REPORT TO THE TWENTY-FIFTH LEGISLATURE
STATE OF HAWAII
2009

PURSUANT TO SECTION 334-10 (E), HAWAII REVISED STATUTES, REQUIRING THE STATE COUNCIL ON MENTAL HEALTH TO SUBMIT AN ANNUAL REPORT TO THE GOVERNOR AND THE LEGISLATURE ON IMPLEMENTATION OF THE STATE PLAN

STATE OF HAWAII
DEPARTMENT OF HEALTH
October 2008

HAWAII STATE COUNCIL ON MENTAL HEALTH
ANNUAL REPORT TO THE GOVERNOR AND LEGISLATURE

Legislative Session 2009

State and Federal Mandate

This annual report is in response to HRS 334-10 (e): "The council shall prepare and submit an annual report to the governor and the legislature on implementation of the statewide comprehensive integrated service plan. The report presented to the legislature shall be submitted at least twenty days prior to the convening of each regular session".

Under federal mandate (P.L.102-321, Sec. 1914, State Mental Health Planning Councils), the State Council on Mental Health (SCMH) is required to review plans and submit recommendations for modification, and monitor and review annually the allocation and adequacy of mental health services in the State. States are also required to review the annual AMHD/CAMHD Implementation Report of the State Plan.

SCMH Response to Review Implementation of the FY 2007 State Plan

In November 2007, the Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Division (CAMHD) solicited the SCMH's review of the Implementation Report for the results of the FY 2007 State Plan. The Council's comments (Appendix I) included accomplishments and challenges for both Divisions:

Adult Mental Health Division

Accomplishments

- Capacity to measure two additional Evidence-Based Practices: 1) Integrated Treatment for Co-Occurring Disorders (IDDT) and, 2) Illness management and Self-Directed Recovery (IMSR);
- Various programs to address the needs of forensic consumers; and,
- Increase in the number of persons receiving Supported Housing and New Generation Medications.

Challenges

- Re-admissions to Hawaii State Hospital: Continue to focus on decreasing re-admission through use of best practices in forensic services, such as the pre-booking and diversion programs.
- An expanding population of new persons being served coupled with a workforce shortage: Develop workforce capacity through ongoing training.
- Assurance of consumer satisfaction in the face of an expanding population.
- Implementation of the State Plan despite termination of federal court oversight.
- Decreased support from Legislature: Continue to use every opportunity to bill for services through the Medicaid Rehabilitation Option.

Child and Adolescent Mental Health Division

Accomplishments

- Support of suicide gatekeeper trainings across the State;
- Innovative project to develop a video series highlighting social and emotional challenges
- of pre-school age children;
- "Children's Mental Health Matters" public awareness activities; and,
- Specialized programs to provide outreach to homeless, transgender and rural youth.

Challenges

- Meet the needs of youth requiring Support for Emotional and Behavioral Development (SEBD) as they transition to adulthood.

SCMH Response to Review the FY 2009 State Plan (Federal Mandate)

In July 2008, the Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Division (CAMHD) solicited the SCMH's review and input on their respective State mental health plans. At that time, the SCMH provided advisory comments and recommendations for the AMHD and CAMHD State Mental Health plans. The SCMH's comments and recommendations are included, along with the Behavioral Health Administration's response to the State Council's comments below:

SCMH Recognized Highlights of the Plan

2009 State Plan actions that were positively recognized by the SCMH included:

1. State Comprehensive Integrated Service Plan
   Adult Mental Health Division (AMHD)
   - Services initiated at the Honolulu Police Department's Central Receiving Division (CRD);
   - Community-based Fitness Restoration Program (CBFR);
   - Conditional Release Tracking and Exit Support and Transition (CREST);
   - Mental Health Court;
   - Mental Health Calendars;
   - Supported Employment (rewarding consumers outcomes);
   - Inpatient Oversight;
   - Case Management Resource Guide;
   - Case Management and Support; Consumer Resource Fund (restructuring)

2. Children's State Mental Health Plan:
   Child and Adolescent Mental Health Division (CAMHD)
   - Juvenile Justice Mental Health – Juvenile Drug Court and Girl's Courts Programs;
   - Development of a new category of Eligibility, "Mental Health Only", for children not eligible through IDEA or Medicaid;
   - Use of Parent Partners statewide, to train, provide outreach to, and support families;
   - Implementation of Cross-system Training Initiatives;

- Development of a new tactic to work with youth, Transition to Adulthood at the community level.

3. Overall Comments:

The State would enhance communication with the State Council on Mental Health and community input through provision of plans and decisions on an ongoing basis, rather than a once per year review.

SCMH Indicated Concerns of the Plan

2009 State Plan issues and concerns indicated by the SCMH (bulleted and bold) included:

1. Adult Mental Health Division
   - **AMHD discontinuance of Assertive Community Treatments (ACT) services (summary): Monitoring ACT for fidelity rather than clinical outcomes; the lack of use of community development and integration for ACT resources in a defined community; and need for consideration of payment for performance rather than unit rate services were indicated as concerns with ACT (summary).**

     AMHD Response (summary):

     Difficulties in achieving fidelity (integrity of clinical practice) to ACT according to the Evidence-Based model were explained in the FY 2009 State Plan under the "New Developments" section and in an AMHD staff presentation to the SCMH. The literature supports that if ACT is performed in such a manner that it meets fidelity, as measured by the Dartmouth Assertive Community Treatment Scale), positive outcomes such as reduced hospitalization would be achieved. Two studies are representative of the reasons for AMHD action to discontinue ACT. The first study demonstrated greater reductions in alcohol and drug use, higher retention in treatment and fewer hospital admission among persons in high fidelity programs than low fidelity programs (Hawaii's fidelity scores largely did not meet the minimum threshold for fidelity over the course of two years, with the exception of one team). The second study was representative of the services that the AMHD will provide in place of ACT- the Strengths-Based model of Community Based Case Management. Results of this study indicated that the Strengths-Based model demonstrated significant advantage over ACT in producing reduction of clinical symptoms, fewer negative symptoms and greater life satisfaction scores, attributable to more emphasis placed on consumer abilities and strengths. The ACT model was designed to be an all-inclusive, self-contained treatment program. One of the reasons for its discontinuance as a bundled service was that providers were purchasing community resources that the ACT Team should have provided.

   - **Cross-walking the AMHD Array of Services with outcomes for each service and service utilization would have been helpful for the State to analyze prior to discontinuing ACT, and may still be helpful to maximize efficacious services to consumers, especially with the ongoing fiscal issues.**

     AMHD Response (summary):

     This is an area that the AMHD supports and is a key item on the agenda as a priority area for future action. However, there are concomitant issues in its implementation that

require significant resources, such as adoption of a psychiatric scale to measure symptomatology.

- **The State's discontinuance of ACT services and Community Based Case Management (CBCM) in the Waianae community required querying this community about what services were important to them. This is a community that requested their own Community Health Center. To discontinue this contract without seeking a community perspective (Homestead, Neighborhood Board, Queen Liliuokalani Children's Center, Ho'omau Ke Ola, Waianae Coast Comprehensive Health Center, Legal Aid, kupuna (elders), etc. undermines collaborative relations with the State in this community. The Council is concerned that community desires be respected. Mediation is strongly suggested.**
  SCMH Minority Opinion (1) is that it would be difficult to perform mediation within a program that was discontinued.
  AMHD Response:
  The AMHD takes the Council's comments under consideration for future action. However, the only service being discontinued in the Waianae community is ACT, which is being discontinued statewide. All other AMHD services continue to be available to consumers in the Waianae area from providers located in the Waianae community and staffed by employees who represent the Waianae community.

- **Preparation for CMHC CARF accreditation and Clubhouse accreditation has been ongoing for at least 3 years. Low staff ratios to consumers in the clubhouses have not been corrected. Private providers are allowed only one year to prepare and attain CARF accreditation. It is recommended that more Clubhouse staff be hired as required by the International Center for Clubhouse Development (ICCD) rules.**
  SCMH Minority Opinion (1) is that accreditation is only given for three years, and clubhouse staffing is a guideline of a 15:1 staff/client ratio, not a requirement.
  AMHD Response (summary):
  AMHD supports this recommendation, noting that several AMHD Clubhouses are not in compliance with recommended 15:1 ICCD consumer-to-staff ratios. This is a high priority in order that ICCD standards for clubhouses are met and maintained for ICCD certification. Overall, Clubhouse consumer-to-staff ratios have improved from 19:1 in FY 2006 to 18:1 in FY 2007.

- **The State created the AMHD Mental Health Operations Center (AOC) Infrastructure for quick response to both natural and man-made disasters. This was based on the National Incident Management System. It provides for role assignments and planning for critical incidents or potential loss of providers. The State appears to be using this mode of operation to bypass community and settle contract disputes. Furthermore, the location of the AOC is impractical for the services it is intended to provide for natural and man-made disasters.**
  SCMH Minority Opinion (1) is that having lived through Hurricane Iniki, it is much easier to have one main source of information and communication with centralized guidelines and training. In addition, there is the question of the

Council's comment on a subject (AOC) that was not mentioned in the Council meetings, negating accurate comment by the Council on this subject.
AMHD Response (summary):
The State routinely uses the NIMS approach to test its preparedness for disaster response through the use of "what if" disaster simulations. With the layoffs that have been occurring over the last year (Aloha Airlines, Molokai Ranch, and AMHD's reliance on contracted providers, it was recognized there was need to test its ability to continue services if there was loss of a major contractual provider. As an island state, the limited number of providers which are available demands contingency planning for their loss. Use of the NIMS drill also assisted staff to become more familiar with the NIMS protocol in the event of any disaster. The AMHD Operations Center (AOC) (for disasters) is a team of people, not a place, and includes persons from across the Division who are in contact within any space available. However, the AOC has never held a meeting in the Waianae area, and the establishment of the AOC was unrelated to Hale Na'au Pono.

2. Child and Adolescent Mental Health Division

- **The State Legislature reduced CAMHD's budget. Reductions in the biennium budget will be offset with Federal Medicaid reimbursements and CAMHD's functioning as a behavioral health plan. There are major areas that CAMHD has identified regarding statewide implementation: Transition to Adulthood services; Trauma and Violence; Prevention and Early Intervention between the ages of 3- 9 years; Juvenile Justice and Mental Health; Homeless and At-Risk Children and Youth. The Council will continue closely monitoring and advocating at the Legislature.**
  CAMHD Response (summary):
  In response to the economic downturn and the resultant fiscal constraints, CAMHD is continuing to pursue federal reimbursement and is implementing cost-cutting measures.

- **CAMHD implements Child and Adolescent Service System Program principles (CASSP) in its system of service delivery. This is not necessarily the foundation for service delivery in the Department of Education (DOE). If this were the case, there would be a decreased amount of requests for Fair Hearings. The Council requests that CAMHD staff, family advocates, and providers continue to reinforce CASSP with the DOE line staff.**
  CAMHD Response:
  CAMHD had adopted and fully implements the CASSP principles throughout its system of care. CAMHD has shared and promoted the CASSP principles with all CAMHD partners and collaterals.

- **The Mental Health Transformation State Incentive Grant (MHTSIG) along with AMHD and CAMHD has initiatives regarding medical records. The Dikel Report (DOE-funded), needs to be reviewed in the context of sharing mental health, substance abuse, and HIV information protected under HIPAA with the DOE. Policies and procedures need to be enacted between all Departments accessing**

medical records. Parents need to be told when they are giving up certain rights to confidentiality when information is released from the DOH to the DOE.
CAMHD Response (summary):
All sharing of information between departments is subject to the various federal and state rules and laws. In addition to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the US DHHS *Standards for Privacy of Individually Identifiable Health Information* (Privacy Rule) which CAMHD complies with, there are a number of federal privacy related laws that apply to schools. These include the Family Educational Rights and Privacy ACT (FERPA), Protection of Pupil Rights Amendment, and IDEA. Hawaii Revised Statutes Title 8, Chapter 34, also provides for the protection of educational rights and privacy of students and parents.

- **Both AMHD and CAMHD have implemented the ASIST training for suicide prevention which is another Evidence-Based Practice. The high rate of suicides in young Native Hawaiian males presents another cultural competency issue to address.**
  CAMHD Response (summary):
  The high rates of suicide ideation and attempts among Hawaiian youth and Native Hawaiian males were precisely the reasons why CAMHD began investing in suicide prevention three years ago. CAMHD began partnering with the Department of Health's Injury Prevention Program, recruiting representative from the Native Hawaiian community for the Suicide Prevention Steering Committee, tasked to develop a Five Year State Suicide Prevention Plan. Through the advocacy efforts of this Committee a Suicide Prevention Program was authorized by the Hawaii State Legislature two years ago.

3. Child and Adolescent Mental Health Division and Adult Mental Health Division

- **The Chief's Roundtable which was held on a monthly basis has been an avenue for consumers to connect with the Chief, which is empowering for consumers to know that they have been heard. Quarterly focus groups should not be in lieu of the Chief's Roundtable. Both the CAMHD and AMHD Chiefs would do well to hold monthly roundtable discussions with consumers and family members around the State. Family education and outreach services have been underutilized. Consideration should be given to broader community outreach and see it as an opportunity to inform the public about signs and symptoms of mental illness and substance abuse, how to support family members as caregivers, and support the consumers, etc.**
  SCMH Minority Opinion (1) is that the AMHD Acting Chief is doing double duty and maybe the Council should wait to see what our new Chief will do.
  AMHD Response (summary):
  The State Plan did not indicate that the AMHD intends to substitute focus groups for the Chief's Roundtable. Quarterly focus groups are planned in addition to the Chief's Roundtable to assure the consumer's voice is heard on an ongoing basis. In addition, when the AMHD makes significant changes to programs, such as changes with regard to Case Management and ACT, special informational meetings are held to inform

consumers. The Office of Consumer Affairs also intends to continue to provide outreach to consumers living in groups homes or at clubhouses and other facilities.
CAMHD Response (summary):
CAMHD has instituted measures to ensure family involvement in its system of care. CAMHD partners with the statewide family organization, Hawaii Families as Allies (HFAA), to ensure the involvement of the family voice in many aspects of its system of care. CAMHD also endeavors to keep stakeholders informed and involved by holding quarterly provider meetings, distributing quarterly newsletters, and inviting them to CAMHD trainings.

- **Both CAMHD and AMHD continue to expand its knowledge of Evidence-Based Practices. Culturally competent Evidence-Based services do not largely exist for Native Hawaiians and Asian/Pacific Islander groups. Imported mainland practices may not serve these groups and indigenous, local and/or community beliefs and practices need to be considered in outreach and service delivery**.
  CAMHD Response (summary):
  CAMHD's three imported major Evidence-Based Practices, Multi-Systemic Therapy (MST), Multi-Dimensional Treatment Foster Care (MTFC) and Functional Family Therapy (FFT) were established with infrastructure to assure fidelity to the model AND responsiveness to local issues. A Clinical Psychologist assigned to work with providers, consultants and trainers in implementation of NTFC AND FFT to assist clinicians to adapt the models to fit both CAMHD needs and local culture. Multi-year data from MST indicates it is successful with Hawaii families. A new training series teaching contracted providers to utilize Evidence-Based Practice elements in their work with CAMHD youth, may choose from an array of techniques designed to be responsive to individualized needs while still utilizing "what works" to address the mental health problem.
  AMHD Response (summary):
  In recognition of this need, the Mental Health Transformation Grant Workgroup #4 has proposed a collaborative including Native Hawaiians, Asians and Pacific Islanders whose charge will include determination of culturally appropriate practices with the capacity to become a reimbursable Evidence-Based Practice. Through the COSIG grant, the Behavioral Health Divisions have been working with Hawaiian and Pacific Islander community leaders to recommend culturally-informed practices for consumers with a co-occurring mentally ill substance abuse disorder (MISA) which are incorporated in the multi-year COSIG Strategic Plan. Also, a pilot project on Maui is being developed to provide more bi-lingual, multicultural services in the context of Community-Based Case Management services.

- **Trauma-informed system of care: AMHD is using and training on the Seeking Safety curriculum and CAMHD is using Dialectical Behavior Therapy (DBT). Both are Evidence-Based Practices. Policies and procedures need to be reviewed in the prevention of trauma and minimizing triggers. Besides seclusion and restraint these include admission and transfer and institutional requirements. Addressing historical issues of cultural trauma through culture-informed care is important.**

CAMHD Response (summary):
CAMHD is currently completing a four-year SAMHSA grant to develop alternatives to seclusion and restraint in hospital and residential programs. This has included the development of trauma-informed care with training for service providers, and consultation with four residential programs. CAMHD has also updated its Policies and Procedures to reflect trauma-informed care; is planning ongoing training; is expanding seclusion and restraint adoption with additional partners; and is incorporating the trauma-informed approach into CAMHD's foundation training for care coordinators.
AMHD Response (summary):
AMHD's plan, which was initiated in the spring 2008 and will be ongoing throughout 2009, is to review standards for a trauma-informed mental health system; conduct an assessment of needs and gaps; develop a plan to address gaps and implement the changes necessary to transform the system to one that is trauma-informed and trauma-sensitive. Policies and Procedures, admission, transfer and discharge are just a few of the items that will be addressed in the overall trauma initiative.

Federal Mental Health Planning Directions

In May 2008, a SCMH representative to the annual Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), National Community Mental Health Block Grant Planning Conference reported to the Council membership the following federally recommended areas for consideration in planning:

- Expand efforts to develop a positive context in which veterans are encouraged to seek help. The stigma of seeking help for mental illness is especially relevant for returning veterans. Currently, Post-traumatic Stress Disorder (PTSD) is uncommonly high among this population and it affects family members.
- Hire consumers to help other consumers through development of new programs or by expanding presently operating programs.
- Develop micro-enterprises or consumer-run businesses.
- Further the development of consumers taking charge of their illness through inclusionary decision-making and programs such as Illness Management and Self-Directed Recovery (IMSR).
- Develop programs to address the needs of the teen to adult gap group (Young Adults in Transition).
- Address needs of the severe and persistent mentally ill elderly, including physical illnesses such as diabetes, heart disease and suicide.

SCMH: Areas of Recommended Need by County/Island

County Mental Health and Substance Abuse Service Area Board (SAB) Member Representatives who are also SCMH members reported on the FY 2008 needs of their respective service/island areas:

Hawaii County:

- Additional office space is needed for the Ka'u Clinic which is in poor condition; van transportation for consumers is needed since the present van is not in working order; and state cars cannot pass safety inspections due to their state of dilapidation.

- Jobs for Certified Peer Specialists.
- Sufficient health/mental health personnel to meet island's needs

Kauai County
- Consumer transportation, especially in rural areas.
- AMHD service: Licensed Crisis Residential Services.
- Legal documents for consumers including both physical and mental advanced directives, wills, power of attorney and safe storage of such documents.

Lanai Island
- Permanent full time psychiatrist.
- Formal employment program for consumers.
- Transportation services for consumers.

Maui County
- Psychologist (vacant due to low salary).
- Sufficient personnel to serve aging Maui geriatric population with mental illness.
- Appropriately longer hospital stays at Maui Memorial Hospital's Molokini ward (mental illness) to prevent untimely crisis readmission.
- Timely assessment of mentally ill persons.
- Address child suicides.
- Assure adequate supervision of providers and provide state oversight of providers.
- ACT Program needs competent, responsible staff.

Molokai Island
- Child psychiatrist to prevent suicides and handle crises.
- Adult psychiatrist.
- Clubhouse (work–ordered day).
- Services for youth where few or none exist.
- Certified Peer Specialist jobs.

Oahu (City and County of Honolulu)
- Crisis beds.
- Enable consumers to retain housing.
- Information regarding use of Consumer Based Intervention Services, and Consumer Resource Funds.
- Promote the Certified Peer Specialist Program through development and by publicizing job opportunities and through provision of support to Peer Specialists.

These needs were identified as prevailing over two or more Service Areas:
- hiring of psychiatrists;
- prevention of suicides;
- crisis services, especially crisis beds,
- consumer transportation; and,
- provision of jobs and support for AMHD's Certified Peer Specialists.

SCMH Major Area of Focus and Concern

A major area of concern in FY 2008 as reflected in the SCMH minutes relative to implementation of the State Plan included the following:

AMHD Certified Peer Specialists

SCMH discussion of the three-year old Certified Peer Specialist Program elicited a number of questions and issues. These included:

- Receive ongoing information of all the Certified Peer Specialist training sessions in order that SCMH members may publicize the training to constituents and stakeholders.
- Ensure Peer Specialists living in rural areas have access to employment.
- Determine the reasons for which providers are not hiring Peer Specialists.
- Become informed of the sources of funding for Peer Specialists.
- Become informed as to how employment for Peer Specialists is supported by the AMHD.

Areas suggested by the SCMH membership for consideration in relation to the Certified Peer Specialist Program included:

- Inclusion of referrals from the Division of Vocational Rehabilitation
- Linkage of the Peer Specialist program with Supported Employment through the AMHD's Statewide Service Director for Psychosocial Rehabilitation
- Development of "permanent" civil service status for these positions.
- Development of a policy from top management stating that this is a needed service and how it should be implemented at each level of management.
- Assignment of number of peer specialist positions to islands, not only counties; and
- Consideration for solving the conflicts of interest issue of working for and receiving services by the same provider, especially in rural areas.

SCMH Goals

During the past six months, the SCMH has been working on goals that the membership will consider for future action. These goals are:

1. Educate Administration about the importance of addiction challenges being part of the SCMH agenda reports.
2. Ensure there is timely access to an array of services on each island that is consumer-driven, community-focused, evidence-based, culturally relevant, and island connected.
3. Advocate for culturally competent services that allow for provision of Hawaiian perspectives on healing.
4. Ensure providers are held accountable for delivering contracted services.
5. Maintain interagency focus on ensuring the health, self-determination and well-being of all individuals (including youth) and their families through promoting early proactive intervention and recovery-based supports in the community.
6. Support comprehensive services for youth still requiring care upon aging out of the CAMHD system.
7. Advocate for more types of transitional housing with sufficient supports.

Attachments