REQUEST FOR COMMENT

FY25 MENTAL HEALTH BLOCK GRANT MINI-PROPOSAL

aka 2025 MHBG Only Application/Behavioral Health Assessment and Plan

THIS IS A DRAFT, PLEASE DO NOT QUOTE

Section I. BSCA Plan

BSCA Funding Plan 2025. ***Describe the proposed, planned activities using the Bipartisan Safer Communities Act (BSCA) Supplemental funds 3rd allotment, including an estimated budget.*** Hawaii's 3rd allotment will be $282,204 and the spending period will be September 30, 2024 to September 29, 2026. The 3rd allotment will continue to build on the priorities set under the 1st and 2nd allotments. The following are planned uses and, based on past experiences in carrying out BSCA activities, the cost estimates are subject to change:

Activity	3rd Allocation Expenditure	Notes
1. Advancing Mass Violence Incidence Response Training: Cultural Responsiveness, Psychological First Aid, and Skills for Psychological Recovery	$40,000	This builds on previous year's collaboration with the State's Crime Victim's Compensation Commission. The focus will be sustainability through content development and training of trainers.
2. Resiliency Training for First Responders. Taps the International Critical Incident Stress Foundation (ICISF) training program.	$ 180,000	This is a continuation and final part of the resiliency training initiative for first responders who are often the first people that individuals living with mental health illness may encounter when they are in crisis. Hawaii 1st responders (police officers, EMTs/Paramedics, fire fighters, sheriffs and others) are being trained to be ICISF Approved Instructor Candidates to increase the number of instructors who can train other and thus, build the state's capacity for crisis intervention, stress management & resiliency for emergencies and natural or man-made disasters.
3. Hawaii's crisis counselor certification program	$10,000	BSCA will contribute to the development of this program.
4. 10% Set-Aside for Early Serious Mental Illness	$29,000	This amount contributes to the expansion of services and practices supporting young adults with ESMI.
5. Leadership development for behavioral health leaders in disaster preparedness	$23,204	Professional development (e.g., national disaster preparedness summit)
TOTAL	$ 282, 204	

Section II. None Required

n/a

Section III. Planning Tables

Table 2a. Table 2a includes columns to capture state expenditures for COVID relief, ARP funds, and BSCA. Please use these columns to capture how much the state plans to expend over a 12-month period (SFY 2025, 7/1/24 - 6/30/25). Please explain the planned use of COVID, ARP, and BSCA funds during this period in the footnote section. Explain the numbers provided in Table 2 for these supplemental funds, e.g., total funds received, or portion of the funds received.

MHBG Table 2a									
Planning Period	From	7/1/2024		To	6/30/2025				
ACTIVITY	A. Mental Health Block Grant	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., ACF, TANF, CDC, CMS, Medicare SAMHSA)	D. State Funds	E. Local Funds (exluding local Medicaid)	F. Other	G. COVID-19 Relief Funds MHBG [a]	H. ARP Funds (MHBG)[b]	I. Bipartisan Safe Community Funds[c]
1. Mental Health Preventions[d]	0	0	0	0	0	0	0	0	0
2. Evidence-Based Practices for ESMI incl FEP 10 percent of total MHBG award[e]	477,224	0	0	0	0	0	0	777,715	58,204
3. State Hospital	0	0	0	103,247,511	0	0	0	0	0
4. Other Psychiatric Inpatient Care	0	0	0	291,338	0	0	0	0	0
5. Other 24-Hour Care (Residential Care)	0	0	0	14,104,891	0	0	0	0	0
6. Ambulatory Community Non-24 Hour Care	3,078,123	0	0	47,547,089	0	0	0	581,820	0
7. Crisis Services (5 percent set-aside)[h]	320,025	0	0	12,352,019	0	0	104,595	400,000	0
8. Administration (exlcuding Program and Provider Level)[g]	50,500	0	0	6,223,514	0	0	0	80,811	40,000
TOTAL	3,925,872	0	0	183,766,362	0	0	104,595	1,840,346	98,204

Explanation/Footnotes:

1. COVID 19 Relief Act supplementary fund. The State received a total of $ 4,106,967. The State will spend down the remaining amount of $104,595 by November 16, 2024. This final amount will contribute to the cost of providing SICM services. To clarify, this is only for one type of beds. SICM or Stabilization Intensive Case Management program services covers the provision of community-based beds in a safe a therapeutic environment for individuals experiencing emotional, behavioral and psychological crises and who may be homeless, and/or medically vulnerable. The program provides adults, eighteen (18) years and older a structured setting for a short-term stay for up to fourteen (14) days.

2. ARPA or American Rescue Plan Act supplementary fund. The State received a total of $ 7,188,108 and has a spending period ending September 30, 2025. The State will spend down the remaining amount on several activities including:

- $581,820 for technical assistance for the development of enhanced treatment and recovery support services through planning for Certified Community Behavioral Health Clinics (CCBHC).
- $370,000 for partial support of behavioral health crisis centers (BHCC).
- $777,715 for Evidence Based Practices for youth with SED – will be used for providing mental health services to youth with SED who are referred to CAMHD from judiciary, the education department, family court and other referral sources.
- $30,000 for Crisis Services – to address crisis service issues on rural islands in the state of Hawaii which has relatively less resources than the island of Oahu.
- $80,811 for Administration – for continuing efforts toward Trauma Informed Care for Hawaii to be a trauma informed state which includes but is not limited to addressing adverse childhood experiences to prevent physical and mental health challenges later in life.

3. BSCA or Bipartisan Safer Communities Act supplementary fund. The State received two allocation and expects a 3rd one. Each allocation sums up to $282,204. For the spending period, July 1, 2024, to June 30, 2025, Hawaii is projected to spend down $123,245 from its 1st allocation, all or $282,204 of its 2nd allocation, and $123,204 from its 3rd allocation. The total, $530,751* will address key priorities including:
    - $220,000 Resiliency Training for First Responders. This is in collaboration with various entities at the State and Local levels whose personnel are often the first that individuals experiencing mental health crisis encounter. This is reflected in Table 6.
    - $40,000 to support training activities that will sustain advancing practices in mass violence incident response.
    - $114,000 Technical assistance and consultation services for AMHD and CAMHD covering facilitated planning for disaster behavioral health response and assessment and improvement of internal disaster preparedness. This is to align efforts and directions of the Department's lead entity for response, the Office of Public Health Preparedness. This is reflected in Table 6.
    - $194,547 Partial support for the following which will also meet set-aside requirements for crisis service and EMSI: a) Technical Assistance for developing a Hawaii's crisis counselor certification program for incumbent and potential workers who do not have 4-year college degrees and beyond. b) Climate change and mental health needs survey; c) expansion of Hawaii's Early Serious Mental Illness/First Episode Psychosis program. And d) disaster kits supporting supportive housing facilities' preparedness. Note: he $58,204 which is allocated for ESMI/FEP program expansion and the $40,000 for developing Hawaii's crisis counselor certification program are reflected in Table 2. The rest are reflected in Table 6 as indirect cost expenses.
    - $22,204 Professional development for leadership in disaster preparedness.

This is reflected in Table 6.

4. Regular Mental Health Block Grant. Hawaii's FY24 allocation is $5,021,990 with a spending period between July 1, 2023 to June 30, 2025. The same amount is projected for FY25 with a spending period of July 1, 2024 to June 30, 2026. The planned expenditures for the July 1, 2024 to June 30, 2025 are reported as follows:

   AMHD
   Table 2:
   - $ 2,457,185 ambulatory community non-24 hour care
   - $200,000 SICM

   Table 6:
   - $2,030,000 For Data Information Improvement, to cover agreement with the Research Corporation of the University of Hawaii, and Epidemiologist payroll
   - $ 330,000 For a Service Providers Rate Study
   - $5,000 for State Council Planning-related activities
   - $ 92,185 Training, primarily to support Clubhouses.

   CAMHD
   Table 2:
   - $477,224 for Hawaii's only comprehensive FEP program for youth. Staff was increased to accommodate more referrals into the program and Interns were hired to support mental health clinical staff and to serve as a recruitment source. (SAMHSA provided TA consultation to further fund FEP services through Medicaid reimbursement.)
   - $620, 938 for ambulatory community non-24-hour care – funds CAMHD's Kealahou program for female youth who are at risk for, have or experienced running away, trafficking, truancy, abuse, suicide, arrest and incarceration.
   - $120, 025 to support crisis services for youth – funds CAMHD"s Crisis Liaison & Community Trainer position who serves as a resource statewide for youth in crisis.
   - $50,500 to support administration-related activities – for professional development of CAMHD staff in administrative positions, and to purchase equipment (laptops, etc.) needed for telework. Telework is heavily used by CAMHD because Hawaii is a chain of islands and most of its resources are on the island of Oahu. All other islands are considered rural.

   Table 6:
   - $273,656 for Information systems – for support of CAMHD's information systems which include but are not limited to the division's electronic health records, Medicaid reimbursement, processing payments for contracted service providers, etc.

- $110,000 for infrastructure support – these funds are used to have continuous family peers to help parents whose children have SED.
- $ 5,000 to support State Council activities, resource needs mapping
- $ 70,000 for quality assurance (QA) and improvement (QI) to support CAMHD's continuous quality assurance and improvement. (Previously, CAMHD's QA and QI were funding by another grant.)
- $ 248,678 for research and evaluation – used primarily to fund 2 research positions to produce annual reports, consumer surveys, provider satisfaction surveys and other research as assigned. Click: https://health.hawaii.gov/camhd/technical-reports/.
- $101,742 for training and education – for CAMHD Family Guidance Centers' and Family Court Liaison Branch's psychiatrists, psychologists, and mental health professionals' professional development.

Table 6a. Funds to be expended by categories of expenditure for system development/ non-direct service activities. This table covers MHBG grant funds only.

MHBG Table 6				
MHBG Planning Period 7/1/2024 to 6/30/2025				
ACTIVITY	**A. FY25 Block Grant**	**B. FY25 COVID Funds**	**C. FY25 ARP Funds**	**FY25 BSCA Funds**
Activity				
1. Information Systems	2,303,656	-	1,500,000	-
2. Infrastructure Support	440,000	-	-	5,000
3. Partnership, community outreach, and needs assessment	89,362	-	112,000	145,343
4. Planning Council Activities	10,000	-	-	-
5. Quality assurance and improvement	-	-	-	-
6. Research and Evaluation	248,053	-	12,006	-
7. Training and Education	276,202	-	-	322,204
8. TOTAL	**3,367,273**	**-**	**1,624,006**	**472,547**

Explanation:
Please see explanation under Table 2a for MHBG Regular Funds and BSCA funds.
FY25 ARPA funds: This is the last of remaining ARPA funds with CAMHD.
FY25 BSCA funds – This is from all 3 allotments (remaining of the 1st allotment, all of 2nd allotment, and part of the 3rd allotment)

CAMHD:
ARPA Fund:
- $1,500,000 for Information Systems – to have a scheduling system which preferably is compatible with CAMHD's Electronic Health Records System (aka MAX) for the divisions' FEP, telepsychiatry, and Family Guidance Centers.
- $112,000 for Partnerships, Community Outreach, and Needs Assessment – for communication and public education on CAMHD services for SED Youth, Kealahou

Services for female youth at high risk, OnTrack Hawaii (FEP) program, and LGBTQ+ Safe Spaces for youth.

- $12,000 for Research & Evaluation – to survey users of Hawaii 988 to evaluate crisis mobile outreach services for youth.

Section IV. Environmental Factors and Plan

1. Crisis Services.

Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

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/). In addition, the State is currently working on securing a vendor to assist with those continued efforts to include more awareness about crisis services available with digital and traditional media marketing. As previously reported, Hawai'i rated the system is in the 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 "Safe place to go or to be". This is asserted again this year. We continue efforts to establish crisis stabilizations beds in our smaller communities and islands such as Kaua'i, Moloka'i, and Lana'i. 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 workforce availability issues, as illustrated by the temporary closure of a Licensed Crisis Residential Services (LCRS) in Maui due to the lack of required twenty-four-hour Registered Nurse coverage. This is also evident in the difficulty in hiring and retaining crisis mobile outreach workers in the smaller rural communities and regions such as Kailua-Kona (West Hawai'i) and Kaua'i. 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. Hawai'i Cares 988 and the crisis mobile outreach services are available statewide, 24 hours a day, 7 days a week.

The response in the case of youth and children is reiterated here. The crisis system starts with a call to Hawai'i Cares 988. 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 may 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 (CMO) is

available to any child in Hawai'i 24 hours a day 7 days a week. CMO is available 24/7 and can be provided where the person may be such as home, school, or elsewhere. The goal of CMO is to help resolve crisis in a least restrictive setting and develop future plans which may improve resiliency.

In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

a) The Exploration stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
b) The Installation stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.
c) Initial Implementation stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.
d) Full Implementation stage: occurs once staffing is complete, services are provided, and funding streams are in place.
e) Program Sustainability stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Other program implementation data that characterizes crisis services system development.
1. Someone to talk to: Crisis Call Capacity
a. Number of locally based crisis call Centers in state: One crisis call center.
i. In the 988 Suicide and Crisis lifeline network: Yes.
ii. Not in the suicide lifeline network: N/A
b. Number of Crisis Call Centers with follow up protocols in place: One crisis call center.
c. Percent of 911 calls that are coded as BH related: Information not currently available from 911 PSAPs.

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities): All communities. Crisis Mobile Outreach (CMO) is available statewide.
a. Independent of first responder structures (police, paramedic, fire): Yes.
b. Integrated with first responder structures (police, paramedic, fire): No.
c. Number that employs peers: One, however, others CMO teams are actively recruiting.
3. Safe place to go or to be:
a. Number of Emergency Departments: Twenty-eight.
b. Number of Emergency Departments that operate a specialized behavioral health component: Eight.
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): Eight.

a. Check one box for each row indicating state's stage of implementation.

Exploration Planning	Installation	Early Implementation/ less than 25 % of counties	Partial Implementation/ about 50 % of counties	Majority Implementation/at least 75% of counties	Program Sustainment
Someone to talk to					x
Someone to respond					x
Safe place to go to or be at				x	

b. Briefly explain your stages of implementation selections here.

Last year, Hawai'i rated and reported that the system is in the sustainment level in the categories of "someone to talk to" and "someone to respond." This means that the "someone to talk to" is available through Hawaii CARES 988 to anyone statewide, 24 hours a day, 7 days a week. In addition, crisis mobile outreach (CMO) is also available to anyone statewide, 24 hours a day, 7 days a week. Both these services and supports have been in place for more than two decades.

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 "some place to go or to be." This is asserted again this year. Although Emergency Departments (ED) are available on each island, EDs that have a specialized behavioral health component or unit is limited to one on the four major islands for adults but for children and youth, only found on the island of Oahu. Crisis stabilization beds are also limited to only three of the four major islands for adults only.

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 workforce availability issues, as illustrated by the temporary closure of a Licensed Crisis Residential Services (LCRS) in Maui due to the lack of required twenty-four-hour Registered Nurse coverage. This is also evident in the difficulty in hiring and retaining crisis mobile outreach workers in the smaller rural communities and regions such as Kailua-Kona (West Hawai'i) and Kaua'i. 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.

3. *Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.*

The State seeks to develop the crisis continuum of care with the target to earning a nationally accredited Hawaii CARES 988 as well as establishing formal MOUs/MOAs with and amongst

911 PSAPs, Emergency Departments, Crisis Receiving and Stabilization Centers, and Crisis Mobile Outreach providers.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.
The State seeks to use the set-aside for increasing crisis stabilization receiving centers, seeking that residents have access to them in their own communities across every county and island.

5. Please indicate areas of technical assistance needed related to this section.
How have other States addressed issues with staff shortage especially for those services that may require higher levels of credentials such as a Registered Nurse or a bachelor's degree level?

2. State Council

How was the Council involved in the development and review of the state plan and report? Narrate in the text box. Also, upload supporting documentation (e.g., meeting minutes, letters of support, etc.). Don't forget to attach the Council's comments after reviewing the Application and Report, if any.

The chronology of Council's involvement in development and reviewing this mini proposal is outlined below:

June 18, 2024. The Council meeting agenda includes MHBG Planning Update. Staff recommended and the Council approved to create an MHBG Planning and Performance Committee. See https://calendar.ehawaii.gov/calendar/meeting/73163/details.html

July 9, 2024. The Council holds its monthly public meeting and MHBG Planning Update continues to be in the agenda. The meeting packet included the SAMHSA guidance for this FY25 MHBG Mini-Proposal that was released on July 1. See https://calendar.ehawaii.gov/calendar/meeting/73319/details.html

August 5, 2024. The MHBG Planning and Performance Committee met and received briefing on the SAMHSA guidance and staff's progress in completing the mini-proposal. Staff provided insights on crisis services, the Hawaii MHBG funding allocation and direction. It received comments from the public (one individual).
https://calendar.ehawaii.gov/calendar/meeting/73454/details.html

August 13, 2024. The Council holds its monthly public meeting and the MHBG Planning Update was on the agenda. Council members received the first rough draft of the mini-proposal, engaged in discussion, and posed questions which were answered by staff.
https://calendar.ehawaii.gov/calendar/meeting/73512/details.html

Council comments and public input to be attached later.

What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services? The State relies on the collaborative leadership within DOH, particularly within its Behavioral Health Administration, to align efforts, resources, and priorities to plan and implement these services. The State Council itself has monthly public meetings where members and resource speakers can talk about relevant topics. The State Council itself is also engaged in advocacy on relevant sub-topics and have been providing input. See Council's 2024 Report to the State Legislature for example https://scmh.hawaii.gov/about/annual-reports.

Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? YES NO

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

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

The duties and responsibilities of the Council are defined by State Laws which, among others, are aligned with the Council's role as the State Council for MHBG planning. See https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0334/HRS_0334-0010.htm. It holds full meetings every 2nd Tuesday of the month which are public meetings governed by Hawaii's Sunshine Law. These meetings often include presentations and discussions on relevant topics and issues. It gathers meaningful input by way of these discussions and the public in attendance providing input. The public meetings regularly include informational reports from its members, which includes family members, advocates, and other stakeholders. Its 2024 Report to the Governor and Legislature sums up last year's results. See https://scmh.hawaii.gov/wp-content/uploads/2024/03/2024-Report-to-the-Legislature-SCMH-FINAL-1.pdf

Council Members

Start Year: 2025 End Year: 2026

Name	Type of Membership*	Agency or Organization Represented
Katherine Aumer	Family Members of Individuals in Recovery (to include family members of adults with SMI)	
John Betlach	Others (Advocates who are not State employees or providers)	
Naomi Crozier	Family Members of Individuals in Recovery (to include family members of adults with SMI)	
Lea Dias	State Employees	
Jon Fujii	State Employees	
Heidi Ilyavi	Parents of children with SED	
Jackie Jackson	Family Members of Individuals in Recovery (to include family members of adults with SMI)	
Kathleen Merriam	State Employees	
Ray Rice	State Employees	
Marian Tsuji	State Employees	
Mary Pat Waterhouse	Family Members of Individuals in Recovery (to include family members of adults with SMI)	
Forrest Wells	Providers	
Kristin Will	State Employees	

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

Council Composition by Member Type, Summary

Start Year: 2025 End Year: 2026

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	4	
Parents of children with SED	1	
Vacancies (individual & family members)	5	
Others (Advocates who are not State employees or providers)	1	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**11**	**52.38%**
State Employees	6	
Providers	1	
Vacancies	3	
Total State Employees & Providers	**10**	**47.62%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**21**	

Public Comment on the State Plan

Title XIX, Subpart III, section 1941 of the PHS Act (42 USC section 300x-51) requires, states will provide an opportunity for the public to comment on the state block grant plan in such a manner as to facilitate comment from any person both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Did the state take any of the following steps to make the public aware of the plan and allow for public comment? Please answer yes or no as appropriate for questions a – c and provide the URL where the application was posted.

Yes. MHBG Planning has been in the Council's agenda since its June meeting. By law, public notices and agenda of these meetings are posted no later than six days before a meeting. By law, the notices are posted on the State's public calendar, sent to the Council's distribution list, and sent the Lt. Governor's Office.

The mini-proposal draft will also be posted on the State Department of Health website for a short public comment period ending August 30, 2024.
#end#