitted at least twenty days prior to the convening of each regular session.”

The Council’s Response to the FY 2020 – FY 2021 State Plan

As submitted to the Center for Mental Health Services, the FY 2020 – FY 2021 Community Mental Health Services Block Grant State Plan (“Plan”) describes, through a detailed assessment, the status of Hawaii’s mental health service system by reviewing and commenting on its organizational capacity and the strengths, populations served, and goals for the behavioral health system of care for adults and children/youth.

The Council uses this Plan as a reference point for setting its priority focus areas, to support legislative initiatives indicated by the DOH, and to advise the DOH about Behavioral Health Administration (BHA) and Division-level considerations related to community mental health activities. With this Plan information, the Council can best advocate for service recipients who rely on community-based behavioral health services and supports to maintain or improve their overall quality of life.

Organizational Capacity

The DOH BHA is led by Deputy Director Edward Mersereau. The plan notes that he oversees four BHA Divisions including the Alcohol and Drug Abuse Division (ADAD), Adult Mental Health Division (AMHD), Child and Adolescent Mental Health Division (CAMHD), and Developmental Disabilities Division (DDD). The Plan focuses the AMHD and CAMHD, and mentions the ADAD, each led by Division leadership teams who plan, implement, monitor and report behavioral health services and supports they each arrange or provide.

The AMHD has transitioned to new Administrator leadership and is in the process of implementing re-organization of its administrative branches. The CAMHD and ADAD are also in transition with acting Administrator leadership who are committed to assuring that administrative functions continue uninterrupted.

Behavioral Health System of Care for Adults and Children/Youth

Statewide, the Plan acknowledges that the primary ways state behavioral health services are accessed, including an approximate number of served (if noted):

- 15 Federally Qualified Health Centers (FQHCs) – 155,436 patients in 2017
- 16 Community Mental Health Center (CMHC) main and satellite clinics – 7,633 adults with serious mental illness (SMI) in FY 2018
- 7 Family Guidance Centers (FGCs) and a Family Court Liaison Branch
- Various Medicaid programs administered by the Hawaii State Department of Human Services, MedQUEST Division, including the aged, blind, and disabled population (ABD) – 362,037 individuals as of September 2018
- State Judicial System including coordination with staff from probation and the mental health, drug and community outreach courts
- Purchase of Service (POS) state contracted behavioral health service providers

As described in their array of services, the AMHD arranges or provides approximately 45 types of behavioral health services and supports including mental health case management, community residential housing, crisis services, court- and community-based support for forensically encumbered and justice-involved individuals, psychosocial rehabilitation programs, treatment services, long-term care, primary and behavioral health integration, and the Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access and Recovery (SOAR) program.

AMHD strengths include:

- Telehealth – Improving access to psychiatrists in communities where routine community access to in-person psychiatry services are limited including rural areas and locations where in-person services are challenging or impractical.
- Expanded Adult Residential Care Home (E-ARCH) Program – Transitioning hospitalized patients, most of whom are ordered to the care and custody of the Director of the DOH, to residential long-term care who do not meet acute psychiatric criteria but who require assistance with complex medical and/or behavioral health issues.
- Coordinated Entry System – Strategically housing individuals through the Homeless Management Information System (HMIS), a systematic, prioritized screening and assessment process that emphasizes placement of those with higher immediate needs across all HUD-designated subpopulation groups, including homeless and houseless individuals.
- Special Populations – Services are provided to all eligible individuals including all racial and ethnic minorities, the Lesbian, Gay, Bisexual, Transgender, and Questioning, plus (LGBTQ+) community, Native Hawaiian and other historically underserved populations – 10% of AMHD service recipients indicated they identified as Native Hawaiian and Other Pacific Islander.

As described in their array of services, the CAMHD arranges or provides approximately 28 types of behavioral health services and supports including crisis services and multiple specialized educationally supportive intensive mental health services, such as psychological and psychiatric testing and evaluation, ancillary services, respite supports, family focused therapy, in-home paraprofessional support, family foster care and residential treatment.

CAMHD strengths include:

- Hawaii Child and Adolescent Service System Program (CASSP) Principles – Adoption of these nationally recognized principles was based on input from youth, families and stakeholders.
- Culturally Competent Services – The quality and effectiveness of services arranged or provided by CAMHD are integrated within provider and administration staff competency-based training to assure CAMHD operates in culturally and linguistically relevant ways.
- Clinical Model – Developed to ensure appropriate, effective and efficient treatment where each service recipient is assigned to a “Clinical Lead” who oversees and authorizes their care and services.
- Intensive Case Management – Linkage to a Mental Health Care Coordinator (MHCC) within 48 hours of registration ensures service recipients receive services, behavioral interventions and treatment strategies that are coordinated with the recipient and their family.
- Data-Driven Decision Making – Technical reports, continuous quality management, quality assurance in clinical care, feedback from stakeholders during the quality review process, and proactive identification of areas for improvement emphasize CAMHD’s commitment to using data to drive their decision making.

- Health Information Technology – Developing a secure electronic medical records system that compliments real-time data-driven clinical decision making, supports quality assurance and improvement efforts, and enhances data analytics and billing capabilities is a goal that includes telehealth capability.
- Special Populations – CAMHD received three SAMHSA system of care grants that address special populations including girls with a history of significant trauma, children and youth with co-occurring mental health and developmental disabilities, and returning youth from out-of-state residential treatment programs back to their home communities.

State Plan Unmet Needs and Service Gaps

Whether it's maintaining or improving existing services, developing new services, or transitioning services to adapt to the current need in the community, it is critical that the Council and the DOH, along with stakeholders and advocates, work together to identify solutions that address areas within the current array of state behavioral health services and supports.

AMHD and CAMHD identified several unmet needs and service gaps, many of which the Council has acknowledged in its FY 2020 activities and will support efforts to address in FY 2021 including:

- Access to care, services and supports
 - Routine access to quality care in rural and geographically remote areas
 - Transportation to access appointments and employment on the Neighbor Islands
 - Individuals with private health insurance are ineligible for Clubhouse psychosocial rehabilitation programming
 - Hospital psychiatric bed availability for non-forensic consumers
 - Expand interagency partnerships and collaborations within the system of care
 - Integrated behavioral health and primary health care to support population-based services that promote recovery, resiliency and positive health outcomes
 - Case management step-down/step-up options, crisis interventions, residential housing, detox facilities, long-term care placements and skilled nursing beds that specialize in caring for individuals with behavioral health or co-occurring issues
 - Increased access to mental health services for homeless youth is needed
 - 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 early intervention services to address early serious mental illness using evidence-based practices
 - Expand use of interactive communication technologies to engage with service recipients, recovery team members, family/guardians and others
 - Promote self-direction in youth and young adults
- Recruitment and employment
 - Hiring and retaining psychiatrists
 - Hiring and retaining of skilled, trained and experienced behavioral health staff
 - Develop, train, hire and support Peer Specialists in the workforce

Council Activities for FY 2020

The Council meets on the second Tuesday of each month from 9:00 a.m. to 11:30 a.m. and meetings are open to the public. The public is encouraged to attend and observe Council meeting activities and when appropriate, the share comments during the Community Input section of the Council's agenda.

Prior to the COVID-19 pandemic, the Council met in-person at designated sites on Kauai, Maui, Oahu and Hawaii Island. During the COVID-19 pandemic, with guidance from the Office of Information Practices (OIP), the Council transitioned to meeting virtually via Zoom. The majority of members participate via Zoom using both the audio (microphone) and visual (camera) options activated.

Meetings and Membership

Below is a summary of the Council's meetings and membership during the fiscal year.

- The Council held nine meetings.
- With the assistance of the 2018 Hawaii Legislature, changes in quorum requirements resulted in the Council being able to conduct official business during eight of the nine meetings that were held.
- The November 2019, February 2020 and April 2020 Council meetings were cancelled.
- As a result of the Governor's recommendation for appointment and the Legislature's confirmation, the Council welcomed four new members.
- The following speakers were invited to present information to the Council:
 - DOH, Behavioral Health Administration Updates – Edward Mersereau, Deputy Director
 - DOH, CAMHD Annual Evaluation Summary – Trina Orimoto, Program Improvement and Communications Program Manager, and David Jackson, Research Evaluation Specialist
 - DOH, CAMHD Legislative Initiatives – Scott Shimabukuro, Practice Development Officer
 - DOH ADAD Updates – Janelle Saucedo, Administrator
 - Legislative Training – Arwyn Jackson, Office Manager for Representative Chris Lee
 - OIP Sunshine Law Overview – Lorna Aratani, Staff Attorney

The Council's FY 2018 – FY 2020 Strategic Plan identified six focus areas. The Council felt that its time and effort to address trends, problems and issues related to these focus areas directly related to its Vision, Mission and Who Are We? statements as well as aligned with its purpose, as defined by federal and state law.

Administrative-Related Activities

Specific administrative-related activities during this fiscal year include:

- Developing a fully functional Council website inclusive of Council-related updates and current behavioral health resource information.
- Developing legislative processes that enhance the Council's ability to review, identify and respond to legislation related to behavioral health system.
- Recruiting and retaining Council members to fully fill all 21 Council membership positions.

Mental Health Service System-Related Activities

Specific mental health service system-related activities during this fiscal year include:

- Increasing the Council's awareness of behavioral health issues related to human trafficking including learning about the Child Welfare Services (CWS) mandated reporting for sex

trafficking and identifying unfilled needs or problem areas that the Council may consider for its advocacy.

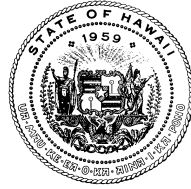
- Increasing community awareness of behavioral health and stigmatization by participating in stigma awareness activities, supporting media campaigns that promote de-stigmatization, writing Letters to the Editor, and creating a calendar of advocacy events.
- Supporting efforts to restore publicly funded addiction services and co-occurring programs by writing letters to the DHS, DOH and the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) advocating for addiction services, specifically services on neighbor islands.

Goals for the Coming Year

The Council experienced a transition in its administrative support. Long-time DOH CAMHD and AMHD Planners retired after decades of exemplary service. The Council currently receives administrative support from the AMHD Communications and Training Specialist and the AMHD Clerk Steno. FY 2021 is a year for the Council to regroup and to re-prioritize its strategic planning focus areas and activities for FY 2021 – FY 2023. The COVID-19 pandemic, including challenges related to physical/social distancing, travel restrictions and limitations on large gatherings outside our immediate households has not deterred the Council from remaining active in its advocacy and advisory roles. It's reasonable to anticipate the Council will continue to conduct its business via virtual meetings for the foreseeable future including work done through its Permitted Interaction Groups (PIGs).

Goals for the coming year include:

- Receive facilitated technical assistance for the development and creation of the Council's FY 2021 – FY 2022 Strategic Plan
- Elect Council Executive Officers – Chair, Vice-Chair and Secretary
- Recruit and retain Council members to fully fill all 21 membership positions
- Use the Council's FY 2021 – FY 2022 Strategic Plan to guide Council activities
- Create and support efforts of existing Council PIGs, new PIGs and committees
- Strengthen the Council's presence as advocates and advisors to DOH leadership, inclusive of input from neighbor island stakeholders and members of the County level Service Area Boards on Mental Health and Substance Abuse



STATE OF HAWAII
DEPARTMENT OF HEALTH
STATE COUNCIL ON MENTAL HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

STATE COUNCIL ON MENTAL HEALTH
Testimony to the Senate Committee on Education and the Senate Committee on Health
in SUPPORT of H.B. 812, H.D. 1
RELATING TO TRAUMA-INFORMED EDUCATION

Monday, March 22, 2021 at 3:10 p.m.

CHAIRPERSON
Richard Ries Psy.D., M.S.Ed.

1st VICE CHAIRPERSON
Carol Matayoshi

2nd VICE CHAIRPERSON
Christopher Knightsbridge,
MAIR, MACL

SECRETARY
Eileen Lau-James, DVM

MEMBERS:

Katherine Aumer, Ph.D.

Antonino Beninato

Charlene "Naomi" Crozier

Cynthia "Cindi" Dang, Psy.D.

Jon Fujii

Heidi Ilyavi

Dina Koyanagi

Beatrice "Kau'i" Martinez

Rusnell Pascual-Kestner

Tara Reed, BSW

Scott Shimabukuro, Ph.D.

EX-OFFICIO:

Edward Mersereau, LCSW, CSAC
Deputy Director, Behavioral
Health Administration

Aloha Chair Kidani, Chair Keohokalole, and members of the Senate Education and Health Committees:

In alignment with §334-10, HRS, the State Council on Mental Health (SCMH) is a 21-member Council responsible for advising, reviewing and monitoring the provision of mental health services statewide. SCMH members from diverse backgrounds serve as volunteers, collectively representing mental health service recipients, students and youth, parents and family members, providers, and state agencies including the Hawaii Department of Health, Department of Human Services, and the Judiciary.

This measure requires the Department of Education (DOE) to appropriate funds to establish a three-year pilot program for the development and implementation of a trauma-informed educational program in the Castle, Kailua, and Kalaheo areas of Windward Oahu, and based on the Nanakuli-Waianae program and report to the legislature.

The SCMH **SUPPORTS** this measure and offers the following comments:

- The SCMH has identified trauma-informed treatment as one of its priority focus areas in our 2020 – 2022 strategic plan.
- Within the proposed report to the legislature, specifically requiring a report back feature that includes sharing metrics and a summary of funds expended for this pilot program may assist with the tracking of funds.

The mission of the SCMH is to advocate for a Hawaii where all persons affected by mental illness can access treatment and support necessary to live a full life in the community of their choice.

Thank you for the opportunity to testify. Should you have any questions, please contact us at DOH.SCMHChairperson@doh.hawaii.gov.

FINAL
Working Document

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Action Plan

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Action Plan

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Focus Area #1 Improve Access to Mental Health Services (existing/new)				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
1.1 – (a) Review the draft Hawaii Substance Abuse and Mental Health Services (SAMHSA) Block Grant Application and (b) Identify the section of the SCISP that the Council is responsible for drafting.	<input type="checkbox"/> Obtain a copy of the SAMHSA Block Grant application	Council staff	August 2021	AMHD Planning Office
	<input type="checkbox"/> Discuss draft content for the Council’s section of SCISP	Council members		Council meeting agenda topic
1.2 – Draft and finalize the Council’s section of the SCISP.	<input type="checkbox"/> Draft content and present for Council review and approval	Council members	August 2021	Council meeting agenda topic
1.3 – Using available resources, including stakeholders within Council members’ area(s) of representation, Service Area Boards and community members, identify existing mental health services, payors and eligibility criteria, statewide, by county (state funded and non-state funded).	<input type="checkbox"/> Create a MS Form for collecting this information	Council staff	September 2021	
	<input type="checkbox"/> Submit information vis MS Form link	Council members		

LAST UPDATED ON: 08/02/21

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Focus Area #1 Improve Access to Mental Health Services (existing/new)				
Measurable Objective(s)	Description of Action Items	Who Will Do it?	When Will It Be Done By?	Resources/Notes
1.4 – Identify feasible ways to improve access to existing mental health services with input from stakeholders within Council member’s area(s) of representation, Service Area Boards and community members.	<input type="checkbox"/> Discuss feasible options	Council members	December 2021	Council meeting agenda topic
1.5 – Identify the Council’s prioritized list of mental health service improvements and reasons for prioritizing those improvements.	<input type="checkbox"/> Create MS Forms rank order list <input type="checkbox"/> Ranked voting to identify prioritized list	Council members	February 2022	Ranked responses
1.6 – (a) Share the Council’s prioritized list with stakeholders within Council members’ area(s) of representation, Service Area Boards and community members and (b) Provide feedback received with other Council members.	<input type="checkbox"/> Obtain feedback from stakeholders <input type="checkbox"/> Discuss feedback received	Council members Council members	April 2022	Council meeting agenda topic
1.7 – Draft, finalize and send letter to DOH DD BHA inclusive of 1.2 to 1.6.	<input type="checkbox"/> Draft content and present for Council review and approval	Council Chair	June 2022	Council meeting agenda topic

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Hawaii State Council on Mental Health Strategic Plan FY 2020 – FY 2022 – Action Plan

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Focus Area #2 Advocate for the Emotional Well-Being of the Community				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
2.1 – Identify ways the Council will advocate for the well-being of the community including references to evidence-based practices, peer reviewed publications and other widely recognized local/state/national references.	<input type="checkbox"/> Discuss Council advocacy initiatives	Council members	November 2021	Council meeting agenda topic
2.2 – (a) Identify brochure content the Council would like to include and (b) Form a Wellness Brochure PIG for brochure production.	<input type="checkbox"/> Discuss content of the brochure <input type="checkbox"/> Form Wellness Brochure PIG <input type="checkbox"/> PIG meets to draft brochure	Council members Council members Brochure PIG	January 2022	Council meeting agenda topic
2.3 – Present a draft of the brochure for Council review.	<input type="checkbox"/> Present draft brochure and obtain Council feedback	Brochure PIG	April 2022	
2.4 – Draft the public communiqué that will accompany the brochure’s debut and (b) finalize brochure.	<input type="checkbox"/> PIG meets to draft the public communiqué and finalize the brochure	Brochure PIG	May 2022	
2.5 – Review and approve the brochure and public communiqué.	<input type="checkbox"/> Distribute public communiqué and brochure	Council members	June 2022	Prepared to publicly distribute during Mental Health Awareness Week (Oct 2022)

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Focus Area #3 Identify the Tools the Council is Empowered to Use				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
3.1 – (a) Identify tools the Council is familiar with and (b) Form a PIG for infographic production (InfoG PIG).	<input type="checkbox"/> Discuss tools and create a list <input type="checkbox"/> Form an InfoG PIG <input type="checkbox"/> Meets to discuss content of the draft infographic	Council members Council members InfoG PIG	October 2021	
3.2 – Share an expanded list of tools for the Council to review, add to, and comment on.	<input type="checkbox"/> Present expanded tool list and obtain Council feedback	InfoG PIG	December 2021	
3.3 – Presents a draft infographic for Council review.	<input type="checkbox"/> Present draft infographic and obtain Council feedback	InfoG PIG	February 2022	
3.4 – Present a draft of the revised Council Mission, Vision and Who We Are document with content from the infographic for Council review and consideration for formal adoption.	<input type="checkbox"/> Present draft of the revised Council Mission, Vision and Who we Are document with infographic and obtain Council approval for adoption	InfoG PIG	April 2022	

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Focus Area #4				
Outline an Onboarding and Annual Reboarding Experience for Council Members				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
4.1 – (a) Identify features of the onboarding and re-boarding experience the Council would like to include and (b) Form a PIG for onboarding/reboarding (Onboard/Reboard PIG).	<input type="checkbox"/> Discuss features of the onboarding and reboarding experience <input type="checkbox"/> Form an Onboard/Reboard PIG <input type="checkbox"/> PIG meets to discuss onboarding/reboarding	Council members Council members On/Reboard PIG	September 2021	Council meeting agenda topic
4.2 – Recommend an onboarding and reboarding draft checklist for Council review.	<input type="checkbox"/> Present draft onboarding and reboarding checklists and obtain Council feedback	On/Reboard PIG	November 2021	Identify a prioritized list of items Council members should be oriented to
4.3 – Review and approve the onboarding and reboarding draft checklists.	<input type="checkbox"/> Discuss and approve onboarding and reboarding checklists	Council members	January 2022	Council meeting agenda topic
4.4 – Present the final onboard and reboarding checklists to the Council.	<input type="checkbox"/> Finalize onboarding and reboarding checklists for distribution to Council members	On/Reboard PIG	April 2022	To be used for the upcoming new term starting July 2022

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Focus Area #4				
Outline an Onboarding and Annual Reboarding Experience for Council Members				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
4.5 – Facilitate onboarding and reboarding sessions with Council members during its August meeting (to re-occur annually).	<input type="checkbox"/> Schedule onboarding and reboarding sessions with Council members	Council staff	August 2022	
4.6 – (a) Provide feedback on their onboarding and reboarding experience using the checklist and (b) Recommend suggestions for checklist revisions.	<input type="checkbox"/> Create MS Forms for data collection <input type="checkbox"/> Submit feedback on onboarding or reboarding experience	Council staff Council members	September 2022	
4.7 – PIG members review suggestions and recommend revisions to checklists.	<input type="checkbox"/> Review feedback on onboarding or reboarding experience and revise checklists as appropriate	On/Reboard PIG	November 2022	
4.8 – Review/approve the onboarding/reboarding checklists.	<input type="checkbox"/> Present revised onboarding and reboarding checklist and obtain Council approval	Council members	December 2022	
4.9 – Present final revised checklists and determine whether the checklist will be attached to the Council bylaws or referenced separately.	<input type="checkbox"/> Finalize revised onboarding/reboarding checklists for distribution to Council members <input type="checkbox"/> Discuss whether to attach to bylaws or keep separate	On/Re-Board PIG Council members	January 2023	(to be used annually in August) Council meeting agenda topic

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Focus Area #5 Strengthen the Council’s Presence as Advocates and Advisors to DOH Leadership, Inclusive of Input from Neighbor Island Stakeholders and Service Area Board Members				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
5.1 – Council meetings will acknowledge Council member efforts to share/disseminate/distribute mental health information.	<input type="checkbox"/> Meeting minutes will capture this information for documentation and reference	Council staff	Starting March 2021	
5.2 – Council meeting handouts will include approved meeting minutes for SABs, Mental Health Task Force and HACDACS.	<input type="checkbox"/> Meeting handouts will be requested for inclusion each month.	Council staff	Starting March 2021	
5.3 - DD BHA or their designee to attend Council meetings, share relevant updates, answer Council member questions, etc.	<input type="checkbox"/> Schedule DD BHA to attend the Council’s December 2021/ January 2022 and June/July 2022 and meetings.	Council staff	Sept/Oct 2021 Mar/Apr 2022	Council sends letterhead invite addressed to DD BHA
5.4 – Discuss this focus area and re-assess the Council’s efforts to strengthen its presence, inclusive of neighbor island stakeholder and Service Area Board input.	<input type="checkbox"/> Obtain copies of meeting minutes	Council staff	February 2022	Requested by Council support staff and shared as available.

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Focus Area #6				
Share Information on the Council’s Website About Existing Mental Health Services (Local/State/Federal)				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
6.1 – Identify the top five local/state/federal mental health and behavioral health resources that are helpful for individuals within their area(s) of representation.	<input type="checkbox"/> Discuss mental health and behavioral health resources <input type="checkbox"/> Create MS Forms for data collection <input type="checkbox"/> Submit top five local/state/federal mental health and behavioral health resources that are helpful for individuals within their area(s) of representation.	Council members Council members Council members	May 2021	
6.2 – (a) Review the resources shared by Council members and (b) Vote to approve resources to be listed on the Council’s Resource webpage.	<input type="checkbox"/> Review Council member resources and vote to approve resources to be listed on the Council’s Resource webpage.	Website, Social Media and Advocacy (WSA) PIG	May 2021	
6.3 – Present an update to the Council including recommendations for sharing resources.	<input type="checkbox"/> Recommend how the Council will publicly share the resources	Council staff	June 2021	

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Focus Area #6				
Share Information on the Council’s Website About Existing Mental Health Services (Local/State/Federal)				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
6.4 – As additional resources become known, submit information that will be automatically added to the Council’s webpage so long as it is mental health focused.	<input type="checkbox"/> Submit information via the Council’s e-mail address	Council members	Ongoing	Include topics/key words (i.e., crisis support, mental health, substance use, family member support, child/youth support, etc.), possibly incorporating information from SCISP and CISAP, Service Area Board members, etc.
6.5 – Dissolve the 2021 WSA PIG and form a new Website and Social Media (WSM) PIG.	<input type="checkbox"/> Dissolve 2021 WSA PIG <input type="checkbox"/> Form new WSM PIG	Council members Council members	July 2021	
6.6 – Revise the Council’s Resource webpage inclusive of approved resources (per 2021 WSA PIG).	<input type="checkbox"/> Revise webpage content	Council staff	September 2022	
6.7 – (a) Review the Council’s Resource webpage and (b) Recommend updates/revisions.	<input type="checkbox"/> Preview the Council’s Resources webpage and identify any additional resources	WSM PIG	As need arises but no less than annually between October and December	

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Focus Area #7				
Identify, Track and Share the Status the Council’s Prioritized Legislative Bills				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
7.1 – (a) Pilot the draft of the Council’s Participation Guidelines for Council Legislative Activities and (b) Document areas of the draft that will be recommended for revision.	<input type="checkbox"/> Continue LEG PIG activities and piloting of the draft Participation Guidelines for Council Legislative Activities	LEG PIG	Between January 2021 and May 2021	Use design/thinking strategy to determine whether guidelines are effective in both time and action: produce product.
7.2 – Present revised Participation Guidelines for Council Legislative Activities to the Council and determines whether the guidelines will be attached to the Council bylaws or referenced separately.	<input type="checkbox"/> Present revised Participation Guidelines for Council Legislative Activities and obtain Council feedback <input type="checkbox"/> Discuss whether to attach to bylaws or keep separate	LEG PIG Council members	June 2021	Council meeting agenda topic
7.3 – Dissolved the 2021 LEG PIG.	<input type="checkbox"/> Dissolve LEG PIG	Council members	June 2021	

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Focus Area #7				
Identify, Track and Share the Status the Council’s Prioritized Legislative Bills				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
7.4 – (a) Form a new LEG PIG to coordinate the activities in the guidelines and (b) Task new LEG PIG with reviewing and revising Participation Guidelines for Council Legislative Activities for the 2022 Legislative Session.	<input type="checkbox"/> Form new LEG PIG for the 2022 Legislative Session <input type="checkbox"/> Finalize Participation Guidelines for Council Legislative Activities for the 2022 Legislative Session	Council members LEG PIG	September 2021	
7.5 – Arrange legislative training for Council members.	<input type="checkbox"/> Schedule legislative training with the Hawaii State Legislative Reference Bureau (LRB)	LEG PIG	November/ December 2021	
7.6 – Share preliminary list of bills by priority topic area.	<input type="checkbox"/> Access the Hawaii State Legislature website and review bills introduced that are related to mental health, behavioral health, and substance abuse <input type="checkbox"/> Create list based on researching bills introduced by the House and Senate <input type="checkbox"/> Share list with Council	LEG PIG LEG PIG LEG PIG	January/ February 2022 February 2022 February 2022	

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Focus Area #7				
Identify, Track and Share the Status the Council’s Prioritized Legislative Bills				
Measurable Objective(s)	Description of Action Items	Who Will Do It?	When Will It Be Done By?	Resources/Notes
7.7 – Finalize priority bill list and share with DOH DD BHA.	<input type="checkbox"/> Review LEG PIG preliminary list	Council members	February 2022	
	<input type="checkbox"/> Achieve consensus for included bills and/or add bills based on priority topic areas	Council members	February 2022	
	<input type="checkbox"/> Share a copy with DOH DD BHA	Council staff	February 2022	
7.8 – Receive a copy of legislative priority bill list from DOH DD BHA.	<input type="checkbox"/> Request a copy of the list from the DOH BHA Legislative Liaison	Council staff	March 2022	
	<input type="checkbox"/> Distribute list to Council members	Council staff	March 2022	
7.9 – Pilot the Council’s Participation Guidelines for Council Legislative Activities and recommend revisions.	<input type="checkbox"/> Use Participation Guidelines for Council Legislative Activities	LEG PIG	February to May 2022	
	<input type="checkbox"/> Identify areas of the guidelines where updates may be necessary	LEG PIG		
	<input type="checkbox"/> Present recommendations for guidelines revisions to the Council	LEG PIG		
	<input type="checkbox"/> Review and approve revisions.	Council members		

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FINAL
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Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

Revised Draft: July 2021

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

Purpose: In response to stakeholder feedback about areas of Hawaii’s mental health service system that need improvement, the Hawaii State Council on Mental Health (SCMH) developed its Strategic Plan to prioritize (1) issues that directly affect more than one County service area (Statewide Comprehensive Integrated Service Area Plan; SCISAP); (2) opportunities for the Council to advocate for mental health services; and/or (3) specific ways the Council can be more effective in its advisory role to the Department of Health (DOH), Behavioral Health Administration (BHA).

Focus Area #1 Improve Access to Mental Health Services (existing/new)	
Strategic Planning: <i>Identified during the Council’s Retreat</i>	Category: <input checked="" type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions
Area(s) of Need Addressed: <i>Council’s purpose and responsibilities as required by Hawaii law</i> <i>Includes a narrative statement describing the problem/issue.</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input checked="" type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input checked="" type="checkbox"/> Council’s advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP) (c) <input checked="" type="checkbox"/> Council’s linkage to and advocacy for service recipients (c) <input checked="" type="checkbox"/> Council’s knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) There is an issue with timely access to mental health services. Continuous improvement is necessary to ensure access to mental health services when and where youth and adults need it.
Outcome(s)/Product(s): <i>What the Council wants to see</i>	<input checked="" type="checkbox"/> A well-articulated narrative State Council section within the SCISP as required by 334-10, Hawaii Revised Statutes <input checked="" type="checkbox"/> A comprehensively composed letter sent to DOH advising the Behavioral Health Administration’s Deputy Director (DD BHA) of the Council’s recommendations for improving access to mental health services.
Measurable Objective(s): <i>What the Council wants to accomplish and by when</i>	1.1 – By August 2021, (a) review the draft Hawaii Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant Application and (b) identify the section of the SCISP that the Council is responsible for drafting. 1.2 – By August 2021, draft and finalize the Council’s section of the SCISP. 1.3 – By September 2021, using available resources, including stakeholders within Council members’ area(s) of representation, Service Area Boards and community members, identify existing mental health services, payors and eligibility criteria, statewide, by county (state funded and non-state funded). 1.4 – By December 2021, identify feasible ways to improve access to existing mental health services including input from stakeholders within Council member’s area(s) of representation, Service Area Boards and community members. 1.5 – By February 2022, identify the Council’s prioritized list of mental health service improvements (ranked order) and reasons for prioritizing those improvements. 1.6 – By April 2022, (a) share the Council’s prioritized list with stakeholders within Council members’ area(s) of representation, Service Area Boards and community members and (b) provide feedback received with other Council members. 1.7 – By June 2022, draft, finalize and send letter to DOH DD BHA inclusive of 1.2 through 1.6.

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Note: Elements of the Council’s Strategic Plan template were incorporated from the Hawaii Opioid Initiative 1.0/2.0 (2017/2019).

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

Purpose: In response to stakeholder feedback about areas of Hawaii’s mental health service system that need improvement, the Hawaii State Council on Mental Health (SCMH) developed its Strategic Plan to prioritize (1) issues that directly affect more than one County service area (Statewide Comprehensive Integrated Service Area Plan; SCISAP); (2) opportunities for the Council to advocate for mental health services; and/or (3) specific ways the Council can be more effective in its advisory role to the Department of Health (DOH), Behavioral Health Administration (BHA).

Focus Area #1 Improve Access to Mental Health Services (existing/new)	
Internal/External Partners: <i>Internal: Council members per their area(s) of representation</i> <i>External: Specific organizations, agencies and individuals</i>	Internal: <ul style="list-style-type: none"> ▪ Council members and stakeholders within their area(s) of representation ▪ Council support staff External: <ul style="list-style-type: none"> ▪ State agency partners including public safety (PSD), education (DOE), judiciary (JUD), human services (DHS) ▪ Mental Health Task Force and Legislators ▪ Community-based providers ▪ Organizations specializing in behavioral health support ▪ Community/Stakeholders
Strategies: <i>Action steps the Council will take including PIGs (existing or new), requests for SABs and specialty areas, etc.</i>	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Dedicate standing agenda time at every Council meeting for forward progress. <input checked="" type="checkbox"/> Request and review meeting minutes from the Service Area Boards, the Mental Health Task Force and Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS). <input checked="" type="checkbox"/> Use electronic data collection tools such as Microsoft Forms to centrally collect information.
Status: <i>Updated quarterly (reviewed as a meeting agenda item; 3rd month each quarter)</i>	<ul style="list-style-type: none"> <input type="checkbox"/> Carried forward from (FY 2018 – FY 2020) <input type="checkbox"/> Started (Month/Year) <input type="checkbox"/> In progress (Month/Year) <input type="checkbox"/> Completed (Month/Year)

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

Purpose: In response to stakeholder feedback about areas of Hawaii’s mental health service system that need improvement, the Hawaii State Council on Mental Health (SCMH) developed its Strategic Plan to prioritize (1) issues that directly affect more than one County service area (Statewide Comprehensive Integrated Service Area Plan; SCISAP); (2) opportunities for the Council to advocate for mental health services; and/or (3) specific ways the Council can be more effective in its advisory role to the Department of Health (DOH), Behavioral Health Administration (BHA).

Focus Area #2 Advocate for the Emotional Well-Being of the Community	
Strategic Planning: <i>Identified during the Council’s Retreat</i>	Category: <input checked="" type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions
Area(s) of Need Addressed: <i>Council’s purpose and responsibilities as required by Hawaii law</i> <i>Includes a narrative statement describing the problem/issue.</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council’s advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input checked="" type="checkbox"/> Council’s linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council’s knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) Addressing the emotional well-being of the public at large, first responders/essential workers, and mental health service providers is an essential part of the state’s mental health support system.
Outcome(s)/Product(s): <i>What the Council wants to see</i>	<input checked="" type="checkbox"/> A professionally produced wellness brochure with content directed by Council that promotes and supports the emotional well-being of the community. <input checked="" type="checkbox"/> Distribute a public communiqué referencing the brochure and its availability on the Council’s website.
Measurable Objective(s): <i>What the Council wants to accomplish and by when</i>	2.1 – By November 2021, identify ways the Council will advocate for the well-being of the community including references to evidence-based practices, peer reviewed publications and other widely recognized local/state/national references. 2.2 – By January 2022, (a) identify brochure content the Council would like to include and (b) form a PIG for brochure production (Wellness Brochure PIG). 2.3 – By April 2022, PIG presents a draft of the brochure for Council review. 2.4 – By May 2022, PIG (a) drafts the public communiqué that will accompany the brochure’s debut and (b) finalizes the brochure. 2.5 – By June 2022, the Council reviews and approves the brochure and public communiqué. The brochure should be ready to publicly distribute in October 2022, during the annual Mental Health Awareness Week.
Internal/External Partners: <i>Internal: Council members per their area(s) of representation</i> <i>External: Specific organizations, agencies and individuals</i>	Internal: <ul style="list-style-type: none"> ▪ Council members and stakeholders within their area(s) of representation ▪ Council support staff External: <ul style="list-style-type: none"> ▪ Mental Health Task Force and Legislators ▪ Community-based providers ▪ Organizations specializing in behavioral health support ▪ Community/Stakeholders

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Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

Purpose: In response to stakeholder feedback about areas of Hawaii’s mental health service system that need improvement, the Hawaii State Council on Mental Health (SCMH) developed its Strategic Plan to prioritize (1) issues that directly affect more than one County service area (Statewide Comprehensive Integrated Service Area Plan; SCISAP); (2) opportunities for the Council to advocate for mental health services; and/or (3) specific ways the Council can be more effective in its advisory role to the Department of Health (DOH), Behavioral Health Administration (BHA).

Focus Area #2 Advocate for the Emotional Well-Being of the Community	
Strategies: <i>Action steps the Council will take including PIGs (existing or new), requests for SABs and specialty areas, etc.</i>	<input checked="" type="checkbox"/> Dedicate standing agenda time at every Council meeting for forward progress. <input checked="" type="checkbox"/> Form a new Wellness Brochure PIG. <input checked="" type="checkbox"/> Use electronic publishing tools such as Canva to create a professional brochure and communiqué
Status: <i>Updated quarterly (reviewed as a meeting agenda item; 3rd month each quarter)</i>	<input type="checkbox"/> Carried forward from (FY 2018 – FY 2020) <input type="checkbox"/> Started (Month/Year) <input type="checkbox"/> In progress (Month/Year) <input type="checkbox"/> Completed (Month/Year)

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

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Focus Area #3 Identify the Tools the Council is Empowered to Use	
Strategic Planning: <i>Identified during the Council’s Retreat</i>	Category: <input type="checkbox"/> #1 Public Policy and Legislation <input checked="" type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions
Area(s) of Need Addressed: <i>Council’s purpose and responsibilities as required by Hawaii law</i> <i>Includes a narrative statement describing the problem/issue.</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input checked="" type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council’s advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input type="checkbox"/> Council’s linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council’s knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) Identifying the tools (resources) that Council members should be prepared to access will assist members in being productive and efficient.
Outcome(s)/Product(s): <i>What the Council wants to see</i>	<input checked="" type="checkbox"/> A professionally produced one-page infographic identifying the Council’s tools. <input checked="" type="checkbox"/> Incorporate content from the one-page infographic into the Council’s Mission, Vision and Who We Are statements.
Measurable Objective(s): <i>What the Council wants to accomplish and by when</i>	3.1 – By October 2021, (a) identify tools the Council is familiar with and (b) form a PIG for infographic production (InfoG PIG). 3.2 – By December 2021, PIG shares an expanded list of tools for the Council to review, add to, and comment on. 3.3 – By February 2022, PIG presents a draft infographic for Council review. 3.4 – By April 2022, PIG presents a draft revising the Council’s Mission, Vision and Who We Are document that includes content from the infographic for Council review and consideration for formal adoption.
Internal/External Partners: <i>Internal: Council members per their area(s) of representation</i> <i>External: Specific organizations, agencies and individuals</i>	Internal: <ul style="list-style-type: none"> ▪ Council members and stakeholders within their area(s) of representation ▪ Council support staff External: <ul style="list-style-type: none"> ▪ Non-profit organizations whose focus is behavioral health/mental health
Strategies: <i>Action steps the Council will take including PIGs (existing or new), requests for SABs and specialty areas, etc.</i>	<input checked="" type="checkbox"/> Dedicate standing agenda time at every Council meeting for forward progress. <input checked="" type="checkbox"/> Form a new InfoG PIG. <input checked="" type="checkbox"/> Research may include, but is not limited to, local/state/national tools with demonstrated effectiveness by other similar behavioral health and/or community-oriented Councils. <input checked="" type="checkbox"/> Use electronic publishing tools such as Canva to create a professional one-page infographic.

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

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Focus Area #3 Identify the Tools the Council is Empowered to Use	
Status: <i>Updated quarterly (reviewed as a meeting agenda item; 3rd month each quarter)</i>	<input type="checkbox"/> Carried forward from (FY 2018 – FY 2020) <input type="checkbox"/> Started (Month/Year) <input type="checkbox"/> In progress (Month/Year) <input type="checkbox"/> Completed (Month/Year)

Note: Elements of the Council’s Strategic Plan template were incorporated from the Hawaii Opioid Initiative 1.0/2.0 (2017/2019). LAST UPDATED ON: 08/02/21 7

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

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Focus Area #4	
Outline an Onboarding and Annual Reboarding Experience for Council Members	
Strategic Planning: <i>Identified during the Council’s Retreat</i>	Category: <input type="checkbox"/> #1 Public Policy and Legislation <input checked="" type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions
Area(s) of Need Addressed: <i>Council’s purpose and responsibilities as required by Hawaii law</i> <i>Includes a narrative statement describing the problem/issue.</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input checked="" type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input checked="" type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council’s advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input type="checkbox"/> Council’s linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council’s knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) Providing a streamlined experience for onboarding new members and reboarding existing members will improve communication amongst members and support staff by educating members about their role, responsibilities and Council procedures.
Outcome(s)/Product(s): <i>What the Council wants to see</i>	<input checked="" type="checkbox"/> An electronically accessible administrative checklist detailing the Council’s onboarding and reboarding processes for new and continuing Council members.
Measurable Objective(s): <i>What the Council wants to accomplish and by when</i>	4.1 – By September 2021, (a) identify features of the onboarding and reboarding experience the Council would like to include and (b) form a PIG for onboarding and reboarding (Onboard/Reboard PIG). 4.2 – By November 2021, PIG members recommend an onboarding and reboarding draft checklist for Council review. 4.3 – By January 2022, the Council reviews and approves the onboarding and reboarding draft checklists. 4.4 – By April 2022, Council members receive the final onboard and reboarding checklists to be used for the upcoming new term starting July 2022. 4.5 – By August 2022, the Council will facilitate onboarding and reboarding sessions with Council members (to re-occur annually). 4.6 – By September 2022, Council members (a) provide feedback on their onboarding and reboarding experience using the checklist and (b) recommend suggestions for checklist revisions. 4.7 - By November 2022, PIG members review suggestions and recommend revisions to the onboard and reboarding checklists. 4.8 – By December 2022, the Council reviews and approves the onboarding and reboarding revised checklists. 4.9 – By January 2023, Council members receive the final revised onboarding and reboarding checklists and recommends whether to attached to bylaws or not.

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

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Focus Area #4 Outline an Onboarding and Annual Reboarding Experience for Council Members	
Internal/External Partners: <i>Internal: Council members per their area(s) of representation</i> <i>External: Specific organizations, agencies and individuals</i>	Internal: <ul style="list-style-type: none"> ▪ Council members and stakeholders within their area(s) of representation ▪ Council support staff External: <ul style="list-style-type: none"> ▪ Local/State/Federal boards/committees/councils ▪ Organizations specializing in behavioral health support ▪ Community/Stakeholders
Strategies: <i>Action steps the Council will take including PIGs (existing or new), requests for SABs and specialty areas, etc.</i>	<input checked="" type="checkbox"/> Dedicate standing agenda time at every Council meeting for forward progress. <input checked="" type="checkbox"/> Form a new Onboard/Reboard PIG. <input checked="" type="checkbox"/> Identify a prioritized list of items Council members should be oriented to based on available onboarding and reboarding information for other local/state/federal board/committee/council members.
Status: <i>Updated quarterly (reviewed as a meeting agenda item; 3rd month each quarter)</i>	<input type="checkbox"/> Carried forward from (FY 2018 – FY 2020) <input type="checkbox"/> In progress (Month/Year) <input type="checkbox"/> Completed (Month/Year)

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

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Focus Area #5	
Strengthen the Council’s Presence as Advocates and Advisors to DOH Leadership, Inclusive of Input from Neighbor Island Stakeholders and Service Area Board Members	
Strategic Planning: <i>Identified during the Council’s Retreat</i>	Category: <input checked="" type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input checked="" type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions
Area(s) of Need Addressed: <i>Council’s purpose and responsibilities as required by Hawaii law</i> <i>Includes a narrative statement describing the problem/issue.</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input checked="" type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input checked="" type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input checked="" type="checkbox"/> Council’s advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input checked="" type="checkbox"/> Council’s linkage to and advocacy for service recipients (c) <input checked="" type="checkbox"/> Council’s knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) The Council seeks to be an active contributor in advisory role to the DOH and believes input from neighbor island stakeholders in mental health planning efforts is critical.
Outcome(s)/Product(s): <i>What the Council wants to see</i>	<input checked="" type="checkbox"/> Documentation of Council member attendance at 100% of all Mental Health Task Force meetings scheduled between March 2021 and January 2022. <input checked="" type="checkbox"/> Documentation of Council members sharing/disseminating/distributing mental health information within their area(s) of representation including, but not limited to, who the Council is, what the Council does, and ways to engage with the Council. <input checked="" type="checkbox"/> Schedule the DOH Deputy Director (DD), Behavioral Health Administration (BHA) to attend Council meetings at least twice each calendar year to: (a) share feedback on the Council’s role relative to advising DOH leadership, (b) share about achievements/activities in progress, and (c) discuss areas of concern identified in Council correspondence, handouts, and/or documented in meeting minutes.
Measurable Objective(s): <i>What the Council wants to accomplish and by when</i>	5.1 – Starting in March 2021, Council meetings will acknowledge Council member efforts to share/disseminate/distribute mental health information. 5.2 – Starting in March 2021, Council meeting handouts will include approved meeting minutes for Service Area Boards, Mental Health Task Force and Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS), requested by Council support staff and shared as available. 5.3 – Schedule DD BHA or their designee to attend the Council’s December 2021/January 2022 and June/July 2022 meetings. 5.4 – At the February 2022 Council meeting, Council members will discuss this focus area and re-assess the Council’s efforts to strengthen its presence, inclusive of neighbor island stakeholder and Service Area Board input.

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

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Focus Area #5	
Strengthen the Council’s Presence as Advocates and Advisors to DOH Leadership, Inclusive of Input from Neighbor Island Stakeholders and Service Area Board Members	
<p>Internal/External Partners: <i>Internal: Council members per their area(s) of representation</i></p> <p><i>External: Specific organizations, agencies and individuals</i></p>	<p>Internal:</p> <ul style="list-style-type: none"> ▪ Council members and stakeholders within their area(s) of representation ▪ Council support staff <p>External:</p> <ul style="list-style-type: none"> ▪ State agency partners including public safety (PSD), education (DOE), judiciary (JUD), human services (DHS) ▪ Mental Health Task Force and Legislators ▪ Community-based providers ▪ Organizations specializing in behavioral health support ▪ Community/Stakeholders
<p>Strategies: <i>Action steps the Council will take including PIGs (existing or new), requests for SABs and specialty areas, etc.</i></p>	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Use Council member tools, resources and member knowledge to increase community awareness about the Council <input checked="" type="checkbox"/> Create a Council meeting report template for members to refer to when orally sharing their report or when submitting their written report. <input checked="" type="checkbox"/> Direct communication between the Council and DOH DD BHA <input checked="" type="checkbox"/> Routine engagement opportunities that prioritize mental health/behavioral health topics.
<p>Status: <i>Updated quarterly (reviewed as a meeting agenda item; 3rd month each quarter)</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Carried forward from (FY 2018 – FY 2020) <input type="checkbox"/> In progress (Month/Year) <input type="checkbox"/> Completed (Month/Year)

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

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Focus Area #6 Share Information on the Council’s Website About Existing Mental Health Services (Local/State/Federal)	
Strategic Planning: <i>Identified during the Council’s Retreat</i>	Category: <input checked="" type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input checked="" type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input type="checkbox"/> #4 Administrative Support for Council Functions
Area(s) of Need Addressed: <i>Council’s purpose and responsibilities as required by Hawaii law</i> <i>Includes a narrative statement describing the problem/issue.</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input checked="" type="checkbox"/> Council’s advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input checked="" type="checkbox"/> Council’s linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council’s knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) The Council has the ability to share local/state/federal information related to mental health using its website and its unofficial social media account(s).
Outcome(s)/Product(s): <i>What the Council wants to see</i>	<input checked="" type="checkbox"/> A refreshed consumer-friendly Resources webpage within the Council’s website that includes information about local/state/federal mental health/behavioral health resources.
Measurable Objective(s): <i>What the Council wants to accomplish and by when</i>	6.1 – By May 2021, Council members identify their top five local/state/federal mental health and behavioral health resources that are helpful for individuals within their area(s) of representation. 6.2 – In May 2021, the 2021 Website, Social Media and Advocacy (WSA) PIG (a) reviews the resources shared by Council members and (b) votes to approve resources to be listed on the Council’s Resource webpage. 6.3 – In June 2021, the WSA PIG will present an update to the Council including recommendations for sharing resources. 6.4 – As additional resources become known, Council members will submit the information via the Council’s e-mail address. Per the Council’s Website, Social Media and Advocacy (WSA) PIG (June 2021), resources will be automatically added to the Council’s webpage so long as it is primarily mental health focused. 6.5 – In July 2021, the WSA PIG is dissolved and a new Website and Social Media (WSM PIG) is formed. 6.6 – By September 2022, Council support staff will revise the Council’s Resource webpage inclusive of approved resources (per 2021 WSA PIG). 6.7 – As need arises but no less than annually in October-December, the WSM PIG (a) reviews the Resource webpage and (b) recommends updates/revisions.

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

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Focus Area #6 Share Information on the Council’s Website About Existing Mental Health Services (Local/State/Federal)	
Internal/External Partners: <i>Internal: Council members per their area(s) of representation;</i> <i>External: Specific organizations, agencies and individuals</i>	Internal: <ul style="list-style-type: none"> ▪ Council members and stakeholders within their area(s) of representation ▪ Council support staff External: <ul style="list-style-type: none"> ▪ Community-based providers ▪ Organizations specializing in behavioral health support Community/Stakeholders
Strategies: <i>Action steps the Council will take including PIGs (existing or new), requests for SABs and specialty areas, etc.</i>	<input checked="" type="checkbox"/> Seek input from individuals within Council members’ area(s) of representation to identify the top used/useful or needed resources. <input checked="" type="checkbox"/> Dissolve current WSA PIG and form a new WSM PIG. <input checked="" type="checkbox"/> Create a Resource webpage that includes searchable options such as topics/key words (i.e. crisis support, mental health, substance use, family member support, child/youth support, etc.), possibly incorporating information from SCISP and CISAP, Service Area Board members, etc.
Status: <i>Updated quarterly (reviewed as a meeting agenda item; 3rd month each quarter)</i>	<input type="checkbox"/> Carried forward from (FY 2018 – FY 2020) <input type="checkbox"/> In progress (Month/Year) <input type="checkbox"/> Completed (Month/Year)

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

Purpose: In response to stakeholder feedback about areas of Hawaii’s mental health service system that need improvement, the Hawaii State Council on Mental Health (SCMH) developed its Strategic Plan to prioritize (1) issues that directly affect more than one County service area (Statewide Comprehensive Integrated Service Area Plan; SCISAP); (2) opportunities for the Council to advocate for mental health services; and/or (3) specific ways the Council can be more effective in its advisory role to the Department of Health (DOH), Behavioral Health Administration (BHA).

Focus Area #7	
Identify, Track and Share the Status the Council’s Prioritized Legislative Bills	
Strategic Planning: <i>Identified during the Council’s Retreat</i>	Category: <input type="checkbox"/> #1 Public Policy and Legislation <input type="checkbox"/> #2 Knowledge, Skill-Building, Education and Training <input type="checkbox"/> #3 Communication/Dissemination of Mental Health Information <input checked="" type="checkbox"/> #4 Administrative Support for Council Functions
Area(s) of Need Addressed: <i>Council’s purpose and responsibilities as required by Hawaii law</i> <i>Includes a narrative statement describing the problem/issue.</i>	Area(s) of Need (§334-10, Hawaii Revised Statutes): <input type="checkbox"/> Full Council membership with diverse representation (a, 1-5) <input type="checkbox"/> Effectiveness of the Council in its advisory role to the DOH (b, c) <input type="checkbox"/> Council’s advisory context: Resources; Statewide Needs; and Programs affecting one or more service areas, including review and consideration of County level Comprehensive Integrated Service Area Plans (CISAP)) (c) <input checked="" type="checkbox"/> Council’s linkage to and advocacy for service recipients (c) <input type="checkbox"/> Council’s knowledge, review and comment on the Statewide Comprehensive Integrated Service Plan (SCISP) and annual report to the Governor/Legislature (c,e) Active participation in the legislative process will allow the Council’s voice to be heard in support, in opposition or with comments only on proposed draft bills that affect mental health services, treatment, and community supports.
Outcome(s)/Product(s): <i>What the Council wants to see</i>	<input checked="" type="checkbox"/> Post-pilot Participation Guidelines for Council Legislative Activities.
Measurable Objective(s): <i>What the Council wants to accomplish and by when</i>	7.1 – Between January 2021 and May 2021, the Council’s current Legislative (LEG) PIG continues to (a) pilot the draft Participation Guidelines for Council Legislative Activities and (b) recommend revisions to the draft process. 7.2 – By June 2021, the LEG PIG presents the revised Participation Guidelines for Council Legislative Activities to the Council and determines whether the guidelines will be attached to the Council bylaws or referenced separately. 7.3 – By June 2021, the current LEG PIG is dissolved for the 2021 Legislative Session. 7.4 – By September 2021, the Council (a) forms a new LEG PIG to coordinate the activities in the guidelines and (b) tasks the new LEG PIG with reviewing and revising the Participation Guidelines for Council Legislative Activities for the 2022 Legislative Session. 7.5 – By November/December 2021, arrange legislative training for Council members. 7.6 - By February 2022, LEG PIG shares with the Council, its preliminary list of bills by priority topic area. 7.7 - By February 2022, the Council finalizes its priority legislative bill list and shares a copy with DOH DD BHA. 7.8 - By March 2022, Council receives a copy of legislative priority bill list from DOH DD BHA for consideration. 7.9 – Between February and May 2022, LEG PIG pilots the Participation Guidelines for Council Legislative Activities and recommends revisions. Repeat 7.3 to 7.9 annually.

LAST UPDATED ON: 08/02/21 **14**

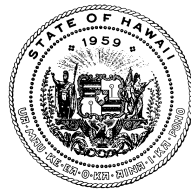
Note: Elements of the Council’s Strategic Plan template were incorporated from the Hawaii Opioid Initiative 1.0/2.0 (2017/2019).

Hawaii State Council on Mental Health
Strategic Plan FY 2020 – FY 2022 – Focus Areas

Purpose: In response to stakeholder feedback about areas of Hawaii’s mental health service system that need improvement, the Hawaii State Council on Mental Health (SCMH) developed its Strategic Plan to prioritize (1) issues that directly affect more than one County service area (Statewide Comprehensive Integrated Service Area Plan; SCISAP); (2) opportunities for the Council to advocate for mental health services; and/or (3) specific ways the Council can be more effective in its advisory role to the Department of Health (DOH), Behavioral Health Administration (BHA).

Focus Area #7	
Identify, Track and Share the Status the Council’s Prioritized Legislative Bills	
<p>Internal/External Partners: <i>Internal: Council members per their area(s) of representation</i></p> <p><i>External: Specific organizations, agencies and individuals</i></p>	<p>Internal:</p> <ul style="list-style-type: none"> ▪ Council members and stakeholders within their area(s) of representation ▪ Council support staff <p>External:</p> <ul style="list-style-type: none"> ▪ State agency partners including public safety (PSD), education (DOE), judiciary (JUD), human services (DHS) ▪ Mental Health Task Force and Legislators ▪ Community-based providers ▪ Organizations specializing in behavioral health support ▪ Community/Stakeholders
<p>Strategies: <i>Action steps the Council will take including PIGs (existing or new), requests for SABs and specialty areas, etc.</i></p>	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Continue positive momentum of existing LEG PIG. <input checked="" type="checkbox"/> Dissolve current LEG PIG and form a new LEG PIG. <input checked="" type="checkbox"/> Use design/thinking strategy to determine whether guidelines are effective in both time and action.
<p>Status: <i>Updated quarterly (reviewed as a meeting agenda item; 3rd month each quarter)</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Carried forward from (FY 2018 – FY 2020) <input type="checkbox"/> In progress (Month/Year) <input type="checkbox"/> Completed (Month/Year)

DAVID Y. IGE
GOVERNOR OF HAWAII



BRUCE S. ANDERSON, Ph.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
STATE COUNCIL ON MENTAL HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File: DOH/AMHD

August 18, 2020

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Carol Matayoshi

2nd VICE CHAIRPERSON
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Tara Reed

Scott Shimabukuro, Ph.D.

EX-OFFICIO:

Edward Mersereau, LCSW, CSAC
Deputy Director, Behavioral
Health Administration

TO: Edward Mersereau, LCSW, CSAC
Deputy Director, Behavioral Health Administration
Hawaii State Department of Health

FROM: Richard Ries, Psy.D., M.S.Ed.
Chair, State Council on Mental Health

SUBJECT: Impact of COVID-19 on Recipients of Mental Health Services

The Hawaii State Council on Mental Health (SCMH) exists to serve as a voice for Hawaii's citizens, including mental health stakeholders from various vantage points. On behalf of the members of the SCMH, I am writing this letter to urgently express our top priorities during this unprecedented time of the coronavirus disease (COVID-19) pandemic.

It is evident that the direct and indirect psychological and social effects of the COVID-19 pandemic are widespread and affects mental health now and in the future. Safety versus disease transmission is not simply a medical factor, but a behavioral one as well. The economic impacts of recent state and county-level changes stand to have broad implications for which mental health services may offer vital support. As we move forward as a state, the SCMH offers the following suggestions.

Leadership

During times of crisis (e.g., COVID-19, economic and political changes, hurricane season), the public looks upon the State of Hawaii's leadership to assuage anxieties. The SCMH, comprised of mental health service recipients and their family members, service providers, and representatives of state agencies responsible for coordinating these services, is poised to offer support and feedback to state and county leaders who may foresee and mitigate potential tragedies and close gaps in consensus that may exist at different levels of leadership. We offer our perspectives and an audience where discussions related to mental health occur.

Testing, Contact Tracing and Tracking

Current protocols for testing and contact tracing for purposes of tracking COVID-19 transmission do not provide for assessment or follow-up with even brief mental health support to our knowledge. Due to cultural factors, factors related to stigma in the community, and health related anxieties such as isolation, and fears of illness and dying, appropriate questions and resources should be included in initial screening and contact tracing outreach efforts. The SCMHS is willing to assist with developing these assessment and follow-up tools.

Helping Residents in Crisis

We are aware that the former Crisis Line of Hawaii has had challenges with providing adequate or timely responses statewide but are optimistic that the new Hawaii CARES Program will address this concern.

Additionally, we are aware that Crisis Mobile Outreach (CMO) and Crisis Support Management (CSM) services may be inadequate with the uptick in community need. With these concerns in mind, we recommend that some CARES Act funding be allocated to “beef up” these emergency/crisis services. For example, allocating some funding to expand staffing and provide phones or other communication devices to staff working remotely and to those who need services but do not have a device might be wise. A separate or connected, but dedicated, statewide mental health support line (possibly a consumer-lead Warm Line) to help those experiencing anxiety, stress, or emotional challenges due to the COVID-19 pandemic has also been discussed. This type of telephonic support should offer COVID-19-related mental health support for all residents toll-free 24 hours a day, seven days a week. We also recommend more training and/or staffing of mental health workers on the frontline as FIRST responders, properly equipped to address mental health crises in the community.

It is imperative that first responders to the majority of mental health crises in the community either have mental health professionals alongside them or are well-equipped and properly trained to calm the individual in crisis and link the individual to appropriate mental health services. Frontline workers may also benefit from mental health support, themselves, to prevent burnout and compassion fatigue. We would like to help the DOH in these areas of COVID-19-related mental health crisis response.

Caring for Residents with Substance Use Disorders and Populations without Housing

State funded homeless programs follow the Housing First model which prioritizes permanent housing placement without requiring behavioral health or substance use problems to be addressed, and does not mandate participation in mental health services before obtaining housing or to retain housing. Recovery Housing is defined by the U.S. Department of Housing and Urban Development (HUD) as housing in an abstinence-focused and peer-supported community for individuals recovering from substance use disorders (SUDs), is a safe and healthy alternative for those who need to live in clean and sober environments. Since the State does not allocate homeless funding for Recovery Housing, CARES Act funds should provide funding for clean and sober housing units, especially with the increase in substance misuse and SUDs as a result of COVID-19.

Caring for Individuals Involved with Domestic Violence

Mental health providers have noted a rise in domestic problems during the COVID-19 pandemic Stay-at-Home order and subsequent shutdown of establishments including those that have closed their doors for good and those that have been temporarily closed. Increased risk of abuse and violence are likely. Stress may also be a primary contributor to how individuals cope with changes, both within and outside of their control. While the specific details have not been shared, we are aware that a recent University of Hawaii at Manoa Graduate Assistant died from circumstances that many believe were related to domestic violence. The SCMH would like to partner with the DOH and local domestic violence advocacy programs to ensure that mental health aspects are addressed with guidance from stakeholders with firsthand knowledge.

Pro Bono Public Services

There are a few *pro bono publico* services that we are aware of that may be particularly helpful for mental health providers and consumers receiving mental health services to know about. For example, the Hawaii Psychological Association (HPA) has begun providing limited, free psychotherapy services to those who have lost their health insurance coverage due to COVID-19-related job loss. Additionally, through the Legal Aid Society of Hawaii, households in need of utility payment assistance may be eligible for up to \$1000 through the Low-Income Home Energy Assistance Program (LIHEAP) COVID-19 Disaster Energy Crisis Intervention Assistance Program. The SCMH supports these types of *pro bono publico* services and seeks to discover if similar organizations that currently partner with the DOH, or the DOH itself, might consider supporting the development or expansion of such programs, especially for psychiatric services.

Accessibility, Language Barriers, and Cultural Consideration

While we realize that the DOH is juggling many priorities, it has been notable to members of the SCMH that many service recipients, or would-be service recipients, require information that is translated into their preferred spoken and understood language. Certain populations have been identified as having higher incidences of COVID-19 infection. This may be in part due to certain cultural practices and to a lack of information provided in their preferred language. We hope that efforts are underway to provide culturally sensitive and linguistically appropriate information to common populations in our state that rely on such resources, as such populations may put others in the community at more acute risk.

Summary/Conclusion

- Leadership: The SCMH is comprised of mental health service recipients, their family members, service providers, and representatives of state agencies who collectively are responsible for advising the DOH about statewide coordination of services. The SCMH is poised to offer support and feedback to state and county leaders.
- Testing, Contact Tracing and Tracking: The SCMH can assist with developing and rolling out contact tracing/tracking programs that include mental health support.

- Helping Residents in Crisis:
 1. Expand emergency/crisis services with more staffing.
 2. Provide phones or other communication devices to staff working remotely and those who need services and do not have them.
 3. Provide a dedicated statewide mental health support line to offer COVID-19-related mental health support toll-free 24 hours a day, seven days a week.
 4. Provide more training and/or staffing of mental health workers on the frontline as FIRST responders.
 5. Provide mental health support for frontline workers to prevent burnout and compassion fatigue.
- Caring for Residents with Substance Use Disorders and Populations without Housing: Allocate CARES Act funds to provide Recovery Housing for individuals recovering from SUDs.
- Caring for Individuals Involved with Domestic Violence: The SCMh can partner with the DOH and local domestic violence programs to ensure that mental health aspects are addressed with guidance from stakeholders with firsthand knowledge.
- Pro Bono Publico Services: Support, develop, and expand *pro bono publico* services.
- Accessibility, Language Barriers, and Cultural Consideration: Provide culturally sensitive and linguistically appropriate information to common populations in our state who rely on these resources.

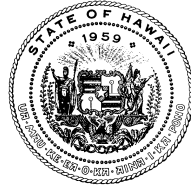
Thank you for taking the time to consider our letter. Our intention is not to criticize, but to offer partnership and assistance for what we are aware is a very complex and large-scale enterprise. We humbly welcome any corrections if we have made any incorrect assertions. Learning about the mental health system is a dynamic experience for us and we strive to have complete and accurate information to guide us in our advisory role. We warmly welcome a response that identifies areas where we may meaningfully support and guide decisions related to Hawaii's mental health services and support programs and invite you to attend a SCMh meeting in the near future to discuss these opportunities.

Sincerely,

Richard Ries, Psy.D., M.S.Ed.

Richard Ries, Psy.D., M.S.Ed.

Chair, State Council on Mental Health



STATE OF HAWAII
DEPARTMENT OF HEALTH
STATE COUNCIL ON MENTAL HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

August 30, 2021

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Christopher Knightsbridge,
MAIR, MACL

2nd VICE CHAIRPERSON
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Jon Fujii

Heidi Ilyavi

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Rusnell Pascual-Kestner

Tara Reed, BSW

Jennifer Renfro

Renee Rivera

Kathleen Rhoads Merriam

EX-OFFICIO:

Marian Tsuji,
Deputy Director, Behavioral
Health Administration

TO: Ms. Michelle Gleason
Public Health Advisor
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Division of State and Community Systems Development

Aloha Ms. Gleason:

The Hawaii State Council on Mental Health ("Council") was provided the opportunity to review the Hawaii State Department of Health's ("DOH") fiscal year 2022-2023 Community Mental Health Services Block Grant ("grant") application.

As part of the Substance Abuse and Mental Health Services Administration (SAMHSA) grantee performance requirements, and in concurrence with federal law, the Council is tasked with (a) reviewing the grant application; (b) making recommendations; (c) monitoring, reviewing and evaluating, not less than annually, the allocation and adequacy of Hawaii's mental health service system, and (d) serving as advocates for adults living with serious mental illness (SMI), children living with serious emotional disturbance (SED), and other mental health service recipients.

We are pleased to report that the Council met Sunday evening, August 29, 2021 with quorum to review a draft of the application. Reviewing the application provided us with the opportunity to understand the innerworkings of the state mental health system related to areas of service planning, budgeting, and operational infrastructure.

The Council's structured application review was insightful and resulted in the following key takeaway points:

- Hawaii's mental health system is strong. The DOH Adult Mental Health Division (AMHD) currently provides over 40 mental health service and support options to eligible adults living with SMI and the DOH Child and Adolescent Mental Health Division (CAMHD) provides over 25 mental health services for eligible youth. Combined, these divisions serve over 10,000 adults and youth across four counties and eight islands.

For more information about the State Council on Mental Health, please visit: www.scmh.hawaii.gov

- Hawaii's mental health system is growing. With the expansion of existing programs and the acquisition of additional grant funding, the AMHD and CAMHD have committed to addressing, for example, crisis stabilization, data informed decision making, houseless youth, peer support, transitional age youth, and more! We look forward to progress updates!
- There is much Hawaii can be appreciative for, especially when it comes to advocacy for mental health services. From the county level Service Area Boards on Mental Health and Substance Abuse, to the Hawaii State Legislature, and numerous agency partners and community-based organizations in between, it is clear that there is no shortage of mental health advocacy throughout the state.

Over the last two years, Hawaii's mental health system of care has not only persevered but has also evolved. For example, alongside the rest of the world, Hawaii continues to address the COVID-19 pandemic to ensure that those who are experiencing challenges related to the COVID-19 pandemic may be supported and offered comfort through mental health services. We acknowledge the COVID-19 pandemic has created numerous mental health workforce challenges that have resulted in shifting how Hawaii's mental health system operates. We commend Hawaii's mental health system, specifically DOH leadership, for the many outstanding ways it has supported first responders, essential workers, and stakeholders to address the health and safety of our communities throughout the pandemic.

In conclusion, the Council has reiterated its unanimous commitment to collaborate with the DOH, mental health service recipients and their family members, the community at large, and policy makers to ensure mental health services are available to individuals when they need it, where they need it, and for the duration of time they need it.

Mahalo for your time and consideration.

Sincerely,

Richard I. Ries, Psy.D., M.S. Ed.
Chairperson, State Council on Mental Health

Who We Are

In alignment with §334-10, HRS, the State Council on Mental Health (SCMH) is a 21-member Council responsible for advising, reviewing and monitoring the provision of mental health services statewide. SCMH members from diverse backgrounds serve as volunteers, representing mental health service recipients, students and youth, parents and family members, providers, and state agencies including the Hawaii Department of Health, Department of Human Services, and the Judiciary.

For more information about the State Council on Mental Health, please visit: www.scmh.hawaii.gov

Ms. Michelle Gleason
Public Health Advisor, SAMHSA/CMHS/DSCSD
August 30, 2021
Page 3

The mission of the SCMH is to advocate for a Hawaii where all persons affected by mental illness can access treatment and support necessary to live a full life in the community of their choice. Should you want to contact us in the future, please e-mail DOH.SCMHChairperson@doh.hawaii.gov.

For more information about the State Council on Mental Health, please visit: www.scmh.hawaii.gov

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: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email(if available)
Katherine Aumer	Family Members of Individuals in Recovery (to include family members of adults with SMI)		[REDACTED]	[REDACTED]
Antonino Beninato	Youth/adolescent representative (or member from an organization serving young people)		[REDACTED]	[REDACTED]
Charlene Naomi Crozier	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		[REDACTED]	[REDACTED]
Jon Fujii	State Employees	HI Department of Human Services, MedQUEST	[REDACTED]	[REDACTED]
Heidi Ilyavi	Parents of children with SED/SUD		[REDACTED]	[REDACTED]
Richard Rick Jackson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Oahu Service Area Board on Mental Health and Substance Abuse	[REDACTED]	[REDACTED]
Christopher Knightsbridge	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		[REDACTED]	[REDACTED]
Dina Koyanagi	State Employees		[REDACTED]	[REDACTED]
Eileen Lau-James	Family Members of Individuals in Recovery (to include family members of adults with SMI)		[REDACTED]	[REDACTED]

Beatrice Kau'i Martinez	State Employees	HI Public Housing Authority	[REDACTED]	[REDACTED]
Rusnell Pascual-Kestner	State Employees	HI Dept of Human Services, Vocational Rehab Div	[REDACTED]	[REDACTED]
Tara Reed	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Maui Service Area Board on Mental Health and Substance Abuse	[REDACTED]	[REDACTED]
Jennifer Renfro	State Employees	Department of Education, Student Support Service Branch	[REDACTED]	[REDACTED]
Kathleen Rhoads Merriam	State Employees	Department of Health, Adult Mental Health Division	[REDACTED]	[REDACTED]
Richard Ries	Providers		[REDACTED]	[REDACTED]
Renee Rivera	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Hawaii Service Area Board on Mental Health and Substance Abuse	[REDACTED]	[REDACTED]

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: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	20	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	4	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	12	60.00%
State Employees	6	
Providers	1	
Vacancies	1	
Total State Employees & Providers	8	40.00%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Youth/adolescent representative (or member from an organization serving young people)	1	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Planning Council had an Executive Meeting Sunday, 8/29/21 at 6pm to 9pm HST specifically to review the application and finalize its letter of support. AMHD Administrator (Amy Curtis) was present to review the application and answer Planning Council member questions at the 8/29/21 meeting. The draft of the application was shared on 8/25/21 as completed at that time. The application was finalized after the planning meeting. Comments from the planning council were incorporated into the final draft.

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

Footnotes:

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:
 - c) Other (e.g. public service announcements, print media) Yes No

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

Footnotes:

1. Environmental Factor 22. "Public Comment on the State Plan" also applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to update Environmental Factor 22. "Public Comment on the State Plan" and complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction^{1,2} on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the [Consolidated Appropriations Act](#), 2018 (P.L. 115-141) signed by President Trump on March 23, 2018³.

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers⁴. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs⁵: These documents can be found on the Hiv.gov website: <https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>,

1. [Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016](https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf) from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy <https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf>,
2. [Centers for Disease Control and Prevention \(CDC\) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016](http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf) The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf>,
3. [The Substance Abuse and Mental Health Services Administration \(SAMHSA\)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs](http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf) <http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf>,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
 - Include proposed protocols, timeline for implementation, and overall budget
 - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

¹ Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds **only** and is consistent with guidance issued by SAMHSA.

² Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C. § 300x-31(a)(1)(F)) and 45 CFR § 96.135(a) (6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the [Federal Register](#) (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

³ Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

⁴ Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set-aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

⁵ ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a [description of the elements of an SSP](#) that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio-hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

1. This Environmental Factor applies to the 2022-2023 SABG Behavioral Health Assessment and Plan.

All tables and sections pertaining to the SABG 2022-2023 Behavioral Health Assessment and Plan were added by mistake to the FFY 2022-2023 Block Grant application for Hawaii when the FFY 2022-2023 Block Grant application for Hawaii was created on 7/12/21 by someone from the Child and Adolescent Mental Health Division, not the Alcohol and Drug Abuse Division (the Hawaii SSA). The Hawaii SSA was informed by the state MHBG Coordinator and the federal MHBG Project Officer on 8/23/21 that the FFY 2022-2023 Block Grant application for Hawaii was a combined MHBG-SABG application, nine days prior to the 9/1/21 application deadline.

The Hawaii SSA usually creates, prepares and submits its annual SABG Application by October 1 of each calendar year. However as a result of this mistake, the 2022-2023 SABG Behavioral Health Assessment and Plan is now due to SAMHSA on 9/1/21 (for states that submit MHBG-only or MHBG and SABG combined applications) instead of the expected 10/1/21 deadline (for states that submit SABG-only applications).

The Hawaii SSA contacted the BGAS Helpdesk to attempt to resolve the mistake after informing the SAMHSA CSAT Project Officer and CSAP Project Officer. The BGAS Helpdesk reply on 8/24/21 stated that "the functionality to reverse the creation of an errantly created application does not exist within the WebBGAS." The BGAS Helpdesk also recommended working with the MHBG and SABG Project Officers for Hawaii.

The MHBG Project Officer replied on 8/24/21 that while it was not possible to separate the SABG portion from the combined application before the 9/1/21 deadline, the Project Officers would as a result of the errantly created combined application "work through revision requests to address the SABG." On 8/25/21 the Hawaii SSA received confirmation from the CSAT Project Officer that revision requests shall be used after the 9/1/21 combined application deadline to ensure that the full 2022-2023 SABG Behavioral Health Assessment and Plan is submitted to SAMHSA by 10/1/21.

The Hawaii SSA has therefore added this footnote to this SABG-related table/section in order to meet the 9/1/21 combined application deadline, and states its commitment to complete the full 2022-2023 SABG Behavioral Health Assessment and Plan for submission to SAMHSA by 10/1/21.

2. Per BGAS revision request on 9/22/21 from the CSAT Project Officer, the Hawaii SSA found that no edits to this section were necessary.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes: