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FY 2024-2025
Mental Health Block Grant Plan
State of Hawai'i
Due September 1, 2023

Public Comment Period:
August 16 to August 27, 2023

PREFACE

"*Prepare yourself for the emotional turmoil*."
-Governor Josh Green, August 11, 2023 Hawai'i News Now-

This Mental Health Block Grant Plan ("Plan") draft acknowledges this message from Governor Josh Green in the throes of the State's most disastrous wildfires that hit Maui and the Big Island of Hawai'i on August 8-9, 2023. This Plan draft was substantially completed before the disaster. Hence, its analysis and recommendations have not considered this recent event. The ongoing situation will be monitored for new data and information that can impact analysis and action.

States must submit a Plan by September 1, 2023, to receive and spend Mental Health Block Grant (MHBG) funds. The federal Substance Abuse and Mental Health Services s (SAMHSA) released the official guidance for preparing the FFY24-FFY25 Plan on June 30, 2023. It followed up with a technical assistance webinar on July 12, 2023. Internal planning and preparation of the proposal started shortly. Introductory presentations to the public were made through State Council on Mental Health meetings in July and August. The feedback received at said meetings was considered in completing this draft.

In a deviation from past practice, the Plan draft is offered in a friendlier format than the submission format. This approach is adapted from other States' methods of having two formats –one format for public comment purposes and the other form for submission to SAMHSA.

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Step 1. Assess the strengths and organizational capacity of the service system.

A State Profile

An assessment of capacity and strengths of a service system for special populations can gain from sensing a little bit about Hawaii first. Hawai'i is a remote island state from the rest of the United States and other continents. It is a string of more than 100 islands, but major human settlements are in seven only. The seven islands are currently organized into four counties --the City and County of Honolulu covers the island of O'ahu. Hawai'i County covers the Big Island. Kaua'i County includes Kaua'i and Ni'ihau islands, and Maui County covers Maui, Lāna'i, and Moloka'i. A fifth county, Kalawao County in Molokai, functions as a judicial district of Maui. An eighth island, Kaho'olawe, is part of Maui but has no permanent residents due to lack of fresh water.

Hawai'i is also a state that codified the aloha spirit and the law asks that government officials contemplate on this in their conduct of public service.[1] Having only four counties make it easier for the State and local governments to work together in the spirit of aloha. However, delivery of goods and services, including mental health care-related, adapts to the limited access between islands. There are no interisland highways and roads. The major interisland transportation is three airlines for people and cargo ships for goods and materials. The county of Maui is the only one with ferries that travels across its three islands.

Hawai'i's resident population is estimated at 1,440,196.[2] Seventy percent of the population is on O'ahu, with about a third of this residing in the urban core area. The rest of the State are in Hawai'i County (14 percent), Maui County (11 percent), and Kaua'i county (five percent). The median age for males is 39 years and females is 41.6 years.[3] The younger population, 18 years and younger, declined from 24.4 in 2000 to 20.6 percent in 2020. The labor force age population, 18 to 64 years old, fell slightly from 62.3 to 60 percent of the total population. However, Hawai'i's older people, 65 years and older, grew from 11.3 percent to 19.4 percent.

Reflecting on U.S. census reports[4], Hawai'i and the United States (US) are alike in some trends and dissimilar in others. There is closeness in binary gender breakdown rates (almost 50:50 male to female ratio), poverty level (a little over 11 percent), average household size (rounds of to three persons), owner-occupied housing rate (61-65 percent), five years old and older who liv in homes where English is not spoken (22 to 26 percent), households having a computer at home and internet subscription (93 percent with computer and 88 percent with

[1] Hawai'i Revised Statutes Chapter 5 section 7.5 capitol.Hawai'i.gov/hrscurrent/Vol01_Ch0001-0042F/HRS0005/HRS_0005-0007_0005.htm
[2] 2022 Population Estimate Data https://census.hawaii.gov/home/population-estimate/
[3] 2021 State of Hawai'i Data Book https://dbedt.Hawai'i.gov/economic/databook/db2021/
[4] US Census Quick Fact https://www.census.gov/quickfacts/fact/table/US/PST045222

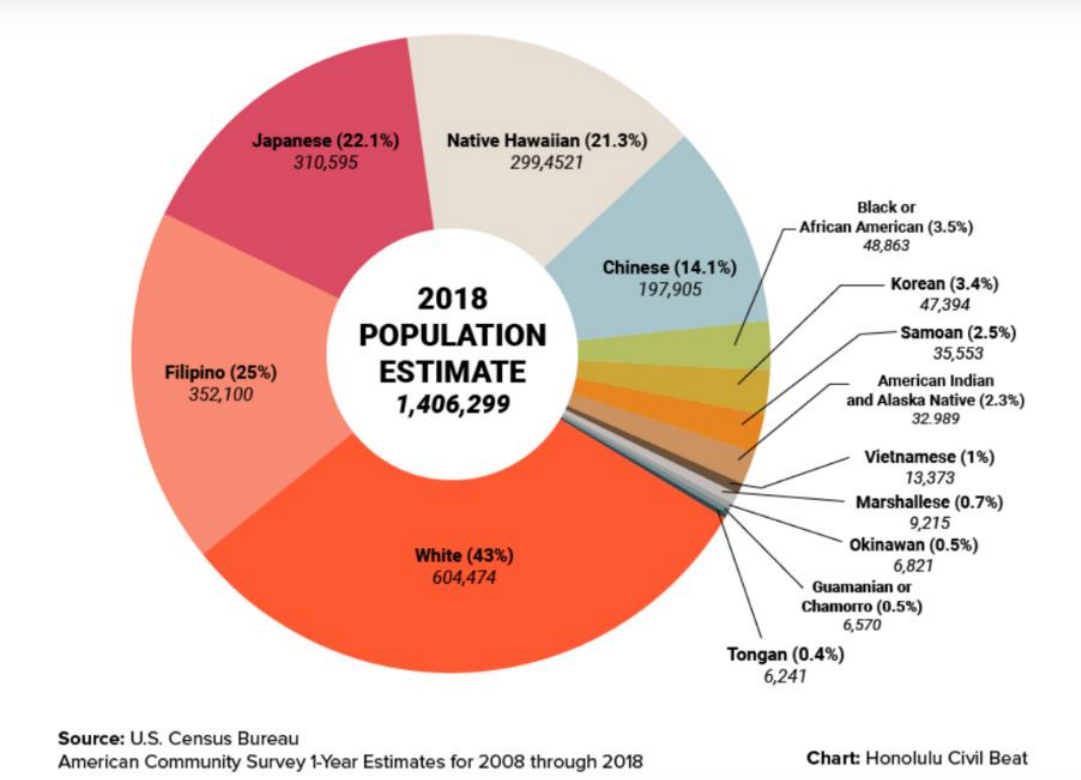
internet subscription). More considerable differences are noted in some areas – 11.4 percent of Hawai'i's population who are 65 years and older are living with a disability while the U.S. rate is 8.7 percent; 95.3 percent of Hawai'i's population have health insurance while the US rate is 90.2 percent; Hawai'i is different in life expectancy but the same in leading cause of deaths. Life expectancy is at 81 years in Hawai'i while the US rate is 76.4 years. [5]The current leading causes are the same – heart disease, cancer.

When it comes to school age population public and charter school enrollment in 2022-23 was at 168,634 students, a decline by 1.7 percent from the previous year.[6] For indicator of economic challenges, approximately 39 percent were eligible for free (subsidized) lunch. Private school enrollment was at 33,533, an increase by 0.9 percent from the previous year.[7] With respect to working age population, the civilian labor force added up to 678, 850 people in the latest quarter of 2023 of which 657, 800 were employed. Of those employed, 122,100 had government jobs and the rest in different industries. The State Center of Aging's 2023 needs assessment focused on the older population in O'ahu. Indicators show that the oldest (ages 85 years and older) are growing at a much greater rate, that 36 percent of older adults have a disability resulting in increased need for care and support, and that 19 percent live alone while another 19 percent are responsible for their grandchildren.[8]

Ethnic diversity distinguishes Hawai'i from other States. In 2021, 26.3 percent or more than a fourth of the population self-identified as having two or more races. A 2008-2018 disaggregation identifies the largest ethnic groups to be White, Filipinos, Japanese, Native Hawai'ians, Chinese (See Chart 1).

[5] CDC National Center for Health Statistics https://www.cdc.gov/nchs/pressroom/states/Hawai'i/hi.htm
[6] https://www.Hawai'ipublicschools.org/ConnectWithUs/MediaRoom/PressReleases/Pages/2022-23-Enrollment.aspx
[7] https://www.hais.us/RelId/622589/ISvars/default/Reports.htm
[8] https://www.Hawai'i.edu/aging/storymap/

Chart 1. Hawai'i Population by Ethnicity, 2008-2018



The socio-economic nuances within ethnic populations are teased out in an older Department of Business, Economic Development and Tourism (DBEDT) report.[9] Marshallese in owner-occupied housing units registered the biggest average household size at 16.45 people and Whites in renter-occupied housing registered the smallest at 2.7 percent. Filipinos and Hawai'ians had the highest percentage of households with children, 48.5 and 44.5 percent respectively. Native Hawai'ians and Whites had the lowest percentage of households in which one or more people are 65 years or older at 26.1 and 26.4 percent, respectively. Vietnamese and Marshallese had the biggest population with less than high school education at 28.7 and 24 percent of respective population. Whites, Okinawans, Japanese, Chinese and Koreans registered the highest percentages of population with graduate or professional degrees at 10.2 to 14 percent. The same group has the highest percentage of population with bachelor's degrees at 19.2 to 28.6 percent. Economy-wise, the greatest proportion of self-employed are within the Vietnamese community at 24.5 percent and least within Filipinos at 4.5 percent. Private sector employment is highest within Filipinos and Marshallese at 80.1 and 90.9 percent, respectively. Government employment is highest within Okinawan and Black or African Americans at 30 and 33.3 percent respectively. Median household incomes that was higher than State average were those of Filipinos, Japanese, Chinese, Okinawans, and Chamorros or Guamanians. At the very least, all these play into differences in capacities and networks that individuals have for resilience and wellness. In terms of population health and wellness, Native

[9] https://files.Hawai'i.gov/dbedt/economic/reports/SelectedRacesCharacteristics_Hawai'iReport.pdf

Hawai'ians rate worse in almost all "high risk" indicators and "chronic disease" indicators than the overall Hawai'i population.[10]

Hawai'i is distinct from other States in being the most expensive state to live in. Its latest cost of living index is 193.00.[11] The nuanced impacts are teased out in a November 2022 ALICE in Hawai'i Report.[12] ALICE (Asset Limited, Income Constrained, Employed) households are above the poverty level threshold but below the living wage threshold. Together with those within the poverty level, they are not earning enough to afford housing, childcare, food, transportation, health care, a smartphone plan, and taxes -the basics needed to live and work in a modern economy. Forty-four percent of Hawai'i households are either within the ALICE level or within the poverty level. There are more within Maui and the Big Island (52 percent of total households) as well as among Native Hawaiians and Filipinos (60 and 50 percent, respectively). It is felt more by larger households (65 percent) and those without a college degree (65 percent).

Hawai'i shares the same experience as California and Washington DC in having high cost of housing and high rates of homelessness.[13] Among all population groups, Native Hawaiians and Pacific Islanders have the highest rates of homelessness. The Statewide Office of Homelessness and Housing Solutions cites that the chronically homeless has the most need for supportive housing (37 percent or 1,433 units), followed by the aging group (15 percent), and those in prison (14 percent). The need for those with mental illness account for four percent (73 institutional and 63 residential).[14]

For a national perspective, Hawai'i is ranked 31st in a US News and World Report Best States 2023. The report ranks it best or first for natural environment as well as healthcare. It is 10th in crime and corrections, 24th in education, and 37th in infrastructure. It is among the last in economy (48th), fiscal stability (46th), and opportunity (45th).

[10] www.Hawai'ihealthmatters.org
[11] https://worldpopulationreview.com/state-rankings/most-expensive-states-to-live-in
[12] https://www.boh.com/siteassets/files/community/alice-report-2022.pdf
[13] USAfacts conclude these two statements based on https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf
[14] https://homelessness.hawaii.gov/news/supportivehousingworkgroup/

An Overview of the State's Mental Health System

The Law

Hawai'i's mental health care act is embodied in chapter 334 of the Hawai'i Revised Statutes.[15] Section 2 calls on the State Department of Health (DOH) to "f*oster and coordinate a comprehensive mental health system utilizing public and private resources to reduce the incidence of mental or emotional disorders and substance abuse, to treat and rehabilitate the victims in the least restrictive and most therapeutic environment possible, and to provide treatment and care for homeless individuals with serious and persistent mental health challenges to enable them to reside in a permanent dwelling unit or homeless facility"* The law further tasks the DOH to *"administer such programs, services, and facilities as may be provided by the State to promote, protect, preserve, care for, and improve the mental health of the people."*

The Department of Health

Within the DOH, mental health care program administration falls under the Behavioral Health Administration (BHA) which has four divisions.[16] The divisions are the Adult Mental Health Division (AMHD), Child and Adolescent Mental Health Division (CAMHD), Alcohol and Drug Abuse Division (ADAD), and Development Disabilities Division (DDD). The first two, AMHD and CAMHD, administer programs, services and facilities that are specific to mental health. The AMHD's administrator serves as the State Mental Health Commissioner for the Mental Health Block Grant (MHBG). The ADAD serves as the single state authority for the Substance Use Prevention, Treatment and Recovery Services (SUPTRS) grant. Within the DOH, collaboration with other units include the Office of Public Health Preparedness (disaster behavioral health), Emergency Medical Services and Injury Prevention System Branch (suicide and injury prevention, first responders), and Office of Language Access. An Office of Health Equity has just been re-established.

An entirely separate department, the Department of Human Services (DHS) serves as the State's Medicaid/MedQUEST Authority.[17]

High Level Structure- Strategic Partnership

At the broadest level, the DOH works within a multi-tiered, multi-sectoral and community-based mental health care network. The network involves the three branches of government – Executive, Legislative, and Judicial.

- *Executive Branch*. This includes the Governor, Lt. Governor, Cabinet, 17 Departments and the University of Hawai'i. The current Governor, Josh Green, is a medical doctor by training and a practicing emergency doctor. Before becoming the Governor, he served as Lt. Governor, senator and representative. It is widely recognized that he brings with

[15] https://www.capitol.Hawai'i.gov/hrscurrent/Vol06_Ch0321-0344/HRS0334/HRS_0334-.htm
[16] DOH program directory https://health.Hawai'i.gov/about/
[17] Med-QUEST division https://medquest.Hawai'i.gov/

him deeper understanding and leadership experiences in the complexity of health care issues. The Governor's Office includes

- Statewide Office on Homelessness and Housing Solutions
- Office of Wellness and Resilience (OWR)
- Boards and Commissions Office which handles appointments to the State Council on Mental Health, Service Area Boards, and others.

Among the department and agencies are:

- Department of Education (DOE). Within the DOE, the Student Services Branch leads in guidance and implementation of programs supporting behavioral health.
- Department of Human Services (DHS). Within the DHS are several divisions supporting the most vulnerable in the community. Among these are the Vocational Rehabilitation, Med-QUEST, Child Welfare Services, and Adult Protective and Community Services. Hawai'i's Public Housing Authority (HPHA) is administratively attached to the DHS.
- Department of Public Safety (DPS). The DPS recently reorganized to have corrections and law enforcement as separate divisions, and within include a Substance Abuse Treatment Service Branch.
- Department of Commerce and Consumer Affairs (DCCA). The DCCA regulates business matters pertaining to insurance, business and professional licensing, and consumer complaints.
- Department of the Attorney General (DAG). DAG advises on legal matters including review of agreements and contracts.
- Department of Human Resources Development (HRD). DHRD has the mandate to support recruitment of government workers, collective bargaining processes and agreements, safe and healthy work environments.

- *Legislature.* The bicameral body has 25 senators and 51 representatives. Last year, there were 33 committees including the Senate's Health and Human Services (HHS) committee and House's Health and Homelessness (HSG) committee. Budgets are addressed by the Senate's Ways and Means (WAM) Committee and the House's Finance (FIN) Committee. The Senate has advise and consent power over the Governor's nominees for executive branch directors as well as members of boards and commissions. The Legislature calls for task forces of stakeholders to study issues, including mental health.

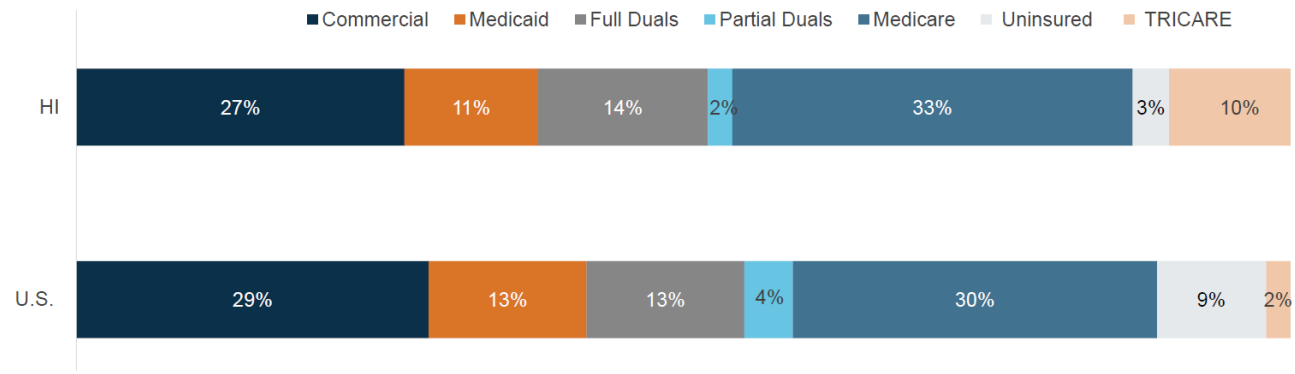
- *Judiciary*. Within the Judiciary, there are specialty courts including family court, mental health court and drug court. The current work with the DOH focus on decriminalization of mental illness, deinstitutionalization, reintegration, and community tenure.

- *Counties.* The county or local governments are led by their respective mayors. Within the counties, DOH also works closely with the police department and emergency management department.

Payee Network and Providers

The statewide and county mental health care network involves both profit and not-for-profit sectors. Access to health services though is payee-based. In 2021, the National Survey on Drug Use and Health (NSDUH) estimated that 11.53 percent or about 125,000 of adults (18 years and above) received mental health services in the prior year. Each service recipient has likely accessed services based on what their respective health insurance coverage covered. A 2022 mapping of behavioral health care coverage offers the following profile of SMI population by payer.[18]

Chart 2. Serious Mental Illness Population Distribution By Payer: Hawai'i and United States



The mapping cites that sixteen percent have dual eligibility with Medicaid and Medicare. Under Medicaid [19], those eligible for serious mental illness services are covered under the Community Care Services Program (CSS) which offers the Ohana Health Plan. Medicaid enrollees who are not eligible under CSS may be served by other managed care organizations. These include AlohaCare, HMSA-Beacon Health Options, Kaiser Permanente, Ohana Health Plan, and University Health Alliance Community Plan. Tricare specifically serves the military community. The top commercial plans are Hawai'i Medical Service Association (HMSA), Hawai'i Management Alliance (HMA), Kaiser Foundation Health Plan, Kaiser Permanente, and University Health Alliance (UHA). The National Alliance of Mental Health Hawai'i (NAMI) offers general resources on understanding health insurance coverage and accessing services.[20] Individuals get services depending on what their respective insurances cover and their abilities to cover required co-payments.

[18] PsychU 2022 Hawai'i Mental Health System Guidebook Prepared by Otsuka Pharmaceutical Development and Commercialization.
[19] https://medquest.Hawai'i.gov/en/members-applicants/already-covered/health-plans.html
[20] https://nami.org/Your-Journey

There is no one directory of the network of behavioral health care providers in the islands. NAMI describes some types of mental health professionals out there, from primary physicians to pastoral counselors.[21] The occupational categories from the U.S. Bureau of Labor Statistics (BLS) include the following: 1) Educational, guidance, career counselors, and advisors; 2)Child, Family and School Social Workers; 3) Substance Abuse, Behavioral Disorder, and Mental Health Counselors; 4) Healthcare Social Workers; 5) Psychiatric Technicians; 6) Clinical and Counseling Psychologists; 7) Community Health Workers; 8) Social Workers; 9) Psychiatrists; 10) Counselors, Other categories; 11) Psychologists, other categories; and 12) Marriage and Family Therapists.[22]

Prioritizing the Uninsured, Underinsured and In-Crisis

Like the nation and the other states, the public mental health care system in Hawai'i has been historically underfunded. DOH strength and capacity evolved out of who it was tasked to help since 2013 - the uninsured, underinsured, and those in crisis. Specifically, eligibility for services prioritizes the following: (1) the underinsured and uninsured among adults with serious mental illness (SMI), (2) and youth and adolescents with serious emotional and behavioral challenges, and (3) individuals in the community who are in crisis.

Provision of Care by CAMHD and AMHD

AMHD and CAMHD programs and services are provided directly and via contracted services.

- *State direct services.* AMHD directly administers the Hawai'i State Hospital (HSH, psychiatric hospital) and a Court Evaluation Branch (CEB). CAMHD administers a Family Court Liaison Branch (CEB). All three units serve court-ordered clients.

- *Service area direct services*. Service areas are organized to bring services closest to where clients live. CAMHD's two broad service areas are O'ahu and the rest of the State. It provides direct services through Family Guidance Centers or branch offices. AMHD has four service areas - O'ahu, Maui, Hawai'i (Big Island) and Kaua'i service areas. All four have been providing services under the Community Mental Health Center (CMHC) and Clubhouse models. Last year, Maui began transitioning to the Certified Community Behavioral Health Clinic (CCBHC) model of care.

- *Contracted services*[23] (aka Purchase of Services or POS). Actual contracted services are results of the interplay of needs, availability of willing and qualified providers and workers, ability to pay in terms of funding and pay rate systems, and abilities to process and meet government contract-related purchasing requirements. The contracts are for various services include

[21] https://nami.org/About-Mental-Illness/Treatments/Types-of-Mental-Health-Professionals
[22] https://www.bls.gov/opub/ted/2022/a-look-at-employment-and-wages-of-mental-health-workers-for-mental-illness-awareness-week.htm
[23] From AMHD 2023 Statewide Provider Directory Draft, unpublished

several models of care in the categories of crisis and non-crisis response, assessment and case management, treatment, recovery and support services.

A Mental Health Epidemiology

Determining the scope of present-day mental health can be elusive. The National Survey on Drug Use and Health (NSDUH),[24] has been a consistent source for sensing *prevalence*. It collects data annually on mental health among the civilian, non-institutionalized population ages 12 years and older in the United States. NSDUH survey excludes people with no fixed address (e.g., homeless people not in shelters), military personnel on active duty, and residents of institutional group quarters, such as jails, nursing homes, mental institutions, and long-term care hospitals. Like other States, Hawaii currently has no methodology for estimating *incidence*.

Prevalence

NSDUH's preliminary report on the 2021 survey results was released with the caveat that the 2021 results should not be compared with previous years because of methodology differences. The 2021 findings indicate the following:

- The major depressive episode (MDE) in the past year was estimated to be 19,000 among those ages 12-17, another 19,000 among those 18-25 years old, and 55,000 among those 26 years and older.
- Any mental illness (AMI) in the year prior was estimated at 20.97 percent or 227,000 individuals, 18 years old and above. It was estimated at 34.72 percent among those 18 - 25 years of age, and 19.26 percent of those 26 years and older. Any mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder.
- Serious mental illness (SMI) in the year prior was estimated at 5.08 percent or 55,000 individuals, 18 years old and older. It was 10.35 percent among those 18-25 years of age, and 4.43 percent among those 26 years old and older. The estimates are based on indicators of SMI rather than direct measures of diagnostic status.
- Serious suicide thoughts were estimated at 55,000 among those ages 18 years or older, 10,000 had actual suicide plans, and 5,000 attempted suicides.

For populations excluded in NSDUH, additional surveys and offer the following:

- The 2023 Point-in-Time Count[25] estimated that there were 2,195 unsheltered and sheltered houseless individuals in the counties of Maui, Kaua'i and Hawai'i. It is estimated that 724 or 33 percent have mental health disability. Meanwhile, it estimated that there were 4,028 in O'ahu, of which 39 percent reported having a mental illness.[26]
- The State Department of Public Safety's corrections population can be gleaned from the latest weekly report which reported a head count of 4,078 including those in Saguaro,

[24] https://www.samhsa.gov/data/nsduh/state-reports-NSDUH-2021
[25] https://homelessness.Hawaii.gov/point-in-time-count/
[26] https://www.partnersincareoahu.org/

Arizona.[27] Prison Policy Initiative estimates that 24,000 Hawai'i residents are behind bars or under community supervision.[28] It is estimated that 37 percent of adults incarcerated in state and federal prisons have diagnosed mental illness. For calendar years 2017 and 2018, close to 150 individuals each year was at a correctional facility for misdemeanor or petty misdemeanor and who were subsequently transferred to the Hawai'i State Hospital.[29]

- Per State Department of Business, Economic Development and Tourism (DBEDT) data, the armed forces population in 2021 was 42,225. In addition, the military dependent population was 54,819. Mental health data is not available for active military population only.

The 2021 Hawai'i Youth Risk Behavior Survey illuminates on some differences between the middle school and high school age groups:[30]

- In 2021, up to 34.4 percent among middle schoolers and 34.8 percent among high schoolers felt sad or hopeless almost every day for two or more weeks in a row so they stopped doing some usual activities.
- Up to 53.6 percent of middle schoolers and 55.7 percent of high schoolers felt sad, empty, hopeless, angry, or anxious but never or rarely got the kind of help they needed.
- Up to 25.8 percent of middle schoolers and 22 percent of high schoolers purposely hurt themselves without wanting to die.
- Up to 3.2 percent of middle schoolers and 1.8 percent of high schoolers had suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse. These findings were statistically much lower than findings of 9/6 percent and 3.2 percent in 2019, respectively.

The May 2023 Substance Use State Plan illuminates on dual disorders - co-occurrence of mental health disorder and a substance use disorder- in an individual:

- Between 2018 to 2019, the State was estimated to have about 40,000 individuals, 18 years and older, with dual diagnosis of having a mental illness and drug or alcohol dependence. Proportionally speaking, Hawai'i's rate higher than the entire US.
- Between 2018 to 2019, among individuals 12 years and older, continued use of substances, specifically marijuana and methamphetamine, was proportionally higher in Hawai'i that the entire US.

For emerging trends, survey results point to the rise of mental health issues because of the COVID-19 pandemic and Red Hill water contamination crisis:

- On the pandemic, a DOH survey of 445 full-time residents reported anxiety (68 percent), loneliness (61 percent), feeling of depression (57 percent) and panic attack

[27] See July 17, 2023 report in https://dps.Hawaii.gov/about/divisions/corrections/
[28] Source: https://www.prisonpolicy.org/graphs/correctional_control2023/HI_correctional_control_2023.html
[29] Hawai'i Mental Health Core Steering Committee A Joint Report January 9, 2020 in www.courts.state.hi.us
[30] Source: https://www.flipsnack.com/dohcamhd/camhd-annual-evaluation-summary-fy-2022.html

(33 percent).[31] The study noted that more impacted were those who live with a child under 18 in their home and those who view the pandemic more in terms of its financial impact; Of those surveyed, 58% of men who have experienced a mental health condition indicated it is a new issue for them that they had not experienced it prior to the pandemic. Over the course of the last six months, however, women were more likely to have experienced anxiety and panic attacks. Japanese residents are hit particularly hard, with 68 percent who are currently experiencing mental health issues indicating they did not experience this prior to the pandemic.

- According to the ALICE Report 2022, mental health issues turned out to be the top persisting concern of ALICE households in the Big Island (31 percent) and Oahu (29 percent). It is the second and third one among those in Kaua'i (23 percent) and Maui (21 percent), respectively.[32]
- For the Red Hill crisis, an assessment survey by the CDC/Agency for Toxic Substances and Disease Registry (ATSDR) was conducted between January to February 2022.[33] The largest percentages of reported symptoms were those related to the nervous system (62 percent), followed by the gastrointestinal system (58 percent), skin (58 percent), ear, nose, and throat (47 percent), mental health (46 percent), eyes (42 percent), and respiratory system (31 percent).

A widely recognized but unmeasured impact are mental health issues among workers. Community input at public meetings, anecdotes and media coverage all point to lingering stresses and burnouts among workers. The State Council on Mental Health received community input on the mental health toll on first responders.[34] A University of Hawai'i study focused on agricultural producers and found that 35 percent experienced mild to severe depression and only 14 percent not experiencing any stress.[35]

The Service Data for Insured, Underinsured and in Crisis

For services covering the uninsured and underinsured, data from the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division offer the following:

- *MHBG Maintenance of Effort (MOE) reports*. Every year, in the last three years, the State reported serving over 15,000 uninsured and underinsured adults and youths. This is from the DOH Child and Adolescent Mental Division, DOH Adult Mental Health Division, and the Department of Human Services Community Care Services Program.[36] It must be noted that data is collected from three separate information systems.

[31] https://Hawaiicovid19.com/Hawaii-department-of-health-survey-shows-pandemic-is-affecting-mental-health-of-Hawaii-residents/

[32] https://www.boh.com/siteassets/files/community/alice-report-2022.pdf

[33] https://www.cdc.gov/mmwr/volumes/71/wr/mm7121a4.htm?s_cid=mm7121a4_w

[34] 2023 Annual Report in https://scmh.Hawaii.gov/about/annual-reports

[35] Rates of stress, depression and suicide among Hawaii Agricultural Producers and Allied Professionals https://www.ctahr.Hawaii.edu/Site/PubList.aspx?key=Mental%20Health%20Issues

[36] Maintenance of Effort Interactive Reports from Bgas.samhsa.gov The public can view this by using username citizenhi and password citizen.

- *CAMHD Annual Evaluation Summary FY22.*[37] The total number of youths served in 2019 was 2,267 which dropped to 1,716 in 2021 and rose back to 1,796 in 2022. Depressive disorders have risen as top diagnoses. The report noted the rise in average age (13.7 years) in 2019 and the rapid increase in the proportion of females (48 percent) in 2022. Information on gender identity improved from 67 percent missing in 2020 and only 43 percent missing in 2022. At least 57 individuals self-identified with genders other than male or female. Based on Child and Adolescent Functional Assessment Scale (CAFAS), discharged youth showed improvements in functioning but may also be showing more problems, like anxiety and depression, than previous years.
- *AMHD Community Report 2021*.[38] AMHD reported serving 8,256 consumers of which 491 were admitted to the State Hawai'i Hospital. For calendar year 2021, 59 percent were in O'ahu, 23 percent in the Big Island, 11 percent in Maui County and five percent in Kaua'i. Demographically, most of the AMHD clients or consumers of services are White/Caucasian (36 percent), Native Hawaiian and Pacific Islanders (28 percent) and Asian-Americans (25 percent). However, between 16 to 35 percent of clients were missing information about their ethnicity. Forty-six percent are 50 years and older while only three percent are 20 years or younger. Data has not been collected beyond binary gender. Between 63 to 88 percent of Hawai'i State Hospital admissions were drug use related.
- *BH808 Hawai'i's Behavioral Health Dashboard*.[39] The number of consumers or clients served by the AMHD has been increasing from 4,801 in 2019 to 7,167 in 2022. The number served with co-occurring conditions (mental illness and substance use) dropped from 1,898 in 2019 to 1,801 in 2022. The Hawai'i State Hospital, which has served forensic population, registered a patient discharge count of 438 in 2019, dipped below 400 in 2020 and 2021, and rose back to 456 in 2022.

Beyond eligibility-based services for the uninsured and underinsured, the State's Crisis Care System (now called Hawai'i CARES 988) responded to uncounted number of individuals in crisis. The BH808 dashboard, informs that for the period July 1, 2022, to June 30, 2023, the system responded to 95,000 crisis line calls, 1,200 911 calls, and 17,000 for 988. There were 8,021 Crisis Mobile Outreach dispatches for the year, July 1, 2022 to June 30, 2023. It will be noted here also that the new Certified Community Behavioral Health Clinic (CCBHC) is a model of care that moves away eligibility-based access.

The post-booking jail diversion for court-involved population program allows for defendants, charged with a non-violent misdemeanor or felony and found to have a serious mental illness, to initiate treatment and have their charges dismissed if they comply with the treatment plan. Since April 3, 2023, the reinvigorated program has conducted 340 screenings, 35 percent of these screenings found the defendant eligible for jail diversion with eight people

[37] https://health.Hawaii.gov/camhd/annual-reports/
[38] https://health.Hawaii.gov/amhd/files/2022/10/AMHD_CommunityReport_2021_FINAL.pdf
[39] https://bh808.Hawai'i.gov/mental-health/

being admitted into the program and the rest declining to participate. Out of 387 total reported charges, six (6) were felonies, leaving 81 percent as petty misdemeanors and 16 percent as misdemeanors.

National Comparisons

Reflecting on AMHD and CAMHD administered services only, the SAMHSA Uniform Reporting System (URS) Mental Health National Outcome Measures (NOMS) offer the following for FY 2021.[40]

- *Penetration rates.* Hawai'i served at a rate of seven percent per 1,000 population which is way less than the U.S. rate of 25 percent. A definitive explanation has yet to be established but Hawai'i undercounts because AMHD and CAMHD data systems are not including persons served through Medicaid/MedQuest health plans.
- *Utilization of services*. Use of services by adults with serious mental illness (SED) and children with serious emotional disorder (SED). Hawai'i reported 100 percent compared to the nation's 71 percent. Hawai'i and the nation are closer to each other in use of the State Hospital at 0.31percent and 0.36 percent per thousand population, respectively.
- *Length of stay at State Hospital*. The median length of stay of patients in Hawai'i is 194 days compared to the nation's 105 days. The median stay is 85 percent longer in Hawai'i. HSH's patients are all forensic population while patients in other hospitals reported for the nation also serve civil non-forensic population.
- *Hospital readmission rate*. The URS only measured state hospital readmission rates for civil non-forensic population. The U.S. outcome for readmission within six months or 1080 days was 18.8 percent. This is not applicable in Hawai'i because the HSH has effectively been serving forensic population only. However, Hawai'i's MHBG performance indicator for readmission rate increased from 14.9 percent in 2021 to 17.6 percent in 2022 based on readmission within six months or less.[41]
- *Utilization of services by those with co-occurring disorders*. The adult rate for Hawai'i and the nation are close at 31 percent and 29 percent, respectively. The youth rate for Hawai'i is 13 percent while the nation's rate is six percent. The youth rate is 100 percent more than the nation.
- *Satisfaction survey.* There are two separate surveys – one for adult consumers and the other for youth clients and their families. The average satisfaction rating was 91.2 percent among adult consumers in Hawai'i and 86 percent among those in the nation. Hawai'i's ratings were higher than the US in all five areas-- access, quality/appropriateness, outcome, participation in treatment planning, and general satisfaction. The lowest was in outcome of services. The average satisfaction rating among youth was 80.3 percent in Hawai'i and 86 percent in the US. Hawai'i's ratings were less than the country in all five areas. The five areas rated are the same as the adults except for the last element which was cultural sensitivity of providers.

[40] https://www.samhsa.gov/data/report/2021-uniform-reporting-system-urs-table-Hawaii

[41] The Hawai'i data is reported as an appendix to the 2023 State Council on Mental Health report https://scmh.Hawai'i.gov/about/annual-reports

- *Improved social connectedness*. Close to 81 percent of adults in Hawai'i agreed that services improved social connectedness while only 77.6 percent in the nation agreed. In the survey, 81 percent of children or their families in Hawai'i agreed to that even more agreed in the county (87.5 percent).
- *Employment status*. Only 43 percent were in the labor force (employed or actively seeking for work) of the 1,253 adult clients in Hawai'i whose employment status were known. The employment rate was at 31 percent in Hawaii and 48 percent in the US. Demographically, employment rate of 18 to 20 years old only was highest at 64 percent and even higher than the US' rate of 52 percent. However, employment of females in Hawai'i was remarkably lower at 26 percent while the US rate was 51 percent.
- *Evidence-Based Practices.* Of the evidence-based practices in SAMHSA's list, Hawaii had a report for in all the ones that applied to youth. All were also applied at higher rates than the US-- Therapeutic Foster Care, Hawai'i's rate is 10 percent to the nation's 1.7 percent; Multisystemic Therapy was 11.7 percent to 3.7 percent; Functional Family Therapy at 10.6 percent for Hawai'i to 5.1 percent for the US.
- *Living Situation*. Hawai'i does not know the living situation of 76 percent of all the persons served. This is twice more that the US rate of 34 percent.

In the 2023 The State of Mental Health in America report, Hawai'i ranked as follows:[42]

- 18th in overall state of mental health among 51 States including Washington DC. It was 14th in 2022 and 8th in 2021. An overall ranking of 1-13 indicates lower prevalence of mental health and higher access to care.
- 12th lowest in overall prevalence of mental health and substance use issues.
- 32nd in overall access to insurance and mental health treatment.
- 26th in mental health workforce availability. The ratio is estimated at 360:1 and close to the national ratio of 350:1.
- Youth only.
    - 43rd in overall ranking, indicating higher prevalence and lower access.
    - 48th in lowest prevalence of youth with one major depressive episode (MDE) in the past year. This indicates that the State had one with higher prevalence rates.
    - 17th in lowest prevalence of youth with substance use disorder in the past year.
    - 21st in lowest prevalence of youth with severe major depressive episode in the past year.
    - 49th in prevalence of untreated youth with depression.
    - 50th in prevalence of youth with severe depression who received some consistent treatment. The estimated absolute number is 1,000.
    - 14th in prevalence of youth lacking mental health coverage. The estimated absolute number is 4,000.

[42] https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf

    - 36th in rate of students identified as having emotional disturbance for an individual education program (IEP). This puts Hawaii in the lower side which is associated with poorer outcomes.
- Adults only.
    - Second in overall state of mental health, indicating lower prevalence and higher access.
    - 4th in lowest prevalence of mental health.
    - 6th in lowest prevalence of substance use disorder.
    - 16th in prevalence of adults with serious thoughts of suicide.
    - 51st in the prevalence of untreated adults with mental illness.
    - 2nd in the prevalence of adults reporting unmet needs, indicating the State had the most prevalent situation.
    - 15th in prevalence of uninsured adults with mental illness, the absolute number estimated at 14,000.
    - 1st in adults reporting 14+ days a month who could not see a doctor due to costs, the absolute number estimated at 13,648.

Step 2. Identify the unmet services and critical gaps within the current systems.

The previous section offers a 30000-foot view of magnitudes and trends that have an impact on the planning and delivery of mental health care services for special populations. The short planning period (July to August 2023) could only accommodate a rapid analysis and brings to attention the following big blocks or themes of emerging needs, unmet services, and critical gaps:

- More residents report mental health issues, but the mental health care system may be unfamiliar, not accessible, or even culturally new to most. Likewise, the mental health care system is seeing new conditions that it has yet to understand fully (e.g., post-COVID-19 pandemic conditions).
- Outcomes among those already receiving treatments need to be better, and more individuals needing treatment need to be treated. There is a need for evidence-based practices that will work for the unique conditions and populations that Hawai'i has to address. Paradoxes hinted at by national rankings need to be addressed.
- Limited or no data must be reversed to better guide practice and care. There is a need for integrity, continuity, and equity care, especially with different co-occurring conditions among adults with serious mental health and children and youth with serious emotional disorders. The co-occurring conditions include socio-economic challenges (e.g., chronically homeless, incarcerated), physical health (aging with disabilities, chronic diseases), and behavioral health (substance use disorder).
- Workforce availability is more dire than in other States, and better than in many others. The State's shared challenges with the rest of the country and its unique set of particular challenges have to be examined more incisively and urgently.

These are covered further in another section, Environmental Factors and Plan.

Step 3. Prioritize State Planning Activities

The broadly identified needs and gaps confirm what the State already know and have been working on. Both CAMHD and AMHD have multi-year strategic plans, priority themes and activities that indicate how some of these are being addressed.[43] The exception is workforce availability, which both plans need to address more distinctly. CAMHD's strategic priority themes include access to care, data-driven decision-making, and prevention. AMHD's themes are reflected in the acronym, "TIES," which stands for telehealth, integrated services (primary care and behavioral health care), evidence-based practices (data-driven decision-making), and special populations (those with co-occurring substance-use disorder, with criminal justice-involvement, with co-morbid chronic conditions).

[43] December 2022 CAMHD Strategic Plan 2023-2026 in https://health.hawaii.gov/camhd/strategic-plan/ and unpublished 2022 AMHD Strategic Plan

CAMHD's priority activities include:

- Increasing access to care and reduce health disparities,
- **e**nhancing mental health system by using data & research, and
- promoting primary, secondary & tertiary mental health prevention.

AMHD's priority activities include:

- Improving its data infrastructure (Electronic Health Records or EHR, Evidence-Based Practices or EBP, Reports),
- expanding and adapting the Certified Community Behavioral Health Clinic (CCBHC)
- completing the rehabilitation of Hawai'i State Hospital (HSH) facilities,
- Increasing stabilization beds, and
- improving the capacity to be a resource for providers and the community.

The state planning activities of CAMHD and AHMD are focused on three of SAMHSA's priority types -- Mental Health Services (MHS), Early Serious Mental Illness (ESMI), and Behavioral Health Crisis Services (BHCS). Key activities, particularly those that have been or will be supported directly by MHBG funds, are covered in Step 4 below.

Step 4. Develop goals, objectives, performance indicators, and strategies.

Given unmet needs and critical gaps in the mental health care system and the strategic priorities of CAMHD and AHMD, the following are priority areas where MHBG funds have been or will be helping directly:

State Priority Area 1
COMMUNITY TENURE

Population:
Adults with Serious Mental Illness (Forensic Population)

Goal:
Community Tenure

Objective:
Decrease the readmission rate of discharged patients of the Hawaii State Hospital

Strategies to attain the objective:
Provide step-down services, talk therapy and other person-centered supportive and recovery services; Address critical workforce (providers) gap.

Annual Performance Indicators to measure achievement of the objectives
Indicator: Decrease in Readmission Rate
Baseline measurement (data collected prior to July 1, 2023): increase by 2.7 percent

First Year target/outcome measurement (progress to the end of June 30, 2024): decrease by 5 percent
Second Year target/outcome measurement (progress to the end of June 30, 2025): decrease by 5 percent
Data Source: AMHD Electronic Health Records
Description of Data: This will be same as in previous report year
Data issues/caveats that affect outcome measures: This is an established measure and no issues are anticipated except for the need to have back up staff to ensure continuity of work.

Priority Area 2
COMMUNITY BASED SERVICES

Population:
Adults with Serious Mental Illness (Including Older Adults, Rural Population)

Goal: Treatment of residents with mental illness

Objective: Increase the number of clients served by community-based services

Strategies to attain the objective: Continue to address fragmentation in the mental health care system, address workforce availability issues, and continue to seek funding for programs and activities.

Annual Performance Indicators to measure achievement of the objectives.
Indicator: Increase in the number of clients served
Baseline measurement (data collected prior to July 1, 2023): 3.4 percent.
First Year target/outcome measurement (progress to the end of June 30, 2024): 5 percent
Second Year target/outcome measurement (progress to the end of June 30, 2025): 5 percent
Data Source: AMHD Electronic Health Records
Description of Data: This will be the same as last year.
Data issues/caveats that affect outcome measures: Adjustments were made to ensure that each client was counted only once. No issues anticipated except for the need to have back up staff.

Priority Area 3
COMMITMENT TO DATA AND EVIDENCE

Priority Type:
Mental Health Services, Early Serious Mental Illness, and Behavioral Health Crisis Services

Priority Population:
Adults with Serious Mental Illness, Older Adults with Serious Mental Illness, Individuals with Serious Mental Illness in the rural and homeless populations, Individuals with Early Serious Mental Illness, Individuals needing Behavioral Health Crisis Services

Goal of the priority area:
Improve mental health outcomes, including reduction of disparities, among priority populations.

Objective:
Data Infrastructure Improvement to support Evidence-Based Practices and Integrated Care involving the Hawaii State Hospital, Community Mental Health Centers, Certified Community Behavioral Health Clinics, Clubhouses, Contracted Service Providers, and Hawaii Care 988.

Strategies to attain the objective:
Modernize Electronic Health Records and Create Data Warehouse to facilitate analysis, epidemiological research, and the implementation of data visualizations/dashboards and other data modernization initiatives. Technical staff will work closely with AMHD researchers, clinicians, and other staff to implement a data warehouse deployed to the secure Hawaii government cloud. Modern technologies to architect a cohesive data warehouse from disparate data sources will be leveraged in this effort to provide a strong foundation for evidence-based research and initiatives. These technologies include use of modern Extract-Transform-Load (ETL) and data science tools to pull data into the data warehouse for full integration with the AMHD technology stack and our ONC-certified HIPAA compliant Electronic Health Records. Additionally, AMHD plans to fully implement key Electronic Health Records (EHR) modules that enable secure data exchange with our Contracted Providers and Community Partners. Such data modernization efforts will promote efficient data collection from our partners and enhance data quality critical to evidence-based practices and integrity of care.

Annual Performance Indicators to measure achievement of the objective:
Indicator 1: Number of Contracted Providers Using Provider Connect NX
Baseline measurement (data collected prior to July 1, 2023): "0" providers
First Year target/outcome measurement (progress by June 30, 2024): Four (4) providers
Second Year target/outcome measurement (progress by June 30, 2025: Fifty (50) providers.
Data Source: Adult Mental Health Division Data Warehouse (cloud based)

Description of Data: Data is collected automatically as part of standard EHR audit trail and made available in the Data Warehouse via modern Commercially Off-the-Shelf COTS) data science tools.
Data issues/caveats that affect outcome measures: Participation by Contracted Providers and Community Partners may be "partial", meaning that the full benefit of the data modernization effort may not be reflected by measure.

Indicator 2: Minimum percentage of encounter-level records with complete (non-missing and usable) data across all demographic and health equity-related Electronic Health Record fields

Baseline measurement (data collected prior to July 1, 2023): 0 percent.
First Year target/outcome measurement (progress by June 30, 2024): 75 percent
Second Year target/outcome measurement (progress by June 30, 2025): 90 percent

Data Source: Adult Mental Health Division Electronic Health Records (EHR)
Description of Data: Demographic and health equity-related data are routinely collected by AMHD providers and other staff upon client intake and as appropriate while clients receive services from AMHD. Demographic fields include age, sex assigned at birth, gender identity, race/ethnicity, marital status, and education. Health equity-related fields include place of residence, food and housing affordability, substance use history and exposure, living arrangement, and insurance/benefits status.
Data issues/caveats that affect outcome measures: Transition to new EHR contracts (anticipated between January - December 2024) may affect data entry as providers and staff acclimate to updates to the EHR system. Ongoing updates to AMHD policies and procedures or data collection due to changes in contractual, operational, or emergency requirements, may add to or modify data fields from year to year.

Priority Area 4
PROMOTING RESILIENCE AND EMOTIONAL HEALTH FOR CHILDREN YOUTH AND FAMILIES

Priority Type:
Early Serious Mental Illness

Priority Population:
Individuals with Early Serious Mental Illness

Goal of the priority area:
Increase and expand accessibility and reduce health disparities for all youth in need of intensive mental health services.

Objective:
Expand the OnTrack (OT) Hawaii program which treats young people experiencing their first psychotic episode regardless of their insurance or other funding sources.

Strategies to attain the objective:
Accept referrals as appropriate for the size of the OT-Hawaii staff.

Annual Performance Indicators to measure achievement of the objective.
Indicator:
The number of monitored clients in the OT-Hawaii program

Baseline measurement (data collected prior to July 1, 2023:18 clients
First Year target/outcome measurement (progress to the end of June 30, 2024: 21 clients
Second Year target/outcome measurement (progress to the end of June 30, 2025: 25 clients

Data Source: CAMHD MAX (electronic record system)
Description of Data Number of clients service by OT-Hawaii
Data issues/caveats that affect outcome measures: OT-Hawaii needs an additional primary clinician to service First Episode Psychosis (FEP) clients. Due to the shortage of licensed mental health professionals nationally, the inability to hire competent staff in a timely manner limits the number of persons that can receive service for FEP.

Priority Area 5
ENHANCING ACCESS TO SUICIDE PREVENTION AND CRISIS CARE

Priority Type:
Behavioral Health Crisis Services

Priority Population:
Individuals in need of behavioral health crisis services

Goal:
Stabilize and improve resilience among individuals in behavioral health crisis

Objective:
Ensure availability of stabilization beds

Strategies to attain the objective:
Retain and expand workforce for managing crisis support services. Increase recruitment efforts to meet rural population needs. Improve continuity of care across the behavioral health crisis continuum, particularly linkages to stabilization services.

Annual Performance Indicators to measure achievement of the objective
Indicator: Number of counties or service areas with stabilization beds (Licensed Crisis Resident Services and others)
Baseline measurement (data collected prior to July 1, 2023) – two service areas
First Year target/outcome measurement (progress by June 30, 2024) LCRS procured for 4 service areas/counties
Second Year target/outcome measurement (progress by June 30, 2025) LCRS maintained in 4 service areas/counties.
Data Source:
Description of Data:
Data issues/caveats that affect outcome measures:

Annual Performance Indicators to measure achievement of the objective
Indicator: Minimum average monthly percentage of stabilization beds available for placement of persons in crisis
Baseline measurement (data collected prior to July 1, 2023) – 5%
First Year target/outcome measurement (progress by June 30, 2024): 10%
Second Year target/outcome measurement (progress by June 30, 2025): 10%
Data Source: Adult Mental Health Division
Description of Data: Monthly occupancy rates for stabilization bed facilities on Oahu and the Big Island.
Data issues/caveats that affect outcome measures: Total number of beds per facility may change due to workforce issues.

Priority Area 6
INTEGRATING BEHAVIORAL HEALTH AND PHYSICAL HEALTH CARE

Priority Type: Mental Health Services, Early Serious Mental Illness, and Behavioral Health Crisis Services

Priority Population:
Adults with Serious Mental Illness, Youth with Serious Emotional Disorder, Individuals with Early Serious Mental Illness, Individuals needing Behavioral Health Crisis Services.

Goal:
Improve outcomes of adult and youth, especially those with more complex needs.

Objective:
Expand services provided to clients to address both behavioral and physical health needs

Strategies to attain the objective:
SAMHSA certification of Maui Certified Community Behavioral Health Clinic (CCBHC)

Annual Performance Indicators to measure achievement of the objective
Indicator: Number of SAMHSA-certified CCBHCs
Baseline measurement (data collected prior to July 1, 2023: "0" fully-certified CCBHC
First Year target/outcome measurement (progress to the end of June 30, 2024): "1" new fully-certified CCBHC
Second Year target/outcome measurement (progress to the end of June 30, 2025): 1 maintained fully-certified CCBHC
Data Source: SAMHSA's Performance Accountability and Reporting System
Description of Data: Data on behavioral and physical health needs and services provided are collected from Maui CCBHC and reported to SAMHSA as part of the CCBHC grant. Certification will come from SAMHSA.
Data issues/caveats that affect outcome measures: Maui has been and continues to be severely impacted by wildfire emergencies. This may heavily impact operations that directly support certification.

Priority Area 7
STRENGTHENING THE BEHAVIORAL HEALTH WORKFORCE

Priority Type:
Mental Health Services, Early Serious Mental Illness, and Behavioral Health Crisis Services

Priority Population:
Adults with Serious Mental Illness, Youth with Serious Emotional Disorder, Individuals with Early Serious Mental Illness, Individuals needing Behavioral Health Crisis Services

Goal:
Improve mental health outcomes for priority populations.

Objective:
Have the workplace culture and workforce numbers and competencies needed to sustain the public mental health care system.

Strategies to attain the objective:
Facilitate a multi-stakeholder strategic planning to prioritize action; Support resiliency-oriented trainings and training of trainers among workers; Build peer specialists program along best practices

Annual Performance Indicators to measure achievement of the objective
Indicator 1: Decrease vacancy rates within AMHD, CAHMD, and among providers
Baseline measurement (data collected prior to July 1, 2023) ~30 to 40 percent vacancy rates in ADMHD and CAMHD
First Year target/outcome measurement (progress by June 30, 2024): Reduce by 20 percent across the board.
Second Year target/outcome measurement (progress by June 30, 2025): Reduce by 20 percent across the board.
Data Source: To be established.
Description of Data: To be established.
Data issues/caveats that affect outcome measures: The establishment of vacancy rates has been a more complicated across the board. Consensus is required to establish rates for purposes of this objective.

Indicator 2: Increase competency of staff and providers in person-centered care, trauma-informed care and resiliency.

Baseline measurement (data collected prior to July 1, 2023): 0 SAMHSA -certified trainer in trauma-informed care among AMHD and CAMHD staff
First Year target/outcome measurement (progress by June 30, 2024): 2 new SAMHSA-certified trainer in trauma-informed care approach or similar program
Second Year target/outcome measurement (progress by June 30, 2025): 12 SAMHSA-certified trainer in trauma-informed care approach or similar program.

Data source: Completion reports of MHBG-funded training.
Description of Data: Copies of certification
Data issues/caveats that affect outcome measures: The strategic planning process will be tapped to establish the approach to measuring and reporting outcomes across employers.

Indicator 3: Increase employment of recently certified peer specialists along best practices.
Baseline measurement (data collected prior to July 1, 2023): To be established.
First Year target/outcome measurement (progress by June 30, 2024): To be established.
Second Year target/outcome measurement (progress by June 30, 2025): To be established.
Data source: To be established as part of AMHD Performance Information Evaluation Research Branch Peer Specialist Program.
Description of Data: To be established.
Data issues/caveats that affect outcome measures: Best practices in certified peer specialist program implementation will guide the establishment of best measure to be used.

Projected Expenditures (aka Table 2a and Table 6a in the guidance)

Many resources are tapped to support the public mental health care system and priority activities. The following are the resources that go through CAMHD and/or AHMD directly.

- Budgeted State funds
- two federal formula grants – the Mental Health Block Grant (MHBG) and Project for Assistance in Transition from Homelessness (PATH);
- Three supplementary funds via the MHBG grant – Coronavirus Aid, Relief and Economic Security Act of 2019 (CARES), American Rescue Plan Act of 2021(ARPA) and Bipartisan Safer Community Act of 2022 (BSCA);
- SAMHSA Competitive grants – Transformation Transfer Initiative (TTI), Certified Community Behavioral Health Center (CCBHC) grant, Asian American Native Hawai'i Pacific Islanders (AANHPI) Center for Excellence, 9Data to Wisdom expansion grant;
- SAMHSA 988 State cooperative agreement.

The projected expenditures covering the period July 1, 2023, to June 30, 2025 are summarized along required form as follows:

Table 1. Planned Expenditures, All Funds for AMHD and CAMHD FFY24-FFY25

Activity	MHBG (Regular)	Other Federal Funds	State Funds	MHBG COVID-19 emergency funds	MHBG ARPA funds recovery funds	MHBG Bipartisan Safe Community Supplement
Evidence-Based Practice For ESMI FEP* (10% set-aside)	1,412,659	0	0	0	105,301	60,000
State Hospital	0	0	181,104,611	0	0	0
Other Psychiatric Inpatient Care	0	0	4,295,748	0	0	0
Other 24-hour Care (Residential Care)	684,671	3,999,966	31,343,420	0	550,000	0
Ambulatory Community Non 24 hour	247,600	490,942	76,440,525	0	0	0
Crisis Care (5 % set-aside)	524,424	0	22,020,256	2,014,376	4,093,942	0
Administration excl program and provider level)	0	2,158,203	12,389,798	0	35,000	0
TOTAL	2,869,354.00	6,649,111	327,594,358	2,014,376	4,784,243	60,000

Table 2. Planned MHBG Expenditures for System Improvement and Indirect Costs Only: CAMHD and AMHD FFY 2024-2025

Activity	FY24 MHBG Regular Grant	FY24 MHBG Bipartisan Safe Community Act Supplement	FY25 MHBG Regular Grant	FY25 MHBG COVID-19 Emergency Funds	FY25 MHBG ARP Recovery Funds	FY25 MHBG Bipartisan Safe Community Act Supplement
Information Systems	2,301,884		2,301,884			
Infrastructure Support	182,448		182,448			
Partnerships, Community Outreach, and Needs Assessments	87,859	162,204	88,135			162,204
Planning Council Activities	20,000		20,000			
Quality assurance and improvement						
Research and Evaluation	247,740		247,740			
Training and Education	241,300	60,000	201,300			90,000
TOTAL	3,081,231	222,204	3,401,507			252,204

Environmental Factors and Plan

Access to Care, Integration, and Care Coordination

Access is explained further in a later section (Criterion 1).The current and latest efforts of Hawaii to improve access, integration and coordination are wrapped up in various activities. CAMHD and/or AHMD have collaboratively work with others on the following:

Telehealth. The COVID-19 pandemic necessitated and facilitated the normalization of telehealth approaches. Hawaii and the mental health care system demonstrated the ability to adjust, and even leapfrog, from non-telehealth to telehealth. The virtual mode within CAMHD and AMHD has become the norm for initial assessment. It overcomes interisland transportation and within-island barrier especially in rural areas. Anecdotally, many youth and adult clients adapted quickly to telehealth, even faster than service providers. Telehealth has been especially helpful also to older people and to people in the rural areas. Service providers have gotten parents/ guardians to join sessions or consultations as needed for youth. Workforce shortage is mitigated by the capacity of a psychiatrist from the Big Island to help clients in Kaua‘i. The treatment teams have been able to gather for the morning rounds. The availability of kiosks and IPads from Community Mental Health Care Centers provided access to those who did not have internet connections nor computers.

Certified Community Behavioral Health Clinic (CCBHC). Maui is setting up the first CCBHC in Hawai’i, and CCBHC is also serving as a pilot for the other service areas. The CCBHC model is designed to provide care for people with unmet needs regardless of ability to pay. CCBHC eliminates barriers to care by providing all relevant services (e.g., behavioral health, co-occurring, co-morbid disorders) in one CCBHC for consumers or clients of all ages. The pilot is progressing along a challenging timeline to meet grant requirements. It is acknowledged that this has become more challenging as the State, and particularly Maui, and will be recovering from the deadly wildfire disaster.

On-Track Hawai’i (OT-Hi). The program is offered to individuals regardless of their ability to pay. CAHMD, with support from the University of Hawai’i Departments of Psychology and Psychiatry, launched the state’s coordinated specialty care treatment clinic for youth experiencing a first episode of psychosis. OnTrack New York (OT-NY) is mentoring for fidelity of program. It is currently at full capacity and scaling up is running against the issue of finding a licensed psychologist amidst workforce shortage. There is also a need for support services that are not payable yet under current billing scheme of Medicaid/MedQUEST.

Jail Diversion. Local police departments’ Crisis Intervention Teams (CIT) are expanding. More law enforcers can recognize behavioral health issues and de-escalate potentially volatile situations. Arrests can become an access, not to jail, but to care for those with mental illness, substance use, and co-occurring substance use disorder. Building on years of committee work and lessons from the Miami model, the DOH and Judiciary has inked a new agreement that improves Hawai’i’s jail diversion program. The new agreement sought to change and improve identification of appropriate candidates who should not be locked up in jail, and instead, should

be receiving appropriate community-based treatment and support services. Like the OT-Hi program, scaling up with good results will require fidelity and sufficient resources. On the youth side, Hawai'i has years and long effort to divert children and youth from juvenile corrections and into community programs and mental health support. Out of this, there are currently no girls incarcerated in the Hawai'i Youth Correctional Facility (HYCF).

Hawai'i State Hospital campus. The newest facility was opened in 2022 and named Hale Hoʻola for a place where people can be healed. It dramatically increased the supply of psychiatric beds in the State. Based on a master plan, the rehabilitation of the other older campus buildings. The entire effort is meant to support continuum of care and better community tenure of discharged patients. The challenges continue to include workforce shortages, overcapacity, and shortage of community-based "step-down" services for patients who are ready to be discharged.

Accreditation. Statewide efforts have and continue to include accreditation under the Joint Commission for the Hawai'i State Hospital, Commission on Accreditation of Rehabilitation Facilities (CARF) International for Community Mental Health Centers, and Clubhouse International for Clubhouses. Internal policies and procedures are being revisited and revised to guide the provision of integrated care. Accreditation also comes with Quality Improvement Plans. Carrying out these improvement plans have been met with workforce challenges, including issues over positions, filling vacancies, staff training, and culture of change.

Certified Peer Specialists program. The AMHD embarked on two certification tracks- Hawai'i Certified Peer Specialist and Certified Forensic Peer Specialist. The former is a prerequisite for the latter. The value of peers is demonstrated well in the Hina Mauka setting, a service provider that serves clients with co-occurring conditions. There is recognition that trained peer specialists have yet to be tapped fully, and providers need help tapping them for better results. The State provided funding to build the peer specialist program and the current challenge is building one along best practice.

Hawai'i CARES 988. Hawai'i's Crisis Response System has been rebranded as "Hawai'i CARES 988" to, among others, simplify and address the counterproductive confusion over numbers. Calls continue to be answered right away. However, assessments show the need for warm hand-off and consistency in the quality and availability of services. Like all other services in the continuum of care, the system is also experiencing workforce shortage and turnovers. Solutions and improvements are sought along those expected of a nationally certified crisis response system.

Crisis Mobile Outreach (Youth). CAMHD sought support and received legislative funding to pilot crisis mobile outreach in two islands- one urban (Oʻahu) and one rural.

Trauma-Informed Care. CAMHD is supporting the Trauma-Informed Care Task Force that supported the creation of the new Office of Wellness and Resilience. To address community

needs, the OWR plans to identify and coordinate trauma-informed and resiliency efforts of state departments and community organizations.

Policy and advocacy. Stakeholder efforts led to enacting new laws that sought to address more access by youth and when conditions call for involuntary treatment. There is a need to continue examining ways to improve regulations to achieve intentions..

- Act 37 from the 2020 legislative session.[44] This law allows 14 years and older to consent to receive mental health care. CAMHD specifically advocated for this.
- Act 19 from the 2018 session. This law established a task force which, among other initiatives, tweaked the existing law allowing youth to consent to mental health care without guardian/parent consent, knowledge, or participation. This law also allowed mental health practitioners to receive insurance compensation to provide services to minor-initiated mental health services. The legislation was crafted especially for youth who are questioning their gender and sexual identity and are reluctant to seek mental health care because of the stigma associated with both mental health and LGBTQ+.
- Act 153 from the 2023 session. This law concerns access to services via involuntary treatment or assisted community treatment order. It clarifies the roles of various parties in requesting an order for involuntary treatment or an extension of such an order. Stakeholders continue to seek improvement in this law, particularly on legal representation.

Workforce Recruitment and Staff Development. Although funding resources have temporarily increased after decades of underfunding, a challenging workforce shortage and instability undermine intended efforts and services. The mental health workforce availability issue is buried further within the State and country's health and behavioral health workforce shortage. CAMHD and AHMD have recently hired two administrators who are now looking at the workforce issues. The situation calls for more outcome-oriented collaboration as almost every kind of employer is looking for the right workers. Meanwhile, the current and recent patchwork of effort includes:

- *Rate or compensation studies* (formal or informal) covering their respective services and professions. Given the extraordinarily high cost of living in Hawai'i and the student loans that potential workers have, low pay is a severe barrier to the recruitment and retention of government and providers. Moreover, the disincentive to service providers includes low Medicaid rates and capitation payments that impact the quality of care.
- *Collaborations*. AMHD and CAMHD are pragmatically tapping others for help, including:
    - *CDC Foundation*. During the early stage of the COVID-19 pandemic and with a Statewide hiring freeze, AMHD tapped CDC Foundation for employees. The

[44] https://www.capitol.Hawai'i.gov/session/archives/measure_indiv_Archives.aspx?billtype=HB&billnumber=2043&year=2020.

arrangement later helped with the hiring freeze, and some employees applied for State jobs opened when the Governor lifted the hiring freeze.
    - *The University of Hawai'i System*. AMHD's data infrastructure improvement plan was implemented with staffing support from the Research Corporation of the University of Hawai'i (RCUH). CAMHD's OnTrack Hawai'i evolved with the help of the UH Departments of Psychiatry and Psychology. The HSH partnered with the Windward Community College (WCC) in developing a mental health technician certificate program to support entry-level positions.
    - *Department of Labor and Industrial Relations (DLIR*). The Hele Imua internship program has been tapped for interns in different areas-information technology, clinical psychology, and others.
- *Training of staff*. MGBG funding has especially been instrumental in supporting staff development, including at trainers of training level. The training support abilities of staff engaged in treatment, recovery and crisis care services (e.g., Dialectic Behavioral Therapy (DBT), Wellness Recovery Action Plan (WRAP), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Employment Supports).
- *Advocacy*. Funding for student loan forgiveness was a key legislation sought to help professionals stay in Hawai'i.

Need for Technical Assistance (TA). Opportunities for SAMHSA technical assistance were judiciously considered. There are many needs staff shortage is a constraint. Hawai'i availed of two TA and is seeking on a special topic:

- TA to improve evidence-based practices in the case of co-occurring disorder. In supporting the state, SAMHSA's TA contractors. JBS International, subcontracted this with the National Association of State Mental Health Program Directors (NASMHD).
- TA to address workforce needs. Hawai'i ais one of the six states that participated in a SAMHSA learning collaborative on workforce needs. This was facilitated directly by JBS International.
- The State is interested in technical assistance to improve the State's FEP program. Specifically, a TA is needed to look into Medicaid reimbursement for the On Track Hawai'i (FEP) Program mental health, employment and peer support services.

Advancing parity enforcement and increasing awareness of parity protections

Hawai'i's Medicaid/MedQUEST program already has mental health and substance use disorder (MH/SUD) parity requirements built into the regulations. There is just need to prove to the Center for Medicare and Medicaid Services (CMS) that there is parity between the member's experiences with MH/SUD services and physical health services. This is done through a MH/SUD Parity Report, which was last completed in 2018. It was reported to CMS that Hawai'i Medicaid/MedQUEST has achieved parity and CMS did not disagree. There is currently in process rulemaking/policy changes to the MH/SUD Parity requirements at the national

Medicaid level. Likely, the current Parity Report will be revisited after the new rules are finalized and released.

Supporting integrated behavioral health and primary health care providers.

The shift to the CCBHC model of care address this in the behavioral health setting. For behavioral health care in primary health care setting, CAMHD is starting to work with the DOH Family Health Services Division (FHSD) to integrate behavioral health and primary health care of children with special needs. CAMHD is also interacting with the Developmental Disabilities Division (DDD) for clients with SED and developmental disabilities.

Providing behavioral health care in the primary health care provider setting is a bigger challenge and issues include the following:

- *Addressing the shortage of primary care physicians.* The most severe challenge in accessing through primary care providers (PCP) is the dire shortage of said doctors. Hawai'i and its counties and many facilities are designated professional shortage areas (DPSA) for both primary and mental health care doctors[45] Act 112 from the 2023 legislative session adopted the Interstate Medical Licensure Compact and directs the DCCA and the Hawai'i Medical Board to provide a streamlined implementation process. [46]Efforts have also included advocacy to expand existing loan forgiveness programs.
- *Awareness of issues*. As part of its strategic planning, the Alcohol and Drug Abuse Division (ADAD) launched a webinar series to understand systems of care issues, including primary care. The series illuminate on reasons for non-intervention, and they include PCP overloads, lack of training of PCPs, low reimbursement for time spent, and lack of treatment resources. The issue extends to the under-preparation of would-be PCPs in behavioral health.[47]

Care coordination

CAMHD care coordinators (CCs) play a vital role in ensuring that mental health care is client and family centered. After clinical leads (psychologists or psychiatrists) determine eligibility for CAMHD services, CC's link the clients and their families to mental health providers for mental health treatment. They coordinate the clients care with the Department of Education, Judiciary's Family Court Parole Officers and/or Child Welfare Services, as appropriate, and with family (peer and/or parental) supports in accordance with the Clinical Lead's clinical management plan. CCs meet with the client and the family regularly at least monthly. CCs monitor the clients' progress and may make recommendations the mental health provider and/or the clinical lead with the goal of helping the client be more resilient. Should the client need continued mental health services after they age out of the eligibility range of

[45] See "What is shortage designation" in https://bhw.hrsa.gov/

[46]https://www.capitol.Hawai'i.gov/session/measure_indiv.aspx?billtype=SB&billnumber=674&year=2023

[47] https://health.Hawaii.gov/substance-abuse/state-plan/

receiving CAMHD services, CCs work with clinical leads for the clients' referral of the client to Community Services and Support funded through the State's Medicaid program.

AMHD may assign a case manager (CM) who is responsible for assisting the client or coordinate services, health insurance, and other support. AMHD currently supports four levels of case management –Case coordination handled by the CMHCs, community-based case management (CBCM), intensive case management plus (ICM+) for high service users, and intensive case management plus (ICM+) for the houseless. If a consumer or client is covered by the Medicaid/MedQuest-supported Ohana Health Plan, payment for case management is by capitation. If uninsured and covered by AMHD, and the case management is contracted out, then funding is via rates (e.g., per hour). The rates differ depending on intensity. Case management requires face-to-face interaction with clients/consumers. An AMHD Recovery Guide offer tips for clients on how to work with their case managers and if they have grievance about their CM. Beneath the surface are tools that ensures quality of case management-accreditation, agreements, contract provisions, policy and procedures, monitoring, and training.

Health Disparities

CAMHD tracks all variables, while AMHD mandates tracking of race, ethnicity, age, and gender. AHMD's information system (Avatar) is currently set up to collect the two other fields-sexual orientation and identity. AMHD's current problem is inconsistency in how and when data is collected. Planning is in the early stages of developing a standardized policy and procedures for better data collection. The DOH had an Office of Health Equity, which is being re-established. This indicates that there will be more unified efforts toward equity epidemiology and culturally and linguistically appropriate services (CLAS) training. Meanwhile, the standing policy encourages all service-providing units, including the Hawai'i State Hospital and service providers, to follow the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.

No dedicated budget item is allocated to identify and remediate disparities in M/SUD care. However, the current grants or initiatives are sought to address inequities and evidence-based practices. Hawai'i highlights the following efforts:

- The DOH has a new Office of Health Equity led by equity epidemiologists.
- The Asian American Native Hawaiian Pacific Islanders (AANHPI) 'Ohana for Center of Excellence is creating the space to motivate critical thinking, capacity-building, and best practices. The initial webinar offerings include "The Importance of Disaggregating AANHPI Race/Ethnicity Data."
- The DOH ADAD and the UH School of Social Work partnership supports the Mapuna Lab. This is specific to the professional training that can help better outcomes for Pacific Islanders and Native Hawaiians. Professionals are motivated to attend because attendance is free and Continuing Education Unit (CEU) credits may be earned.[48]

[48] https://mapunalab.com/hanai-ahu/

- The CAMHD's Safe Spaces Committee and Youth Peer Partners are developing and presenting training on the basics of working with LGBTQ youth.[49] Safe Spaces Committee, made up of adult and youth advocates, meets monthly to review and revise old and to develop new policies and to actively participate in state legislation to be more inclusive of the LGBTQ+ community.
- The Office of Wellness and Resilience in the Governor's Office will look at existing trauma-informed care programs across the State.
- The DOH Office of Language Access provides technical assistance or training focusing on the law, improving language access practices in organizations, rules and responsibilities of staff and volunteer interpreters, working effectively with clients with limited English proficiency (LEP), and locating and working with interpreters.

Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (10 percent set aside)

The MHBG funded On-Track Hawai'i First Episode Psychosis Program (OT-Hi), the only FEP program in the State[50]. It is based on On-Track New York.[51] This program aims to empower youth with FEP to find meaning in their experiences and pursue their goals for education, employment, and relationships. The proposed MHBG spending for FY 2024 and FY 2025 will be at least the required ten percent set aside. The State funds part of the salary of the OT-Hi's psychiatrist /Medical Director. Said position manages the program and does medicine management for FEP clients. State funds are also used for office essentials.

OT-Hi is a new program and was fully staffed only recently. The number of referrals to OT-Hi exceeds the program's capacity. Hiring additional staff is being considered. Medicaid funding of OT-Hi is in its discussion phase. CAMHD monitors the fidelity of the program, and OT-NY has been mentoring staff. More training is planned to build capacity to deliver services. OT-Hi team is flexible when working with youth and their families to make treatment easier to access on their terms. OT-Hi offers services virtually, in the office, and the community. OT-Hi does not prescribe a specific frequency or intensity of services; this is determined collaboratively with the youth/family. OT-Hi works creatively to re-engage in care when a youth/family disengages. During transitions from the program, OT-Hi offers to provide follow-through support. These efforts are made to try and engage youth/families in treatment and prevent "falling through the cracks." In May 2023, OT-Hi saw all six (6) seniors in high school graduate, and all 23 participants remained housed with their families.

The planned activities for OT-Hi for the upcoming two years include: 1) hiring at least part-time (0.5 FTE) primary clinician to help meet the demand for the program; b) obtaining Medicaid reimbursement for FEP services; c) training the education/employment specialist on Individual Placement Supports (IPS) and other skills to help clients attain competitive integrated

[49] https://health.Hawaii.gov/camhd/lgbtq-safe-spaces/
[50]OT-Hi website https://health.Hawaii.gov/ontrackhi/
[51] OT-NY website https://ontrackny.org/

employment; and d) addressing FEP for youth/younger adults who may fall into the cracks in CAMHD and AHMD system of providing services as well as adults who have FEP.

The diagnostic categories identified for Hawai'i's ESMI/FEP program are: Schizophrenia, Schizoaffective, Schizophreniform, Delusional, Other specified schizophrenia spectrum and other psychotic disorder, Unspecified schizophrenia spectrum, and other psychotic disorder. The incidence and presentation of FEP among Hawai'i's population have not been researched. An incidence rate of 0.03 percent per population is offered based on a calculation tool offered by Humensky, Dixon, and Essock.[52] In 2022, the State's population, ages 15 to 24, was estimated at 168, 071 with 47.7 percent in O'ahu.[53] Based on this, about 50 individuals in the said age group can be experiencing FEP every year and almost half in O'ahu.

As previously mentioned, it would be helpful to get technical assistance to receive Medicaid reimbursement for first-episode psychosis services.

Person Centered Planning (PCP)

CAMHD and AMHD have individual PCP policies that include clients and, as appropriate, their families in the decision-making process for mental health treatment. CAMHD's Child & Adolescent Service System Program Principles (CASSP) emphasize that the CAMHD system of care be child and family centered and culturally sensitive, with the needs of the child and family determining the types and mix of services provided. CAMHD's case management have at least monthly meetings with the client and their family to determine progress in recovery and coordinates changes in treatment, as needed, with the clinical leads, contracted service providers and community supports.

Meanwhile, the overarching policy in AMHD would be its Policy and Procedure on Recovery Planning. This is reinforced by CMHC System Policy and Procedures and by accreditation. CARF Behavioral Health Standards Manual Section 2 General Program Standards C. Person Center Planning has six specific and extensive criteria areas to be met for accreditation. The 2022 CARF surveyors recommended improvement actions which the CMHCs included in the CARF Quality Improvement Plan (QIP). Among others, there is consensus that more education on patient centered care would be helpful along with trauma informed care. Both will need to be implemented as a culture change for the organization and outside training would be beneficial.

Hawai'i has a law on "Advance Mental Health Care Directives"[54] and it allows an adult or emancipated minor to write instructions for psychiatric treatment should a person be incapable to make or communicate those instructions. It also allows adults or emancipated minors to

[52] Humensky JL, Dixon LB, Essock SM. State mental health policy: an interactive tool to estimate costs and resources for a first-episode psychosis initiative in New York State. Psychiatr Serv. 2013 Sep 1;64(9):832-4. doi: 10.1176/appi.ps.201300186. PMID: 24026833

[53] https://census.Hawaii.gov/home/population-estimate/

[54] Hawai'i Revised Statues Ch. 237G https://www.capitol.Hawai'i.gov/hrscurrent/Vol06_Ch0321-0344/HRS0327G/HRS_0327G-.HTM

designate an agent to make instructions for them. AMHD encourages clients by supplying "how to" instructions and forms.

Program Integrity

Working closely with the few providers and intermediaries is essential. The State's Policy and Procedures for assuring that the legal federal requirements are conveyed to intermediaries and providers start with uniform adherence to the State 's procurement system. Communication of federal program requirements start with uniform approaches to requests for information, requests for proposals, and contract agreements. Within AMHD, the bulk of technical assistance rests on a Performance Information Evaluation Research Branch that supports with technical assistance, monitoring, forum, e-bulletin, manual among others.

Statutory Criterion

Criterion 1. Comprehensive Community-Based MH Service Systems

(Notes: An extended description and diagrams of access to CAMHD and AHMD services will be inserted back here)

All service areas support the rural population. Two, O'ahu and Maui, have urban areas based on metropolitan area designation.

CAMHD provides services and supports through an integrated public-private partnership consisting of contracted community-based agencies, state-managed community-based Family Guidance Centers (FGCs), and a centralized state office to provide administrative, clinical and performance oversight functions. The system of care has a comprehensive array of evidence-based services and supports for children and youth with the most challenging emotional and behavioral difficulties, and their families. Services include assessment, case management, and an array of therapeutic supports provided in the home and community, or temporary out-of-home placements. Every effort is made 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. Each of CAMHD's Family Guidance Center has a "Parent Partner" to help support parents of clients understand the mental health system and services recommended to their child and to talk to another parent who has experienced similar challenges. Parent Partners also offer workshops, support groups, and assistance at meetings.

A referral is a key starting point for access to CAMHD-administered services and continuum of care. This is outlined in Diagram 1 below. In 2020, the referral sources included the DOE or schools (eight percent), Judiciary juvenile justice (10 percent), parents or guardians (39 percent), DHS- Child Welfare Services (15 percent), and "Others" (28 percent which most likely means self-referral).[55] The Certified Community Behavioral Health Clinic (CCBHC) will be a new referral source in Maui. CAMHD clients are between three to 17 years old. The "age of majority" is 18 years old. Medicaid clients or youth with an open Individualized Education Plan (IEP) under the Individual with Disabilities Education Act (IDEA) may receive CAMHD services up to 21 years. On-Track Hawai'i program, which is the State's program for First Episode Psychosis

[55] CAMHD Strategic Plan 2023-2026

(FEP) may see clients up to 24 years old. Fundamentally, CAMHD is child-centered and provides access and services as close as possible to where a client lives. Adapting to the geography of an island State and transportation barriers, CAMHD has Family Guidance Centers (FGC) or CAMHD offices as listed by county below.

Meanwhile, access to AMHD's continuum of services have been eligibility-based but this has started to change with the introduction of the CCBHC. Eligibility is based on having a diagnosis and uninsured or underinsured (i.e., no insurance or have health coverage under the Medicaid/MedQuest CCS program). The array of services that make up the continuum of care is outlined by county or service are below. It must be noted that for court-involved clients, the following are based in Oahu but serve the entire State:

- Hawai'i State Hospital
- CAMHD Family Court Liaison Branch
- AMHD Court Evaluation Branch

O'AHU SERVICE AREA

Child and Adolescent Mental Health Division

Family Guidance Centers (FGC)

Honolulu O'ahu Family Guidance Center (HOFGC) serving the Honolulu area
Central O'ahu Family Guidance Center (COFGC) serving the Central and Windward area
Leeward O'ahu Family Guidance Center (LOFCG) serving the Leeward Coast, Ewa Beach and Kapolei Services via other contracted providers (purchase of services)

CAMHD also supports services from contracted providers (purchase of services)

Adult Mental Health Division

State-Operated Mental Health Community Centers (CMHC) Treatment Services Sections (TSS) and Clinics:

East Honolulu TSS
West Honolulu TSS
Windward O'ahu TSS
Central-Leeward O'ahu TSS
Wahiawa Clinic
Makaha Clinic

State-Operated Clubhouses (aka Rehabilitation Services):

Diamond Head Clubhouse
Hale O Honolulu Clubhouse
Koolau Clubhouse
Waipahu Aloha Clubhouse
Kauhale Lahilai Clubhouse

The following are provided via contracted services:

Case management services

- Community-based case management (CBCM)
- Intensive Case Management -High Utilizer of Services (ICM)
- Intensive case management plus -Homeless (ICM+)

Crisis response and care services

- Crisis management outreach (CMO)
- Crisis support management (CDM)
- Licensed crisis residential services (LCRS)
- Mental health emergency workers (MHEW)

Inpatient treatment and other services

- Psychiatric inpatient

Long-term care services

- Expanded Adult Residential Care Homes (E-ARCH)
- Skilled Nursing Facility (SNF)

Residential services

- Therapeutic living program (TLP)
- 24 hours group homes
- 8-16 hours group homes
- Semi-independent housing
- Supported housing

Support services

- Homeless outreach

Treatment services

- Day treatment/co-occurring disorder
- Intensive outpatient hospitalization (IOH)
- Specialized residential services program (SRSP)

MAUI SERVICE AREA

Maui has the unique setting where it is transitioning to the CCBHC model.[56] Among the distinct services are physical health screening, substance abuse services, and pediatrics. Partnerships are evolving and the following does reflect such updates:

Child and Adolescent Mental Health Division
State-operated *Family Guidance Centers (FGC)*
Maui Family Guidance Center (MFGC) -Wailuku Office
Maui Family Guidance Center (MFGC) -Molokai Office

CAMHD also supports services from contracted providers (purchase of services)

Adult Mental Health Division
Maui Branch- Community Mental Health Centers (CMHC) Branch
Maui Community Mental Health Center -Main Branch
Maui CMHC Rehabilitation Service Section
Lanai Services Section
Molokai Services Section

Clubhouses (aka Rehabilitation Services)
Hale O Lanakila Clubhouse

Services provided via contracted providers
Case management services
- Community-based case management (CBCM)

Crisis response and care services
- Crisis management outreach (CMO)
- Crisis support management (CDM)

Residential services
- 24 hours group home
- 8-16 hours group homes
- Semi-independent housing

Support services
- Homeless outreach

Treatment services
- Day treatment/co-occurring disorder

[56] Requirements for CCBHCs as a model of care https://www.samhsa.gov/certified-community-behavioral-health-clinics

HAWAI'I SERVICE AREA

Child and Adolescent Mental Health Division
Direct Services
Family Guidance Centers (FGC)
East Hawai'i Family Guidance Center (EHFGC) Hilo office
West Hawai'i Family Guidance Center (WHFGC) Kona office
West Hawai'i Family Guidance Center (WHFCG) Waimea office

CAMHD also supports services from contracted providers (purchase of services)

Adult Mental Health Division
Hawai'i County Mental Health Community Centers (CMHC) Branch
Hawai'i CMHC – Hilo Office
Forensic Services Section - Hilo
East Hawai'i Clinic section- Hilo Clinic unit
- North Hawai'i Unit- Honokaa
- North Hawai'i Unit Kamuela
- Puna Unit
- East Hawai'i Rehabilitation Services Section

West Hawai'i Clinic section
- Kona Unit
- Kau Unit
- West Hawai'i Rehabilitation Services Section

Clubhouses (aka Rehabilitation Services)
HaleOluea, Hilo
Kona Paradise Club

Contracted Services
Case management services
- Community-based case management (CBCM)

Crisis response and care services
- Crisis management outreach (CMO)
- Crisis support management (CDM)
- Licensed crisis residential services (LCRS)
- Mental health emergency workers (MHEW)

Residential services
- Group homes 24 hours
- Group home 8-16 hours
- Semi-independent housing

Support services
- Homeless outreach

KAUA'I SERVICE AREA

Child and Adolescent Mental Health Division
Family Guidance Centers (FGC)
Kaua'i Family Guidance Center (KFGC)

Adult Mental Health Division
Kaua'i Community Mental Health Center Branch
Kaua'i CMHC – Lihue
Kaua'i Rehabilitation Services Section/Clubhouse "Friendship House" - Kapaa

Services provided via contracted providers
Crisis response and care
- Crisis management outreach (CMO)
- Crisis support management (CSM)

Residential services
- 24 hours group home
- 8-16 hours group homes
- Semi-independent housing

Criterion 1. Mental Health System

CAMHD's Child & Adolescent Service System Program (CASSP) Principle pertaining to this question on "functioning outside of inpatient or residential institutions" is: "Services which require the removal of a child from his/her home will be considered only when all other options have been exhausted, and services aimed at returning the child to his/her family or other permanent placement are an integral consideration at the time of removal." CAMHD provides treatment services and supports within the clients' community so that should they be discharged; they have a support system in place. Telepsychology or Telepsychiatry may be used when necessary, when there is a mental health professional shortage in the client's community.

CAMHD's current system coordinates the following services as follows

- Physical health - with the Federally Qualified Health Centers (FQHCs), Maui Certified Community Behavioral Health Clinic, Hawai'i State Family Health Service Division/American Academy of Pediatrics
- Mental Health- with DOE, Judiciary, DHS-Medicaid, Child Welfare Services & Office of Youth Services & others
- Rehabilitation services with DHS Vocational Rehabilitation Division
- Employment services -For OT-Hi Program which has Education/Employment Specialty
- Housing services -CAMHD refers to least restrictive and most familiar environment to minimize trauma
- Educational services C–with DOE
- Substance misuse prevention and SUD treatment services. CAMHD refer clients with SUD to SUD providers with residential facilities, as necessary

- Medical and dental services – CAMHD refers clients to FQHCs or Providers
- Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)

Criterion 2. Mental Health System

The State currently relies on NSDUH for estimating prevalence, and supplement it with other reports (e.g., Point-in-Time Count for Homelessness and Mental Illness).
Currently, the State does not have a methodology for estimating incidence. Meanwhile, the data infrastructure improvement project is sought to have better information from which incidence may be explored in the future.

Criterion 3. Children's Services

The island state has children's services that provides for a system of integrated services for children to receive care for their multiple needs. It is a comprehensive system of social services, educational services (including services provided under IDEA), juvenile justice services, substance mis-use prevention and SUD treatment services, health and mental health services. As presented in a previous section, the State has only 4 counties and the system of providing is aligned with that.

Criterion 4. Targeted services to rural and homeless population and to older adults

The community-based mental health system includes targeted services to rural and homeless populations. Unlike in the case of the homeless population or forensic population, there are no services that are distinctly for older adults.

Criterion 5 Management System

The Department of Health is one of the State's large agencies that provides the leadership in managing the public mental health care system and its limited resources.[57] CAMHD and AMHD have direct management role in managing resources for the mental health care system that serves as a safety net for the uninsured, underinsured and those in crisis. In AMHD, strategic directions are set by a Strategic Planning Executive Group (SPEG) while CAMHD has a publicly reviewed multi-year plan. CAMHD and AMHD are responsible for implementing State procurement system and policies and procedures in using various funds. CAMHD and AMHD personnel are subject to the personnel policies and procedures from the State Department of Human Resources Development (DHRD), including in recruitment and compensation. They craft their own implementing policy and procedures within said broader framework (e.g. for implementation of a new State teleworking policy). They recruit, retain, compensate and train within the larger DHRD framework. CAHMD and AMHD information technology systems and resources policies and procedures are subject to State IT policies and procedures from the State's Office of Enterprise Technology Offices. CAMHD's system for electronic health records is called MAX while AMHD is called Avatar. There are other IT resources for internal management of finances, personnel, and training. There are IT resources

[57] https://health.Hawai'i.gov/orgchart/fy-2022-org-charts-functional-statements/

for public interface included websites of CAMHD, AHMD, the State Council on Mental Health, and others.

As previously discussed, the COVID-19 pandemic accelerated the adoption of telehealth modalities. Using SAMHSA's model[58], the modalities included home to clinic, home to home, clinic to clinic, clinic to community (including mobile). There is a need to evaluate and assess these pandemic-driven modalities for current and future settings. Early action point to the need for better electronic health records system, equity (e.g., billing for audio only services that have been supportive of older clients), teleworking options for workers, evidence-based practices, and staff onboarding and continuous training to work effectively in the new setting.

Trauma (Requested Information Only)

The CAMHD leads the statewide Trauma-Informed Care Task Force comprised of multi-state and private sector entities in the field of health, education, public safety (including prisons), early childhood development, and others. One of the outcomes of this task force is the establishment of the Office of Wellness & Resilience within the Governor's Office. This newly established office is tasked with developing statewide policy for trauma and help build overall capacity. The priorities of the OWR include identifying and coordinating existing trauma-informed care and resiliency efforts.[59] It seeks to identify needs and gaps, including over quality efforts and their consistency with SAMHSA's recommended public health approach in addressing trauma. The other part of effort is building resilience. OWR plans to survey State workers to support workers wellness and resiliency.

CAMHD and AMHD have policy and procedures on trauma-informed care but more can be done to improve practice. M/SUD providers have been provided with training, tools, peer specialist support, evidence-base practice. The extraordinary diversity of clients and many changes in workforce requires leadership in expanding evidence-based practices and more training.

In the throes of the current wildfire disaster, the OWR is leading in coordinating response.

Crisis Services

Since the September 1, 2022 update, the State's crisis system rebranded to Hawai'i CARES 988 with intent to increase user friendliness to someone in crisis or someone helping (see https://hicares.Hawaii.gov/). Last year, Hawai'i rated and reported that the system is in the in program sustainment level in the categories of "someone to talk to" and "someone to respond." It reported that the system is in major implementation stage (i.e., available for at least 75 percent of the peopled in the state) in "A place to go." This is asserted again this year. Assessments show the need for warm hand-off and consistency in the quality and availability of services. Like all other services in the continuum of care, the crisis care system is experiencing

[58] https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf
[59] See OWR website https://governor.Hawai'i.gov/main/ke-ala-hou-the-office-of-wellness-and-resilience/

workforce availability issue, and illustrated by non-opening of a Licensed Crisis Residential Services in Maui due to the lack of required Advanced Practice Registered Nurse. Solutions and improvements are sought along those expected of a nationally certified crisis response system. The five percent set aside will continue to increase the crisis continuum, specifically to have stabilization beds across counties and crisis mobile outreach staffing.

The response in the case of youth and children is reiterated here. The crisis system starts with a call to 988 Hawai'i Cares line. A connection is made to a crisis mobile outreach worker at one of CAMHD's contracted provider agencies. These provider agencies specialize in child and adolescent mental health and differ from those used for adults. A crisis mobile outreach service may then be deployed to provide mental health assessment for safety and makes recommendations regarding whether the crisis is appropriate for stabilization in the community setting or Emergency Room referral or referral into one of CAMHD's Therapeutic Crisis Homes or the Residential Crisis Stabilization Program. Crisis Mobile Outreach is available to any child in Hawai'i 24 hours a day 7 days a week.

In the throes of the current wildfire disaster, the Hawaii CARES 988 has also been putting out information on community resources.[60]

[60] See https://hicares.hawaii.gov/resources/hawaii-wildfire/

Children and Adolescent Mental Illness/ Substance Abuse Disorder (M/SUD) Services

The CAMHD is part of a comprehensive mental health system for youth and regularly meets with public and private sector agencies in effort to improve access and seamless mental health services for youth. These agencies include but are not limited to:

- *Hawaii State Department of Education (DOE)* – CAMHD and DOE have a Memorandum of Agreement to provide mental health care for students. It is statutorily required for DOE and CAMHD to have a tiered mental health system for youth – DOE refers students with SED to CAMHD for treatment.
- *Hawaii State Judiciary, Family Court* – CAMHD's Family Court Liaison Branch provides mental health services for youth who are court ordered to receive such services and/or are incarcerated in the Hawaii Youth Correctional Facility. CAMHD Care Coordinators help link youth and their families to other supports as needed.
- Hawaii State Department of Human Services (DHS)
    - Child Welfare Services (CWS) – CAMHD receives referrals from CWS or recommends parents apply for CAMHD services. Care Coordinators include CWS in mental health treatment discussions as appropriate
    - Medicaid (aka MedQuest) – CAMHD meets with MedQuest regularly to discuss Medicaid reimbursement for youth mental health services. CAMHD is conducting a rate study of Medicaid compensations to contracted mental health providers in collaboration with MedQuest. CAMHD is the mental health provider for Medicaid recipients.
    - Office of Youth Services (OYS) – CAMHD receives referrals from OYS. OYS works with the Hawaii Youth Correctional Facility, Hawaii Juvenile Justice State Advisory Council and the Hawaii Youth Commission to prevent delinquency, reduce recidivism to help youth become productive, responsible citizens through community based and family focused treatment interventions.
- *Hawaii Youth Services Network (HYSN) and other non-profit agencies* – HYSN is a coalition of youth serving organizations (public and private) to build partnerships and collaboration to maximize resources for high-risk youth. HYSN convenes state government and non-profits to discuss and advocate for system changes to provide comprehensive services for youth.

CAMHD works with divisions within the Hawaii State Department of Health for better access to for youth who have multiple needs and or to provide emergency mental health services:

- *Developmental Disabilities Division* - The medical directors of this division and CAMHD's meet regarding eligibility for clients who have dual diagnosis of developmental disabilities and SED.

- *Family Health Service Division (FHSD*) – CAMHD is starting to work with FHSD who has grant funds to address mental health for children 0-3 years old. FHSD developed a questionnaire for pediatricians in conjunction with the American Academy of Pediatric Hawaii Chapter to assess youth mental health during annual physical exams (CAMHD's services are for youth 3-18 years).
- *Adult Mental Health Division (AMHD)* – CAMHD clients are transitioned to the Ohana Health Plan's Community Care Services after they "age" out of eligibility for CAMHD services. AMHD provides forensic mental health care and administers the Hawaii State Hospital which cares for court ordered patients with SMI. CAMHD partners with AMHD to expend BCSA funds to:
    - Provide mental services at Emergency Family Assistance Centers, in collaboration with the Office of Public Health Preparedness, as well as other state and county agencies and non-profits are working together during man-made or natural disasters.
    - Have a facilitated discussion to discuss client transfers between the new Maui Certified Community Behavioral Health Clinic for the present and during emergency situations.
    - Entering into a Memorandum of Agreement with the University of Hawaii, Kapiolani Community College to include Resilience Training in the curriculum for new and continuing education of Paramedic and Emergency Medical Technicians.

CAMHD and other child mental health advocates help pass state legislation to form a Trauma-Informed Care (TIC) Task Force. The TIC Task Force in turn successfully advocated for an Office of Wellness and Resilience (OWR) within the Office of the Governor to promote trauma-informed and trauma-responsive care. OWR aspires to prevent childhood trauma which can lead to mental and physical illness later in life.[61]

Recovery

MHBG is supporting trainers' training in WRAP or Wellness Recovery Action Plan. It is also supporting the training of Clubhouse staff, helping ensure that new staff are supported to have the competence to be a team member in the recovery of clients. The State is also supporting two peer specialist tracks at this time to meet needs – Hawai'i Certified Training Certificate and Forensic Peer Specialty Training Program. MHBG funds are also being used in the data infrastructure improvement project, which was initiated to, among others, have good data and understand impact of efforts. There is a special interest in building the best practices in peer specialist program to ensure desired impact on consumer or client recovery. As mentioned previously, technical assistance has been sought to improve the system's use capacity to support the recovery of clients with co-occurring substance use disorder.

[61] https://www.capitol.hawaii.gov/sessions/session2022/bills/GM1420_.PDF

Collaborative work with the ADAD on OD2A is also supporting mutually supportive priorities and action.

For children and youth specifically, CAMHD services are designed to be comprehensive in scope and breadth to meet recovery needs of each client. The Child and Adolescent System Serving Principles (CASSP) guide the process for each case. Important recovery principles such as focusing on returning youth to their families and communities as soon as possible and using patient and family voice in the treatment process all foster the goal of recovery. CAMHD uses evidence-based practices whenever possible and use data to make decisions about treatment length The goal is to return the youth to maximal functioning and to remain within their natural supportive environments whenever possible.

As soon as CAMHD is alerted that a client has been admitted to an inpatient hospital for suicide attempt or ideation, CAMHD contacts with the inpatient treatment via their social workers and ready for treatment team meetings. CAHMD clinical leads, mental health supervisors, and care coordinators follow along with case and are prepared to discuss disposition options from the time of first treatment team meetings. When treatments will be needed following discharge, CAHMD team makes appropriate referrals to appropriate service providers.

From a broader vantage, CAMHD is part of task forces on Employment First! And Trauma-Informed Care, to shape the expansion and enhancement of best practices in recovery, for those with substance use disorder.

Suicide Prevention

Hawai'i's Injury Prevention Plan 2018-2023 is the current plan in place. The Prevent Suicide Hawai'i Task Force and the DOH Emergency Medical Service and Injury Prevention System Branch (EMSIPS) lead the updating of this plan. The goal under suicide prevention is to create a healthy, safe, and empowered community by reducing suicide attempts and deaths. The strategies target risks and protective factors, framed across the individual, relationship, community, and policy levels.[62] To incorporate strategies supportive of the Zero Suicide Initiative, the Task Force and EMSIPS have key partners including the University of Hawai'i (UH) Department of Psychiatry, American Foundation for Suicide Prevention- Hawai'i Chapter, Mental Health of America, Liliuokalani Trust, AMHD, CAMHD, US military, US veterans and the Pacific Region Behavioral Health Alliance.

Within AHMD, a plan has been initiated to train all crisis service providers to assist those at risk of suicide. This will be through ASIST which stands for Applied Suicide Intervention Skills Training. It is noted here guidance from the State Plan on Drug Use and supported by a Disaster Response State Grant Program, the DOH ADAD and the UH Thompson School of Social Work and Public Health partnership resulted in Mapuna Lab. The Lab is a space that is supporting professional training that provides culturally relevant connection to mental health

[62] https://health.Hawai'i.gov/hipp/focus-areas/suicide-prevention/

and substance use disorder support services that are specific to Native Hawai'ians and Pacific Islanders. Some of these training are proving to be relevant in preventing suicide among said specific population.

Support of State Partners

Discussion in Step 1 include a presentation on the high level structure of broad partnership for mental health care. New and future partners include, but not limited to:

- AANHPI Ohana for Excellence- San Jose State University, Papa Ola L Lōkahi
- CCBHC – Hana Clinic, Kaiser Permanente
- Employment First Task Force -University of Hawai'i Center on Disability Studies
- Disaster Behavioral Health, Resiliency Training – Kapiolani Community College and First Responders Network; The Disaster and Emergency Preparedness Network's new partner include the State Victims Compensation Commission which brought attention to mass violence incidents.

It is anticipated that there will also be new partnerships for workforce needs, co-occurring conditions, and CCBHC expansion in Kaua'i and the Big Island.

State Planning/Advisory Council and Input on the MHBG Application

In reviewing last year's mini application, the Council recommended earlier participation in planning. At its August 8, 2023, meeting, the Council approved the drafting of a formal letter to the Department of Health reiterating the same. At said time, the Plan draft was not ready to be released.

The Council is abreast of several of the efforts because of meeting presentations and discussions. [63]

For formal involvement in the planning of this plan, an ad hoc committee on MHBG planning was created. Key members of the ad hoc committee on MHBG planning participated in the July 12 Guidance Webinar. However, only introductory presentations of the Plan have been presented at ad hoc committee and full council meetings. This Plan draft considered members' and public input that were received during said meetings.

The short time between guidance and meetings continues not to be conducive for more meaningful and early participation. For this plan, the concern will be mitigated by allowing the Council to provide their formal response after their September meeting. The Council has been informed also that request for revision can be explored after submission if needed.

The Council has 21 seats and has 4 current vacancies during the last year. - DOE, Service Area Board for Mental Health and Substance Abuse (SAB) representatives for Kaua'i and Maui SAB. One seat for a youth representative or consumer advocate was vacated in July 2022 to

[63] To be updated in https://scmh.hawaii.gov/meetings/agendas-and-minutes

resignation for reasons that are highlighted as a gap in local workforce preparation. He had to move to Nevada to complete his residency requirements for his doctorate degree.

List of Council Members

CHAIRPERSON

Katherine Aumer

1st VICE CHAIRPERSON

Kathleen Merriam (Behavioral Health)

2nd VICE CHAIRPERSON

John Betlach

SECRETARY

Eileen Lau-James

MEMBERS:

Antonino Beninato

Naomi Crozier

Jon Fujii (MedQuest/Medicaid)

Heidi Ilyavi

Jackie Jackson

Chris Knightsbridge (resigned July 2023)

Kau'i Seguancia (Public Housing)

Lea Dias (Vocational Rehabilitation)

Jean Okudara

Ray Rice (Social Services, Adult Protection Services)

Mary Pat Waterhouse

Kristin Will, (Judiciary)

IMMEDIATE PAST CHAIRPERSON:

Richard I. Ries

Public Comments

-to be added
#end#