REPORT TO THE TWENTY-FIFTH LEGISLATURE
STATE OF HAWAII

Legislative Session 2010

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 2009

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

Legislative Session 2010

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 the State Plan for Mental Health (Statewide Comprehensive Integrated Service Plan) and submit comment and recommendations for modification, and, monitor, review, and evaluate annually the allocation and adequacy of mental health services in the State. Planning Councils are also required to review the annual Adult Mental Health Division (AMHD) and Child and Adolescent Mental Health Division (CAMHD) Implementation Report of the State Plan including results of national and state performance indicators.

SCMH Response to Review the FY 2010 State Plan (Federal Mandate)

From March through August, 2009, the AMHD and the CAMHD provided sections of the FY2010 State Plan for the SCMH's review and input. On August 19, 2009 the SCMH provided its written comments and recommendations for the AMHD and CAMHD State Mental Health plans. The SCMH's comments and recommendations are summarized below.

Adult Mental Health Division

1. Peer Specialist Program: Ensure the development of a plan that includes long and short term goals with target dates; the number of peer specialists trained, certified and who are employed per island location/Community Mental Health Center (CMHC); clarity regarding the requirements for passing the oral and written tests; and strategies for ensuring the hiring of peer specialist at each location/CMHC.

2. County Breakdown of Consumers Served, Types of Services Received and Satisfaction with Services: Written county reports will assist the State Council in identifying needs and assist in making recommendations regarding resource allocations.

3. Lack of Employment Relative to the Economy. Provide more consumers with opportunities in education and in micro-enterprises.

4. Serve Persons Who Are Deaf and Hard of Hearing: Develop a plan for provision of mental health services for persons who are Deaf and hard of hearing through the guidance of a task force including representation from the Office of Health Equity, inclusive of the Behavioral Health Administration.

Child and Adolescent Mental Health Division:

1. Identify Core Functions: The CAMHD plan highlights an array of evidence-based programs but there is no connection with whether these services are replicated or not in the Department of Education's provision of School Based Behavioral Health services (SBBH). The cost of these programs with the numbers served is not identified. CAMHD should list their core priority functions, which will also identify priority in funding.

2. Shortage of Child Psychiatrists: Consider hiring advance practice registered nurses with prescriptive authority and support the nursing program at the University of Hawaii at Manoa.

3. Reallocate Funding for Public Awareness Activities and Technology: Consider stimulus funding for technology, which is presently being provided through block grant funding. Public awareness activities to reach youth should include social networking, which would reach larger numbers of youth at minimal cost.

4. Provide Data Indicators with Matrices or Graphs as in Previous Years: Provide data indicators comparisons as in previous years. If not presently tracked, please consider completion of high school as an important youth mental health indicator.

5. County Service Data is not provided nor is Data Provided by School Districts and Complexes: Track services provided in each county/school district/complex and ensure that the count of statewide services does not include those youth flown from neighboring islands to Oahu to receive services. If certain evidence-based services are unavailable in communities/school complexes/districts**,** the available partnerships or accommodations to meet the needs of youth should be a part of CAMHD's plan. Please identify costs of these services/programs with the numbers served in each of the counties/school districts/complexes.

6. Cultural Competence Issues are Often Health Equity Issues:
   a. Suicide in Native Hawaiian males is cited in the plan. Consultation with Dr. Kawika Liu in DOH, Office of Health Equity is suggested.

   b. A plan for serving children, adolescents and adults who are Deaf and hard of hearing is missing. Deaf and hard of hearing persons have unique needs in the mental health system. Professionals in the system, as well as providers, need to be trained in the intricacies of Deaf culture and the nuances of American Sign Language (ASL) for accessibility of Deaf and hard of hearing individuals to mental health. Provision of adequate services to this population requires staff development and training. A task force would be an appropriate start to improve services to Deaf and hard of hearing persons. Please include someone from the Office of Health Equity on this Task Force.

7. Department Of Health Resources, Particularly Those Listed Under the Maternal and Child Health Branch (MCHB) May No Longer Be Available: Due to budget cuts, early intervention programs no longer serve the environmentally at-risk. It is not clear which programs are funded for early intervention of mental health issues in child welfare. The Council requests that the Evidence Based Services Committee review the practice elements for infant and early childhood mental health with recommendations to the State Council. The State Council should receive a written report including the program's outcome data.

Adult Mental Health Division and Child and Adolescent Mental Health Division:

1. Criteria for Admission: Review all issues of criteria change with Departmental standards for health equity. The Council is concerned about the lack of available vocational rehabilitation services for those who are privately insured and the discontinuation of the "mental health only" category for CAMHD.

2. Core Mental Health Functions Across the Lifespan: Please consider block grant funding as a package that supports core mental health functions across the lifespan where other funding streams are not available and have been limited. This would require a unified planning process between both CAMHD and AMHD. In the past, block grant funding has been used as a means of innovation and not necessarily to support core functions. State budget shortfalls demand funding of core functions that can still be innovative in approach.

SCMH Response to Review Implementation of the FY 2008 State Plan

In November 2009, the Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Division (CAMHD) solicited the SCMH's review of the Implementation Report of the FY 2008 State Plans. Their response included comments on the accomplishments and challenges for the Transformation Grant and both Divisions which follow:

Mental Health Transformation State Incentive Grant (MHT-SIG)

1. The Uluakupu Awards for pilot programs provide an opportunity to learn through culture and should be emphasized in the provision of accessible services to culturally diverse groups. Less emphasis should be placed on public education (See Implementation Report for FY 2009 for description of Uluakupu Awards).

2. ACCESS Line is expanding to include four Behavioral Health Administration Divisions plus the Department of Education and the Office of Aging. It will also ensure physical and mental health screening and improvement of accessibility to services.

    a. Consider separation of the Suicide and Crisis Line from less urgent calls with separate staff coverage.
    b. Promote Text Telephone (TTY) and Telecommunications Relay Services (TRS) among agencies that use ACCESS Line.
    c. Consider ACCESS Line credentialing from the National Council for Quality Assurance (NCQA).

3. Development of the Statewide Consumer, Family and Youth Alliance is recognized. This group should participate in Transition from Youth/Adult programming in the community.

4. The Council strongly supports the establishment of a research collaborative within the Adult Mental Health Division.

Child and Adolescent Mental Health Division

1. The Council appreciates outreach to homeless and transgender youth, but is concerned these services are not available on the Neighbor Islands and that the number of RFP bidders for provision of these services is low. CAMHD may consider partnering with Department of

Education (DOE) School Based Behavioral Health Services (SBBH), DOE's Homeless Services, and County and State Homeless Programs.

2. Transition to Adulthood initiatives should include partnering with the Transformation Grant's (MHT-SIG) Consumer, Family and Youth Alliance for the development of a sustainable infrastructure.

3. Community-based approaches with the understanding and implementation of Child and Adolescent Service System Program (CASSP) principles is important in CAMHD's plan and includes early mental health screening, assessment and referral to services. Many of the children from 3-9 years of age are known to the Department of Education. The importance of timely referral cannot be stressed enough. The System of Care (namely CAMHD) assumes the burden of costlier services in more restrictive settings. Although the DOE provides School Based Behavioral Health services; in some school settings and complexes there is *impression management.* The Council recommends that there be system and child/family outcomes. The Council also recommends that CAMHD work very closely with each complex in implementation of CASSP, as the leader of Children's Mental Health Services in this state.

4. In reducing stigma and barriers to services, CAMHD has done an exemplary job in developing various partnerships with Hawaii Youth Helping Youth (HYHY), Hawaii Families as Allies (HFAA) and Honolulu Theater for Youth. To preserve these worthwhile endeavors the Council recommends that the use of the arts be expanded including application of initiatives to the juvenile justice population and with community reintegration.

Adult Mental Health Division

1. The Council lauds AMHD for its Pre-booking and Post-booking Jail Diversion Programs, Fitness Restoration, Conditional Release and Exit Support (CREST) Programs, plus the ongoing work to decrease the census at Hawaii State Hospital; to monitor conditional release consumers; and to track outcomes. The Community-Based Forensic Services Program is vital in assuring a path for recovery for a group of consumers that is highly stigmatized and about which the community has safety concerns.

2. The Council has concerns about Community-Based Case Management (CBCM) Services with the ending of Assertive Community Treatment (ACT), the lowering of qualifications for case managers and an ongoing staff training and education program. More information is needed as to the impact for both private and public providers, and the clients served in the areas mentioned. Since all Certified Peer Specialists will meet the minimum qualification of a high school diploma, some question remains as to whether Certified Peer Specialists will be used in lieu of case managers, or become case managers. The effectiveness of Community-Based Case Management has not been evaluated. Although there is a pilot program on Kauai for a Strengths-based CBCM model there is no control group comparison. Neither is it clear whether the Community-Based Case Management Program as described in this report is different from the Strengths-based CBCM that is occurring on Kauai.

3. The Targeted Capacity Expansion Grant is also a needed and important endeavor that provides training for older adult caregivers on mental health and depression in the older adult. The Council also requests that these grant activities be closely linked with the Consumer, Family member and Youth (C/F/Y) Alliance that is a part of Mental Health Transformation. Elder consumers often lack voice and should be represented as well as their family members.

CMHS, SAMHSA Mental Health Block Grant Monitoring Visit:

During their periodic monitoring visit to states, Community Mental Health Block Grant monitors attended the February 10, 2009 State Council on Mental Health meeting. After the meeting, the monitors met with the SCMH Chair and other members. Members shared their concerns about communication, especially concerning the Neighbor Islands. Monitors shared that this is not unusual and that while other states are not island entities, some have wide distances to cover which are problematic. A report from CMHS is forthcoming.

Conversion of SCMH Face-to-Face Meetings on Oahu to Multiple Inter-island Video Teleconferencing Sites.

Based on a directive from the Director of Health, the Adult Mental Health Division commenced holding the monthly SCMH meetings through Video Tele-Conferencing (VTC/VCC) in November 2008. Cost savings of transporting five Neighbor Island members to Oahu for each meeting were approximately $10,000 per year. Seven VTC venues are normally scheduled each month at state sites on Oahu (Kapolei and the Queen's Conference Center), Lanai Community Hospital through Hawaii Health Systems Corporation, Maui, Molokai, Hilo, and Kauai. Bridging Services are provided by the Department of Accounting and General Services (DAGS), Information and Communications Services Division (ICSD).

Council members were provided with informational sessions on the transition to VTC/VCC meetings and provided with informational reminder cards to cope with the technological changes. In addition to no-cost meetings, VTC/VCC benefits include the availability of attendance at SCMH meetings to other Neighbor Islands residents; and decreased time spent in travel. Challenges include gaining access to VTC/VCC venues, particularly in Hilo, the technology, and involvement of many persons in arranging and canceling of meetings if there is a lack of quorum.

SCMH: Areas of Recommended Need by County/Island

County Mental Health and Substance Abuse Service Area Board (SAB) Member Representatives[1] who are also SCMH members reported on the FY 2008 needs of their respective service/island areas: Throughout FY 2009, these needs included the following:

Hawai`i County

- Lack of Psychiatrists on the Big Island (at present in East Hawaii).
- West Hawaii Crisis Center beds (Crisis Center closed)
- More rapid response to ACCESS Line calls.
- Peer Coaches paid on a timely basis.

Kaua`i County

- Maintenance of Community Mental Health Center (CMHC) Crisis "Walk In Services."
- Decrease suicides; 12 have occurred on Kauai in 2009.
- Peer Specialist positions (loss if not filled).
- Residential Substance Abuse Treatment Facility.
- Provision of Integrated Dual Diagnosis Treatment (Substance abuse provider ended services).
- Advanced Directives.
- Mental health staffing /contact in public housing.

[1] Lana`i and Moloka`i representatives are included in the Maui Service Area Board and on the State Council on Mental Health.

Lana`i Island

- Psychiatric services

Maui County

- Health insurance ad assessment services for critically ill consumers.
- Access to behavioral health insurance from both private and public providers. (Consumers are unclear as to where to go for their health plans).
- Homeless shelter for persons with mental illness and substance abuse.

Moloka`i Island

- Medicaid benefits of children who have been incarcerated.
- Programs, services and resources for transitional age youth (to prevent easy access to drugs resulting in substance abuse and homelessness).
- Sufficient vocational rehabilitation services for transitional youth (waiting list exists for admission to state vocational rehabilitation services)
- Alternative housing for transitional youth.

O`ahu (City and County of Honolulu)[2]

- Lower caseloads at Windward CMHC.
- Concerns regarding Clubhouse budgets; continuing member tenure, and private insurance of members.
- Integration of homeless social service programs with supported housing

These needs were identified as prevailing over two or more Service Areas:

- Psychiatrists;
- Prevention of suicides;
- Crisis services, especially crisis beds,
- Consumer transportation;
- Provision of jobs and support for AMHD's Certified Peer Specialists in rural area;
- Assistance for consumer transition to new health plans; and,
- Continuance of Clubhouse Rehabilitation programs at CMHCs.

SCMH Motions Passed by the Council Membership: FY 2009

MOTION	SCMH Meeting Date
1. Council non-support of the elimination of the ACT program due to lack of information and the speed of the decision; and that the Council copy the Governor on these concerns and request that the Department of Health provide additional information.	July 8, 2008
2. Oahu Service Area Board letter of support, of action taken by the State Council in relation to ACT, to the Director of Health and the Governor.	August 12, 2008
3. Council Letter of comment and recommendations of the FY2009 State Plan to the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA) approved.	August 12, 2008

[2] Minutes, Oahu Service Area Board on Mental Health and Substance Abuse, 2-23-09.

MOTION	SCMH Meeting Date
4. Peer Specialist application materials to be sent to SCMH members by email.	August 12, 2008
5. Approved SCMH Report to the Governor and Legislature with SCMH revisions/additions.	October 14, 2008
6. Place SCMH member Island Reports back on the SCMH agenda for oral, rather than written presentations.	December 9, 2008

SCMH Education

Continuing education, a major component of SCMH meetings, assures the ability of the Council to make informed decisions. With many persons entering the Council membership with limited knowledge of AMHD services, system perspective, and administrative procedures, ongoing training and education is a necessity. During the last year, administrative procedures, particularly those in relation to Council functioning were highlighted. Included were:

- Roles and Functions of the SCMH Pertaining to Federal Public Law 102-321; Hawaii Revised Statutes (334-10); Hawaii Administrative Rules, (175-11) – *Office of the Attorney General.*
- Written response from the Office of the Attorney General to thirteen questions posed by the SCMH on roles and the law – *Office of the Attorney General.*
- Management of Council Meetings according to Role and Functions and the Sunshine Law – *Dee Dee Letts, Specialty Courts Coordinator, State Of Hawaii, Family Drug Court.*
- State Plan Overview of the AMHD and CAMHD Mental Health systems and description of services provided – *Staff.*
- AMHD/CAMHD Performance Indicators – *Staff.*
- New Quest Expanded Access (QExA) Medicaid managed care program for seniors and persons with disabilities – *Lisa Wilson, APS.*
- "Elluminate" Web-Based Conferencing System – *Staff.*
- Video Teleconferencing Protocol: System Capacity and Council Adjustments – *Staff.*
- AMHD/CAMHD billable services – *Staff.*
- AMHD's Hawai'i Certified Peer Specialist (HCPS) Program – *Staff, Office of Consumer Affairs Peer Specialist Coordinator.*
- Community Care Services (Managed by APS Healthcare) – *Carol Dixon.*
- University of Hawai'i, School of Social Work – *Supporting A Sustainable System of Care: Master's Project Students.*
- Medicaid Health Plans and interface with AMHD – *Lydia Hemmings.*
- Report on Consumer Surveys for Reporting National Performance Indicators: Annual Quality of Life Interview (QOLI) and Mental Health Statistic Improvement Program (MHSIP) Health and Well-Being Consumer Survey (national) – *Philippe Gross, Ph.D., Mental Health Services, Research, Evaluation and Training (MHSRET).*

APPENDIX

A. Adult Mental Health FY2008 Performance Outcomes

B. Child and Adolescent FY2008 Performance Outcomes

PERFORMANCE OUTCOMES
ADULT MENTAL HEALTH DIVISION

The tables below delineate the National and State Performance Outcome measures for Fiscal Years 2006 through 2008. The percentages obtained are based on targets that are affected by fluctuations in the overall numbers of the sample sizes obtained from the Adult Mental Health population.

MEASURE	**PERFORMANCE OUTCOMES ACHIEVED**			
	FY2006	FY2007	FY2008	% Obtained for FY2008*
Increased Access to Services	11,217	14,576	16,170	115.50%
Reduced Utilization of Psychiatric Beds (180dys)	13.97%	12.92%	12.35%	113.40%
Increase Independent Living	61.60%	68.20%	72.90%	115.71%
Increase Client Perception of Care	70.53%	69.59%	75.80%	106.76%
Adults with Schizophrenia Receiving Atypical Medications	6.53%	4%	35%	126.70%
Decreased Criminal Justice Involvement	10.74%	10.24%	5.58%	179.21%
Increased Stability in Housing (Homeless)	5.83%	12.78%	9.03%	200.27%

*Percent obtained is based on 100%.

MEASURE	**PERFORMANCE OUTCOMES NOT ACHIEVED**			
	FY2006	FY2007	FY2008	% Obtained for FY2008*
Adults with SMI Receiving Supported Housing	7.62%	5.82%	4.58%	.47%
Reduced Utilization of Psychiatric Beds (30dys)	1.61%	3.75%	1.99%	75.4%
Increase/Retained Employment	23.37%	22.54%	18.88%	79.33%
Participation in Recovery Treatment Planning	78.80%	74.40%	76.30%	96.22%

MEASURE	**PERFORMANCE OUTCOMES – New Baseline**			
	FY2006	FY2007	FY2008	% Obtained for FY2008**
Increased Social Supports/Social Connectedness	n/a	n/a	69.43%	
Improved Level of Functioning	n/a	n/a	76.04%	
Housing Stability (Evictions)	n/a	n/a	1.52%	

**New targets set.

PERFORMANCE OUTCOMES NOT IMPLEMENTED

MEASURE	PERFORMANCE OUTCOMES			
	FY2006	FY2007	FY2008	% Obtained for FY2008
Adults with SMI Receiving Family Psychoeducation	n/a	n/a	n/a	n/a
Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders	n/a	n/a	n/a	n/a
Adults with SMI Receiving Illness Self-Management	n/a	n/a	n/a	n/a

Due to Budgetary constraints, the above Evidence-Based Practices were not monitored for fidelity to ensure implementation and therefore data was not collected.

PERFORMANCE OUTCOMES
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

FEDERAL PERFORMANCE INDICATORS	PERFORMANCE OUTCOMES ACHIEVED			
	FY2006	FY2007	FY2008	% Obtained for FY2008
Increased Access to Services	2,094	2,603	2,778	106%
Reduced Utilization of Psychiatric Inpatient Beds (30 days)	4%	10%	12%	136%
Reduced Utilization of Psychiatric Inpatient Beds (180 days)	11%	9%	7%	214%
Youth receiving Therapeutic Foster Care	191	268	267	134%
Youth receiving Multi-Systemic Therapy	287	333	307	154%
Youth receiving Functional Family Therapy	n/a	16	84	112%
Client Perception of Care	64%	59%	53%	82%
Return to/Stay In School ✰	n/a	30%	36%	n/a
Decreased Juvenile Justice Involvement ✰	n/a	42%	30%	n/a
Increased Stability in Housing ✰	n/a	.3%	.3%	n/a
Increased Social Supports/Social Connectedness ✰	n/a	84%	83%	n/a
Improved Level of Functioning ✰*	66%	66%	54%	n/a

✰ New National Outcome Measures. Benchmarks to be established.
* In 2008, CAMHD began using the Youth Services Survey for Families to assess Level of Functioning. Previously CAMHD measured client outcomes with CAFAS or ASEBA assessments.

STATE PERFORMANCE INDICATORS	PERFORMANCE OUTCOMES ACHIEVED			
	FY2006	FY2007	FY2008	% Obtained for FY2008
Number of homeless children and families contacts	563	432	487	97%
Percentage of youth with SED who are served in-state	99.4%	99.4%	99.6%	104%
Number of contact hours of CAMHD staff and providers trained in the application of evidence-based practices	369	234	228	114%