Hawai‘i

FFY 2027 MINI-APPLICATION

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Center for Mental Health Services

Division of State and Community Systems Development

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ENVIRONMENTAL FACTORS AND PLAN
2. Evidence-Based Practices (EBP) for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside-required for Mental Health Block Grant

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations [Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED]. The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset. States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode Initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a

set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

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

Please respond to the following items:

1. *Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.*

Model(s) /EBP(s) for ESMI	*Number of programs*
OnTrack for Hawai‘i for First Episode Psychosis, modeled after OnTrack New York	1

2. *Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds). Answer FY 27 only.*

FY 2026	*FY2027*
Do not answer	$ 508,000

3. *Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.*

The Child and Adolescent Mental Health Division (CAMHD) is not currently billing Medicaid for services provided through the OnTrack Hawai‘i program. At present, most program operations are supported by the Mental Health Block Grant with state general funds supporting client/staff travel between O‘ahu and other islands for direct treatment services. The Hawai‘i Medicaid State Plan Amendment includes Coordinated Specialty Care First Episode Psychosis

reimbursement rates that can be utilized. CAMHD is working to set up the billing infrastructure to be able to use these rates.

4. *Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.*

   OnTrack Hawai‘i is a Coordinated Specialty Care First Episode Psychosis program based on the OnTrackNY model. OnTrack Hawai‘i is an early intervention program designed for teens and young adults (15-24 years old) experiencing psychosis. The team includes a psychiatrist, clinicians, and peer and employment/education specialists, to help clients achieve school, work, and relationship goals. The services are rehabilitative and therapeutic. Evidence-based practices are utilized within each of the service components OnTrack Hawai‘i’s Coordinated Specialty Care for example Cognitive Behavior Therapy for Psychosis, Individual Placement Support.

5. *Does the state monitor the fidelity of the chosen EBP? Yes or No.*

   No.

6. *Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? Yes or No.*

   Yes

7. *Explain how programs increase access to essential services and improve client outcomes for those with ESMI.*

   Hawai‘i a geographically isolated state with most health services, including FEP services, concentrated on the island of O‘ahu. While all OnTrack Hawai‘i staff are located on the island of O‘ahu, On-Track Hawai‘i provides virtual services to clients statewide, and occasionally makes in-person visits to non-O‘ahu clients, as needed. On-Track Hawai‘i has worked closely with CAMHD’s Program Improvement and Communications Office to increase public awareness of FEP, including the early identification and treatment of psychosis, and OnTrack services via an outreach campaign and increased social media presence. OnTrack works to continue implementation of Cognitive Behavior Therapy for Psychosis, Individual Placement Support, and Certified Youth Partner services.

8. *Please describe the planned activities in FY2027 for your state’s ESMI program.*

   The OnTrack Hawai’i program plans to maintain and continue to provide training to our workforce, continue and improve implementation of CBTp, family psychoeducation/support, Individual Placement Support (IPS), and Certified Youth Partner (YP) services. The program also plans to continue and increase outreach. Future goals and objectives include developing, implementing, and sustaining fidelity and outcome measures. With future funding from Medicaid

reimbursements, goals include increasing staffing, adding group interventions, increasing community/social media outreach, and consultation and training for community providers on treating FEP.

9. *Please list the diagnostic categories identified for each of your state's ESMI programs.*
   Schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, other specified schizophrenia spectrum and other psychotic disorder.
   psychotic disorder, unspecified schizophrenia spectrum, and other psychotic disorder.

10. *What is the estimated incidence of individuals experiencing first episode psychosis in the state.*
    According to Simon et al. 2017 and Hong et al. 2019, there is an estimated incidence of 0.126 – 0.33% for individuals experiencing first-episode psychosis. Based on the US Census data from 2024, the State of Hawai'i would have approximately 207-543 new cases of FEP each year for individuals within the ages 15-24 years old.

11. *What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?*
    Outreach efforts include media marketing/advertising (social media, TV and radio ads) and outreach to medical and mental health providers through the state.

12. *Please indicate area of technical assistance needs related to this section.*
    The CAMHD OnTrack Hawai'i Program would like technical assistance on: (1) best practices in fidelity monitoring and implementation support for fidelity monitoring, (2) recommendations for monitoring treatment progress and outcomes, and (3) best practices for providing outreach to FEP clients in geographically isolated states.

Notes:
#1. OnTrack Hawai'i utilizes the OnTrackNY evidence-based model to treat First Episode Psychosis (FEP), locally tailored for Hawai'i's population.
#5. At this time, CAMHD is exploring fidelity monitoring mechanisms for implementation at a future date.
#10. Cited Literature:
Simon, Gregory & Coleman, Karen & Yarborough, Bobbi Jo & Operskalski, Belinda & Stewart, Christine & Hunkeler, Enid & Lynch, Frances & Carrell, David & Beck, Arne. (2017). First Presentation With Psychotic Symptoms in a Population-Based Sample. Psychiatric services (Washington, D.C.).
Hong, S., Proscio, J., & Peterson, M. (2019). "Estimating Incidence of First Psychotic Diagnosis in a Medicaid Population. "A New Method for Estimating Incidence of First Psychotic Diagnosis in a Medicaid Population. Psychiatric Services, 70(12), 1127-1133.

ENVIRONMENTAL FACTORS AND PLAN
9. Crisis Services

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:

- *Crisis call centers*
- *24/7 mobile crisis services*
- *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services

to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include Crisis Services: Meeting Needs, Saving Lives, which consists of the "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit" as well as an Advisory: Advisory: Peer Support Services in Crisis Care There is also the National Guidelines for Child and Youth Behavioral Health Crisis Care which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center

separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent

risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (P.L. 116-172) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the live-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

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

   Child and Adolescent Mental Health Division:
   CAMHD provides several services for children and youth in crisis, including 24-hour crisis telephone stabilization, crisis mobile outreach, residential stabilization program, and therapeutic crisis home. CAMHD recently initiated a pilot of expanded crisis services and will begin a sub-acute residential program soon.

   24-Hour Crisis Telephone Stabilization (Hawai‘i CARES 988): This service serves all youth statewide whose immediate health and safety may be in jeopardy due to a mental health issue. Stabilization provides consultation, referral and the necessary support to dissipate the crisis situation. AMHD maintains this data for the state.

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

mental status, immediate crisis resolution/stabilization and de-escalation if necessary. In state FY25, 443 youth received CMO services.

Therapeutic Crisis Home: Therapeutic Crisis Home (TCH) provides short-term crisis stabilization interventions in a safe, structured setting for youth with urgent/emergent mental health needs. This service includes observation and supervision for youth who do not require intensive clinical treatment in a psychiatric setting and can benefit from a short-term, structured stabilizing setting. Youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances and who cannot be safely managed in his/her natural setting are appropriate for TCH. The primary objective of this service is to provide crisis intervention services necessary to stabilize and restore the youth's functioning and return them to their natural setting. TCH is located in two counties, on Hawai‘i Island and Kaua‘i. In state FY25, 3 youth received TCH.

Residential Stabilization Program: Residential Stabilization Program (RSP) provides round-the-clock care in a structured, therapeutic residential setting for youth experiencing disruption in their primary living arrangement due to a recent emotional or behavioral crisis and residual behavior challenges that are beyond the family's capacity to manage. The program is expected to deliver short-term, intensive case management focused on arranging post-discharge services to expedite transition to a longer-term living environment, as well as therapeutic interventions, recreational activities, brief educational support, and access to medication management. The RSP is located on O‘ahu and service youth statewide, with a new RSP soon to initiate on Maui. In state FY25, 7 youth received RSP services.

Sub-Acute Residential: CAMHD recently initiated a new service, Sub-Acute Residential (SAR), which will provide intensive psychiatric intervention and round-the-clock care for youth requiring rapid stabilization of psychiatric symptoms in a secured residential setting. The program is expected to deliver a full range of psychiatric and diagnostic evaluations, medication titration, symptom stabilization, and intensive short-term treatment informed by a suite of multidisciplinary assessments. SAR is located on O‘ahu and will open soon.

Expanded Crisis Support: CAMHD recently initiated Expanded Crisis Support services, which provides follow-up supportive services to youth statewide who have had a Crisis Mobile Outreach (CMO) encounter and are not currently receiving CAMHD services. The purpose of ESC services is to provide robust follow-up to a CMO encounter, to stabilize the youth and family with short-term therapeutic interventions and to connect youth and families with support in the community and/or state agencies. The ECS service is also meant to prevent unnecessary use of crisis services, such as visits to the emergency department, use of acute psychiatric hospitalization, other out-of-home treatment, or

law enforcement intervention. In state FY25, 46 youth received ECS services across two counties, the program has since expanded to provide services statewide.

YouthLine: YouthLine is a free teen-to-teen peer crisis support and help line, located on Maui, which provides mental health support to Hawai‘i teens statewide through the YouthLine help, support, and crisis line by connecting youth with appropriate and local resources. YouthLine began training their peers at the end of 2025 and opened their call line in 2026.

Adult Mental Health Division:
The State’s crisis system rebranded to Hawai‘i CARES 988 with intent to increase user friendliness to someone in crisis or someone helping, The website for more information is https://hicares.Hawaii.gov/ and it is available to all regions and areas of our state, and provides access 24 hours a day, 7 days a week to “Someone to talk to” through the single crisis contact center. This center is equipped to manage all incoming calls, provide telephonic interventions, assess situations, and connect individuals to additional support when necessary. Similarly, there is “Someone to respond” with mobile crisis services which is available for all regions and areas of our state, 24 hours a day, 7 days a week, by calling the Hawai‘i Cares 988. The mobile crisis delivers on-site support for individuals experiencing distress, offering care in the community setting, collaborating with hospitals, healthcare providers, law enforcement, and social services to effectively address mental health crises and help prevent future crises. Essential functions include triage/screening, assessment, de-escalation, peer support, coordination with medical and mental health services, and crisis planning and follow up. A “Safe place to be” with crisis receiving and stabilization centers that available in only three of the four counties, and on only three of the seven inhabited islands in the State. The crisis receiving and stabilization centers include 23-hour receiving and stabilization and short-term stabilization services. These services are available 24 hours a day, 7 days a week, on the island on O‘ahu, Maui, Hawai‘i Island.

2. *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 published 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 published 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.
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 contact						x
Someone to respond						x
Safe place to be					x	

3. *Briefly explain your stages of implementation selection here.*
The State's implementation is presented from the perspectives of two Divisions below.

Child and Adolescent Mental Health Division:
Since 2002, the ACCESS Line provided a statewide service for youth in crisis. In 2015, the ACCESS Line was renamed the Crisis Line of Hawai‘i. With the nationwide implementation of 988 in 2022, the Hawai‘i CARES 988 was launched. The historical numbers still connect to the local 988 service. As such for over two decades, Hawai‘i youth have had someone to contact.

Since 2002, youth in Hawai‘i have also had someone to respond, with Crisis Mobile Outreach provided statewide for youth in crisis. This system has been maintained and enhanced, despite workforce shortages.

CAMHD has provided a safe place to be (e.g., crisis stabilization service, therapeutic crisis home) for youth in crisis since 2002, however staffing and programmatic challenges have made it difficult to consistently staff and provide this

service statewide. At present, a safe place to be is available in most but not all counties, with the option for client travel to the available service in a different county, if necessary.

Adult Mental Health Division:

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 "safe place to be." Although Emergency Departments (ED) are available on each island, EDs that have a specialized behavioral health component or unit is limited to one out the four major islands for children and youth, only on the island of O'ahu. Crisis stabilization beds are also limited to only three of the four major islands for adults only.

There remains a 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 which is 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.

4. *Based on the National Guidelines for Behavioral Health Crisis Care and the National Guidelines for Child and Youth Behavioral Health Crisis Care, explain how the state will develop the crisis system.*

Child and Adolescent Mental Health Division:

For over 20 years, CAMHD has worked developed, implemented, and sustained core components of the Child and Youth Behavioral Health Crisis Care system, consistent with the National Guidelines for child and Youth Behavioral Health Crisis Care. Since 2002, CAMHD has provided children, youth, and families with essential crisis services, including someone to contact, someone to respond, and a safe place to be. CAMHD has enhanced this foundation by providing the recently piloted expanded crisis services program to youth statewide.

CAMHD plans to advance our current crisis service array by completing an analysis of the crisis system against best practice standards, examining both the payor (CAMHD) standards and provider practices. CAMHD supports local 988 crisis line staff with training to ensure that they are equipped to navigate calls about children and youth and will continue to provide ongoing training in child/youth needs and trauma-informed practices.

Further, YouthLine, a youth peer-to-peer support for prevention and crisis stabilization, and crisis line plans opened a local, Hawai'i-based call center in 2026. At present YouthLine is working to expand their call center, currently located on Maui, to second satellite location on another island and intends to expand the hours per day the line is served by local Hawaii peers. YouthLine is also working to integrate with other local crisis supports (e.g., 988). CAMHD will continue leveraging data-driven approaches and continuous quality improvement to ensure that all youth in crisis receive timely, effective, and culturally sensitive crisis care, ultimately improving outcomes, and supporting the well-being of our communities.

Adult Mental Health Division:

The State seeks to develop the crisis continuum of care with the target of establishing formal Memoranda of Understanding/Memoranda of Agreements (MOUs/MOAs) between Hawaii CARES 988 with and amongst 911 PSAPs, Emergency Departments, Crisis Receiving and Stabilization Centers, and Crisis Mobile Outreach providers. The State seeks to engage Hawaii CARES 988, other crisis services providers, and stakeholders to regarding utilizing of a bed registry to support real-time, efficient connection to needed resources. The State seeks to engage Hawaii CARES 988 and mobile crisis teams to implement a GPS-enabled technology to efficiently dispatch care. It seeks deployment decisions guided by data analytics to ensure timely response, efficient resource allocation, and improved clinical outcomes. It seeks to align admission of 23-hour crisis receiving centers with National Best Practices. All crisis services emphasize the need for rapid connection to treatment and recovery supports to promote long-term health outcomes and reductions in overdose risk, homelessness, and recidivism. The crisis system is designed to reduce avoidable emergency department utilization, support public safety partners, and ensure appropriate clinical placement for individuals with behavioral health condition.

5. *Other program implementation data that characterizes crisis service system development*.

<u>Someone to contact: Crisis Contact Capacity</u>

a. Number of locally based crisis call Centers in state
    i. In the 988 Suicide and Crisis lifeline network: 1
    ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place
    i. In the 988 Suicide and Crisis lifeline network: 1
    ii. Not in the suicide lifeline network: 0
c. Estimated percent of 911 calls that are coded out as BH related:42

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)
a. Independent of public safety first responder structures (police, paramedic, fire): 14
b. Integrated with public safety first responder structures (police, paramedic, fire): 0
c. Number that utilizes peer recovery services as a core component of the model:0

Safe place to be
a. Number of Emergency Departments: 26
b. Number of Emergency Departments that operate a specialized behavioral health component: 6
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 7

6. *Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.*

Child and Adolescent Mental Health Division:

The Expanded Crisis Services (ECS) pilot program was initially funded by legislative appropriation and has sustained and expanded with the use of braided funding. The purpose of ECS is to provide comprehensive follow-up to a crisis mobile outreach encounter to stabilize the youth and family with short-term therapeutic interventions and connect the youth and family with longer-term supports. Data from the ECS shows expanding utilization. CAMHD plans to utilize the MHBG 5% set aside to continue the statewide implementation of this program.

Plans for the CCBHC are currently underway. CAMHD has helped to map out a workflow for youth to move between the CCBHC and CAMHD as warranted (e.g., stepping down from CAMHD to the CCBHC post-crisis).

Adult Mental Health Division:

AMHD will be investing more than the required five percent set-aside to strengthen Hawai‘i’s crisis system. Planned activities include expanding and sustaining stabilization bed services and improving Crisis Mobile Outreach workforce capacity to ensure warm handoff, timely response and follow-up. Currently, each island has a team with Hawaii Island having a mobile crisis service available in East Hawai‘i and West Hawai‘i due to the distance. Each mobile response is a single individual without a first responder. Along a treatment-oriented model, a peer recovery component is engaged only when the person is referred to crisis support management.

In parallel, AMHD conducted a Certified Community Behavioral Health Clinic (CCBHC) Planning needs assessment to guide future implementation. Planned CCBHCs are expected to enhance the crisis continuum primarily through post-crisis follow-up and continuity of care, ensuring that individuals served through Hawai‘i CARES 988 and Crisis Mobile Outreach remain engaged in treatment and recovery supports. By linking with the 988 system for referrals and handoffs, CCBHCs will strengthen ongoing engagement, reduce repeat crises, and expand access to coordinated outpatient and community-based services

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

The technical assistance needs that will be prioritized, and these prioritizes will be articulated further after receiving Results of the State's application for the 988 State and Territory Local Capacity Building. Specific technical assistance sought would be around peer specialists, warm lines to name two.

ENVIRONMENTAL FACTORS AND PLAN
14. State Planning/Advisory Council and Input on the Mental Health Block Grant Application

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S.C. §300x-3 for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the State Behavioral Health Planning Councils: An Introductory Manual.

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation

and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

1. *How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)*

   The full Council participated in the development and review of the state plan and report as follows:
   - April 14, 2026 Meeting Agenda on Ramping up 2026 Planning Role
   - May 12, 2026 Meeting Agenda on Mental Health Block Grant Presentation and Discussion - Presentation on Early Serious Mental Illness and OnTrack Hawaii
   - June 9, 2026 Meeting Agenda and MHBG Presentation and Discussion - Two Presentations: Crisis Services: The last 15 months and FY25; Improving Information Systems and Data Infrastructure at the Adult Mental Health Division.

   Planned meetings include the following:
   - July or August 2026 Planning and Performance Committee meeting
   - August 12, 2026 Meeting- Approval of Letter to SAMHSA from the Council Chairperson

   Notes:
   Meeting agenda and recordings https://scmh.hawaii.gov/meetings
   Mental Health Block Grant Planning Progression https://scmh.hawaii.gov/planning

2. *Has the state received any recommendations on the State Plan or comments on the previous year's State Report?Yes or No*
   a. State Plan – Yes
   b. State Report -Yes

   Provide the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

In response to last year's MHBG plan and application, the Council wrote the following in its letter to SAMHSA: "The Council emphasizes that Hawaii's workforce shortage remains a critical gap that requires overall attention. The Council supports the recommended priority to expand youth services and anticipates progress on additional priorities, including the Bipartisan Safer Communities Act (BSCA) plan for first responder resiliency." See https://scmh.hawaii.gov/wp-content/uploads/2026/01/SCMH-2026-Report-to-the-Governor-and-Legislature-Final-123125.pdf

3. *What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?*

Hawai'i delivers community mental health treatment, substance use prevention, SUD treatment, and recovery services through the Department of Health's Behavioral Health Administration (BHA). The BHA includes four divisions, with three most directly involved in these services: the Alcohol and Drug Abuse Division (ADAD), the Adult Mental Health Division (AMHD), and the Child and Adolescent Mental Health Division (CAMHD). Each division develops multi-year strategic plans and all work together to align priorities and maximize limited resources. Services are provided through community mental health centers, family guidance centers, and licensed community providers. Additional planning and program activities focus on areas such as policies, MHBG/SUPTRSG, crisis services, certified behavioral health clinics, peer support specialists, and rural health initiatives.

The BHA and its divisions also communicate and collaborate increasingly with the Department of Human Services, the state's Medicaid agency.

Community and stakeholder engagement is supported through several advisory bodies whose members are nominated by the Governor and confirmed by the Senate: The State Council on Mental Health, the Hawai'i Advisory Commission on Drugs and Controlled Substances, and the Local Service Area Boards for Mental Health and Substance Use in the counties of Honolulu (O'ahu), Maui, Hawai'i, and Kauai.

4. *Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? Yes or No*

Yes

5. *Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) Yes or No*

Yes

6. *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.*

Hawai‘i Revised Statutes 334-10 directs the Council to:

- Advise the Department of Health on resource allocation, statewide needs, and programs that affect multiple service areas.
- Review and comment on the statewide comprehensive integrated service plan.
- Advocate for adults with serious mental illness; children with serious emotional disturbances; individuals with mental illnesses or emotional challenges; and those with co-occurring mental illness and substance use disorders.
- Prepare and submit an annual report to the Governor and Legislature on implementation of the statewide comprehensive integrated service plan.

The Council meets monthly for three hours to receive presentations from subject matter experts, gather community input, and hear member reports. It currently operates two standing committees, the Legislation Committee and the Planning and Performance Committee—and also uses investigative permitted interaction groups to gather additional information on selected topics.

The Council has completed its own strategic plan and identified practical action areas that support advocacy aligned with its mission and vision.These are outlined in the latest Council Report to the Governor and Legislature.

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

Mission Statement
To advocate for a Hawai‘i where all persons affected by mental illness can access the treatment and supports needed to live full lives in the community of their choice.

7. *Please indicate areas of technical assistance related to this section.*

In 2024, the Council emphasized the need to strengthen data quality and expand the use of reliable data to guide decision-making. A key technical assistance priority is around performance measures and data the State should communicate.

In 2025, the Council's priority action areas. Technical assistance on any of these will be helpful.

- Strengthening Council Capacity. The Council plans to expand outreach across the state to raise awareness of both the Council and local service area boards
- Workforce Development and Local Career Pathways. The Council seeks to examine current mental health career paths and training programs, map workforce resources, and identify gaps in recruitment, retention, licensing, reimbursement, and internships.
- Effective Care Coordination Models The Council seeks to identify best practices as a starting point for effective care coordination models. This will involve briefings from experts and providers, working with insurers and health plans on billing and sustainability, identifying best practices, and analyzing funding gaps and policy barriers that affect long-term success.

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

Individual Members and State Agencies:
Kathleen Merriam, Mental Health Agency
Christine Montague-Hicks, Education Agency
Lea Dias, Vocational Rehabilitation Agency
Jon Fujii, Medicaid Agency
Kristin Will, Criminal Justice Agency

Other members:
Katherine Aumer, Family member
Danielle Bergan, Consumer Advocate
John Betlach, Consumer Advocate (Hawaii Local Service Area Board Representative)
Marissa Celeste, Consumer
Tiana Celis- Webster, Youth Representative
Heidi Ilyavi, Family member

Jackie Jackson, Family member (Oahu Local Service Area Board Representative)
Asianna Torres-Zaragosa, Consumer Advocate
Mary Pat Waterhouse, Family member
Forrest Wells, Provider
*Courtenay Matsu, Ex-Officio DOH BHA

Current vacancies
Housing Agency
Social Service Agency
Maui Service Area Board representative
Kauai Service Area Board representative
At least one more provider, preferably a prescribing one

Advisory Council Composition by Member Type

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery	1	
2. Family members of individuals in recovery	4	
3. Parents of children with Serious Emotional Disturbance/Disorder	0	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, parents	5	23.81 %
6. State Employees	6	
7. Providers	1	
8. Vacancies (State employees and providers)	3	
9. Total State Employees and Providers	10	47.62 %
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from federally recognized tribes	0	
12. Youth/adolescent representative (or member from an organization serving youth)	2	

13. Advocates /representatives who are not state employees or providers	2	
14. Other vacancies (who are not individuals in recovery/family member or state employer/provider)	2	
15. Total non-requjired but encouraged members	6	28.57%
16. Total Membership (all members of the Council)	21	

Actions to address vacancies:
Two vacancies are for two representatives of two local area boards. They are not State employees but can be provider or non-provider.

Housing – State Employee
This position remains difficult to fill. Additional follow-up has been made with the Governor's Office through both the Boards and Commissions Office and the Senior Policy Adviser for mental health.

Social Service – State Employee
This was an unexpected and recent vacancy. The Council re-established communication with the Adult Protective and Community Services Branch of the Department of Human Services to mitigate the vacancy first via presence at meetings.

Service Area Board Representatives – Kauai and Maui
These vacancies are a priority for the Council. Most are non-government, non-provider roles. Efforts continue to identify and recruit qualified community representatives.

Provider
To maintain balanced Council composition, members recommended adding one more provider, preferably a prescribing provider. Council members are reaching out through their respective networks to identify potential candidates.

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PLANNING TABLES

Note: The draft and data below currently reflects projected budget for two state fiscal years instead of the required one fiscal year. The final mini-application will reflect one fiscal year only.

Table 2: MHBG Planned State Agency Budget

States are asked to present their projected one-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. The following tables present projected expenditures for two fiscal years. The final mini application will present SFY27 only.

Child and Adolescent Mental Health Division

Funding/ Activities*	MHBG	Medicaid	Other Federal Funds	State Fund
6. Evidence-Based Practices for Early Serious Mental Illness	1,212,000			
7. State Hospital	-			
8. Other Psychiatric Inpatient Care	-			
9. Other 24 hour Care (Residential Care)	-	1,000,000		20,000,000
10. Ambulatory Community Non-24 Hour Care	1,243,592	1,000,000		15,000,000
11. Crisis Services	270,000			3,000,000
12. Administration	90,000	3,500,000	1,000,000	20,000,000
TOTAL	2,815,592	5,500,000	1,000,000	58,000,000

Adult Mental Health Division

Funding/ Activities*	MHBG	Medicaid	Other Federal Funds	State Fund
6. Evidence-Based Practices for Early Serious Mental Illness	-	-	-	-
7. State Hospital	-	-	-	291,719,419
8. Other Psychiatric Inpatient Care	-	-	-	5,426,000
9. Other 24 hour Care (Residential Care)	-	-		54,554,354
10. Ambulatory Community Non-24 Hour Care	370,436	-	3,965,464	117,646,455
11. Crisis Services	966,988	-	1,422,546	18732064
12.Administration		-	-	9149442
TOTAL	1,337,424	-	5,388,010	497,227,734

Note: AMHD will use MHBG funds to meet critical gaps as much as feasible - SICM, BHCC, and other services.

Table 4: MHBG State Agency Planned Budget –EMSI Only

This table captures the state's projected budget for MHBG-funded services and programs. The tables currently reflect two state fiscal years, and this will be adjusted to SFYT27 only in the final mini-application.

Child and Adolescent Mental Health Division

Services for children	MHBG
a. EBPs Evidence-Based Practices for children	
b. Crisis Services for children	270,000
c. Coordinated Specialty Care (CSC)/EMSI for Children	1,212,000
d. Other outpatient/ambulatory services for children	1,243,592
e. Other direct services for children	-
Other Capacity Building/System Development	1,991,726
Administrative Cost	90,000
TOTAL	$ 4,807,318

Adult Mental Health Division

Services for adults	MHBG
a. EBPs Evidence-Based Practices for adults	
b. Crisis Services for adults	-
……..c. CSC/EMSI for adults	-
d. Other outpatient/ambulatory services for adults	370,436
e. Other direct services for adults	966,988
Other Capacity Building/System Development	3,912,409
Administrative Cost	
TOTAL	$ 5,249,833

Note: There is no separate program under AMHD. Instead, CAMHD's OnTrack Hawai'i may cover older youth/younger adult up to 24 years old, which aligns with typical onset of psychosis

Table 6: MHBG Other Capacity Building/Systems Development Activities

Table 6a captures the state's projected 12-month budget for other capacity building/systems development activities. The following tables currently reflect two state fiscal years instead of SFY27 only.

Child and Adolescent Mental Health Division

Activity	MHBG
1.Information Systems	510,000
2.Infrastructure Support	220,000
3.Partnership, Community Outreach, and Needs Assessment	184,000
4. Planning Council Activities	10,000
5.Quality Assurance and Improvement	-
6.Research and Evaluation	584,000
7.Training and Education	481,726
TOTAL	1,991,726

Adult Mental Health Division

Activity	MHBG
1.Information Systems	$ 3,649,556
2.Infrastructure Support	-
3.Partnership, Community Outreach, and Needs Assessment	-
4. Planning Council Activities	-
5.Quality Assurance and Improvement	-
6.Research and Evaluation	-
7.Training and Education	262,492-
TOTAL	3,912,048

Note:
For AMHD, 5 percent of its allocation will be set-aside for the peer specialist program (see training and education)