NOTE: MEETING MINUTES ARE IN DRAFT FORMAT AND HAVE NOT BEEN APPROVED BY MEMBERS OF THE STATE COUNCIL ON MENTAL HEALTH, AS SUCH, INFORMATION IN THE MINUTES HAS NOT BEEN APPROVED FOR CONTENT AND ACCURACY.

STATE COUNCIL ON MENTAL HEALTH (SCMH)
Behavioral Health Administration
Department of Health, State of Hawaii

Virtual Meeting via Zoom
August 29, 2021
6:00 p.m. – 9:00 p.m.

Members Present: **Aumer, Katherine; Beninato, Antonino; Crozier, Charleen "Naomi"; Jackson, Richard "Rick"; Knightsbridge, Christopher; Lau-James, Eileen; Martinez, Beatrice "Kau'i"; Merriam, Kathleen; Ries, Richard; Rivera, Renee**

Members Absent: **Koyanagi, Dina; Pascual-Kestner, Rusnell "Rus"; Reed, Tara**

Members Excused: **Fujii, John; Ilyavi, Heidi; Renfro, Jennifer**

Guests Present: **Char, Tara**

DOH Staff Present: **Curtis, Amy; Haitsuka, Stacy**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/ CONCLUSIONS	PERSON(S) RESPONSIBLE	DATE DUE
I. Call to Order	Chair R. Ries called the meeting to order at 6:00 p.m. The following definition of quorum was added to the agenda as of the November 10, 2020 meeting: Pursuant to Act 137-18 (SB 203), Chapter 92, Hawaii Revised Statutes: "(f) A quorum for purposes of doing business shall consist of a majority of the members serving on the council immediately before a meeting begins. (g) if a quorum is present when a vote is taken, the affirmative vote of a majority of members present shall constitute a valid act of the council unless this chapter, part I of chapter 92, the articles of incorporation, or the bylaws require a greater number of affirmative votes. For example, if only 16 of the entitled 21 members are appointed, at least 9 must be present to establish a quorum. To validate a council action, of the 9 members	For information only.		

	present, an affirmative vote from at least 5 is required." Quorum was established at 6:00 p.m.			
II. Meeting Announcements	R. Ries shared the following announcements: • This meeting is being recorded and is open to the public. • The purpose of today's Executive Council meeting is to (a) discuss Hawaii's Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Block Grant (MHBG) application for Federal Fiscal Year 2022 to 2023 and (b) finalize the Council's letter of support for the MHBG application. • He acknowledged and thanked each Council member for their time this evening. He recognized that it was an unusual time to schedule a Council meeting as this is a time usually reserved for personal and 'ohana time. • The only items the Council will take action on are items specifically related to the purpose of this meeting. Any discussion outside of the meeting will be tabled to a future meeting. He kindly asked all attendees to assist by keeping discussions and comments focused on the SAMHSA MHBG application and contents of the Council's letter of support.	For information only.		
III. Community Input	Pursuant to section 92-3, Hawaii Revised Statutes, community members will have three (3) minutes to speak during this time. • None received.			
IV. Question and Answer Session About Content in the Hawaii SAMHSA Community Mental Health Block Grant Application	R. Ries explained in the past, the Council had the AMHD Planner attend Council meetings to provide an overview and any clarification. The AMHD Planner coordinates the submission of the MHBG application. R. Ries acknowledged there were challenges with coordinating the application this year. In the absence of the AMHD Planner, Dr. Amy Curtis, Adult Mental Health Division (AMHD) Administrator, was present to assist the Council with reviewing the MHBG application. To comply with Sunshine Law and Office of Information Practice guidelines, Council members received a copy of the meeting handout which includes the			

	Statewide Comprehensive Integrated Service Plan (SCISP). Since providing the revised draft application very late in the evening, Wednesday, August 25th, there have been significant updates to various sections of the application. In preparation for this meeting, Council members were asked to (1) review the application and (2) join the meeting with their comments noted by section/page. To assist with discussion and question and answers, R. Ries will facilitate a structured review process by using pages two and three of the handout as section guides. Dr. Curtis confirmed that usually there are Division Planners and Epidemiologists who help to write the application content; however, due to the COVID-19 pandemic and resulting staffing changes, both AMHD and Child and Adolescent Mental Health Division (CAMHD) have Planner vacancies. She explained the AMHD lost approximately 60 staff, many who were key staff. Subsequently, AMHD was only able to hire just one. Part of the challenge was a one year freeze on hiring new state employees and the legislature cutting positions and budgets for departments. She is an epidemiologist and was assigned to work on COVID-19 pandemic response activities. Right now, both AMHD Planner positions are in the process for being posted for internal vacancy announcements to hire. Additionally, the error with the application type/selection created a lot of confusion because staff are new and did not know why they were seeing the tables or questions they were seeing. These parts are related to substance abuse funding and were mistakenly included in the application. She further noted that the next two days have been dedicated to completing the application and many changes have already been made since Wednesday. She has many staff who are new to working on the application spending a significant amount of time to help contribute content. She assured the Council that input will be taken seriously and there is time over the next two days to include the			

	Council's feedback. R. Ries expressed the Council's existence is in part to ensure there is transparency in government and that there are checks and balances to help build trust between government and the community; to ensure there are no sneaky types of things going on behind the scenes. C. Knightsbridge recognized the DOH has had to be on the defense in terms of COVID-19 pandemic response and Dr. Curtis sharing of ways that the AMHD has continued to push forward, including applying for additional grant funding is great. It definitely looks like a staffing issue. It is her first year going through the block grant cycle and she apologized for the untimely finalization of the application and she expects to be held accountable next year if the same delay occurs again for the next application. The Council's concern is that the MHBG application is due to SAMHSA before September 1, 2021, but the Council has only received a very rough draft at this point. The AMHD policy and procedure 60.520, state and county service plans states that the Council should have received the final draft of the state plan and this application by August 1, 2021. The Council realizes there are staffing issues; however, there are several portions of this MHBG application that were left blank. Those portions could have perhaps been completed months earlier because the information is based on prior years such as the fiscal expenditures, which is something that Michelle Gleason, SAMHSA Project Officer and Hassan Sabre, SAMHSA Program Monitor emphasized at the July 27, 2021 Executive Council meeting with regards to this Council being included in the development of the state plan and not seen as a simple pass through channel. The Council takes it role seriously and looks forward to future partnerships and inclusion with the state planning efforts mentioned in the application. R. Ries noted that he looks forward to the Council partnering with the DOH, AMHD and CAMHD with the current and future application.			

	K. Aumer asked Dr. Curtis about the source documents such as plans and assessments that are cited in the application. For example, the 2020-2023 Hawaii Substance Abuse Block Grant (SABG) application and the Hawaii suicide prevention plan. It would be nice for the Council to see these documents. Dr. Curtis explained that some plans are policies and procedures and others may be related to direct care services via the Community Mental Health Centers or are posted in other places external to the AMHD. She explained she believes in a person-centered approach and that consumers don't care where they are getting the service but care that they are able to get services when they need it. Regarding assessments, Dr. Curtis stated that the AMHD did adopt the use of the Columbia Suicide Severity Rating Scale (C-SSRS) and the AMHD is evaluating the implementation and data for C-SSRS across AMHD's service array. R. Ries asked Council members to please pull up the handout. The structured review will start on page 22-52, Planning Steps, Step 1. R. Ries asked Council members to please have comments ready when we get to the section you're wanting to ask for clarification or feedback about. That would greatly help us with time. Thank you in advance for your help. <u>PLANNING STEPS (pages 22-52)</u> The purpose of Step 1 is to assess the strengths and organization capacity. In other words, in what ways is Hawaii's mental health system doing a good job and what are the organizational parts that support efforts to serve the mental health population. This section is about 1/3 of the entire application. There are many areas that AMHD and CAMHD list as part of their service array. • On page 23, up at the very top, there is a small typo in the title – the word strengths is spelled wrong. This was a typo that was included in the previous application and unfortunately has carried forward. Hopefully this can be corrected.			

	• On page 24, compared to the application data from two years ago, the AMHD has served slightly more service recipients. Dr. Curtis noted that this is true and she cautioned that it does make a difference in how the data is collected and from what services. • What is interesting is the shift in number of service recipients in each age range starting with the 45-64 range. In fiscal year 2018, AMHD served 3,092 service recipients who were 45-64 years of age and in fiscal year 2020, AMHD served 3,568. There was also a notable increase in the number of service recipients served who were 75+ years of age from 162 service recipients in fiscal year 2018 to 261 service recipients in fiscal 2020. It was also interesting that there are 39 service recipients for whom age was not available. It is important to look into this issue of not having ages for 39 people as their demographics should be included as part of intake. Possibly these individuals entered into the system through crisis services. Dr. Curtis noted that AMHD is transitioning to a cloud based electronic health record and part of the data issues are being addressed with this. • Several grammatical and formatting issues with "," and ";" as well as ":" were noted throughout the MHBG application. A thorough read and edit would be very helpful to fix these miscellaneous errors. • On pages 25 through the top of page 36, the AMHD array of services with a description of each service is written out. • Then on page 36, that's where CAMHD begins its introduction. Their eligibility criteria and service array is listed from pages 37 through the top of page 44. • CAMHD briefly acknowledges their contractual relationships and continuity of care expectations before discussing the strengths of the children's system of mental health care which continues thru page 52 which is the end of the Step 1 section. • This is where the Council is wanting additional clarification from AMHD because it appears that this section is incomplete for AMHD's assessment of its strengths. We know, because this was shared on page 24, that the AMHD served 7,762 service recipients in fiscal year 2020.			

	• The Council hopes to learn more about the strengths of the adult mental health system of care. It is unclear from this draft application if AMHD has adequately assessed the strengths of the adult system of mental health care and whether the AMHD organizational capacity has been transparently explained. • For example, what are other examples of activities the AMHD has partaken to strengthen services and build organizational capacity? • For example, Dr. Curtis has come to a few Council meetings and mentioned several activities that the AMHD is working on related to grant funding as well as mentioning about the transition to Hawaii CARES, perhaps not as a strength in terms of program outcomes at the moment, but the expansion of Hawaii CARES was a step towards integrating mental health and substance abuse for a single service entry portal concept. • Dr. Curtis has previously shared with the Council about AMHD's strategic plan and the four priority areas that AMHD staff were working on. It's unclear if AMHD has acknowledged these activities sufficiently in the application with regards to: ○ Using technology to provide in-home treatment and to expand options for virtual participation such as with Clubhouse psychosocial programming and use of the community mental health center telehealth kiosks. ○ Coordinating primary and behavioral health services in a holistic person-centered care setting. ○ Using evidence-based practices and data-driven decision making (one of Dr. Curtis's passion areas). She has shared her knowledge through the recent overdose data to action (OD2A) project. ○ Addressing co-occurring needs beyond judiciary and justice involved service recipients but those who may be dually served such as those who are developmentally disabled or who participate in other ADAD programs, DVR programs, and receive DD/ID services who also have an SMI diagnosis and need linkage to services. ○ Interfacing with the Council is a strength-based approach to community mental health system design and planning.			

	Dr. Curtis stated she will put these into the application. She stated that the AMHD is working to strengthen the crisis service array. She stated AMHD is working on its metrics to see how consumers are progressing through the system and whether they are able to maintain their community tenure (e.g., hospital readmission rates and length of community tenure prior to re-hospitalization as well as what kept them out of the hospital – what worked well for them). Regarding assessing organizational capacity, • Not about only the AMHD and CAMHD internal staff support, but also about agency partners and providers, all of the "hands" that help to build and implement and navigate the community mental health service system. Would it be appropriate to acknowledge in this section the organizational capacity of Hawaii's mental health system of care? • Dr. Curtis shared her excitement during previous Council meetings about expanding the Hawaii Certified Peer Specialist (HCPS) program to include training for forensic peer specialists. We have a Council member who is waiting for this forensic peer training. It seems that this application falls short with regards to acknowledging the HCPS program expansion plans and emphasizing how AMHD is utilizing peer specialists as part of its organization capacity and service support teams. • There are likely examples of ways that the AMHD is addressing gender neutrality and providing culturally competent services. Specifics for how AMHD has gone about being inclusive and how AMHD serves transgender individuals is not found in the application. Would be great if AMHD could include a statement about how it has been inclusive with this population. Starting on page 53 through page 72, in contrast to Step 1, Step 2 involves the identification of unmet needs and critical service gaps, also referred to as leading edges. • On page 54, the physician effort only totals 2,812 FTE but the next line states the national demand model indicates a need of 3,529 FTE demonstrating a shortage of 710 FTE for physician services. This number is			

	wrong. It should be 717 FTE. • Also, on page 54, 55 and 58, fix the semicolons and periods for consistency. • When Dr. Curtis came to the May 2021 Council meeting, we noted the following system gaps: ○ More training around imminent risk and dangerousness is needed as well as increasing community education and education to police officers, other first responders, Mental Health Emergency Workers (MHEW), social workers and community health providers. ○ We noted the constraints for acquiring therapy in an acute inpatient setting and how emergency department staff need options for triaging patients who are seeking help for mental health and co-occurring services that are not offered in the emergency department if not considered serious harm to self or others or not considered imminent risk. A leading edge for the Council is for hospital emergency departments to offer psychotherapy services versus offering medication and wait time as well as to address individuals who are not actively trying to kill themselves but who are seeking mental health services so they do not need to lie about their suicide and suicidal ideation status in order to ring alarm bells for risk of danger to self. ○ We also noted the huge disconnect between SAMSHA funding inpatient behavioral health therapy compared to outpatient behavioral health therapy. Dr. Curtis clarified funds can be used for intensive outpatient hospitalization and day treatment services but not to fund inpatient behavioral health therapy. ○ Lastly, we expressed concern for workforce incentives that would help mental health professionals to not only be trained in Hawaii, but to also stay, live and continue to work in Hawaii post-training and licensure. For example, the application includes mention about			

	the OnTrack program but the staff noted in the application is no longer here in Hawaii. Dr. Curtis mentioned that AMHD was looking to build relationships with colleges and develop pathways for students to have hands on experience. She noted that Clubhouses and the community health centers are being consulted. She is also looking into conversations with UH JABSOM as well as partnerships with Windward Community College for paraprofessional training and certification. R. Ries encouraged Dr. Curtis that this oral information be included in the application. ○ On page 57, minor grammar revision for the part that speaks to houseless youth. Need to revise "living in cars and on beaches" and remove the second "annually" from the sentence. Add a comma after the first "annually." ○ On page 57, Regarding the point-in-time (PIT) count, in 2020 there was a count done but there was none in 2021. Suggestion is to clarify no PIT count was done in 2021. Remove the second "Oahu" and remove the second "are" in that section. Change "and thus are called Neighbor Islands." Need to clarify how the 6,458 fits with the 4,448 count, possibly showing just Oahu numbers. Change the sentence about veterans to "our veterans." ○ On page 58, add the years for the first bullet point, 2019-2020. Last word "violent" should be capitalized as well. ○ On page 59, in the family and peer-to-peer support paragraph, remove "of" in that sentence. ○ On page 63, at the bottom, strengthening practitioner education, remove the capital "I" in "is" and add the number of years for the Data to Wisdom grant as well as add the Overdose to Data grant. ○ On page 65, the Hawaii AMHD – add "Division" ○ On page 66, the word "dialogue" is misspelled. There's reference to the UH Counseling office but it should be referenced as the UH Counseling and Student Development Center. Fix typo in the word			

	"helping" on the third line from the bottom. ○ On page 67, state he "is the clinical psychologist who had been" involved because he no longer is. Clarify the dates for the fiscal year activities to "it did transition" as past tense. There's a lot of reference to 2020-2021 and appears someone lifted a lot of the previous application so be careful to not send this application with the wrong dates/timeframes. Double check if OnTrack has completed the transition and if so, the wording should be past tense here as well. We would like Council feedback to be considered as part of this application and be included where appropriate, especially where we are in agreement around these topics that are identified in the community as gaps, perhaps not AMHD or CAMHD funded, but as community mental health gaps. These could be areas where the AMHD, as the state mental health authority could look at addressing. For example, fetal alcohol spectrum disorder and mental health issues related to CAMHD and youth as well as for mothers who face stigma about their alcohol use before knowing they were pregnant. <u>PLANNING TABLES (pages 73 – 94)</u> There are several planning tables included in this year's application; however, we will skip over the substance abuse specific tables because those belong to a different grant and will be addressed by the Alcohol and Drug Abuse Division (ADAD) at a later time. Table 1 starts on page 73 to page 76 and includes annual performance indicators that speak to the strategies for attaining goals related to various priority areas. This table has changed significantly from the table in our handout. S. Haitsuka shared revised tables and revised sections on the Zoom screen. It may be difficult to see due to the very small font size. There are six annual performance indicators for state fiscal year 2022 to 2023: • Priority Area #1 focuses on community based services with the target			

	outcome of increasing access to mental health services. This priority area aligns with the Council's Strategic Plan Focus Area #1 with regards to existing and new services. Increasing the number of service recipients served by the AMHD by 5% seems reasonable. There's typo in "ethnicity" in the first indicator. • Priority Area #2 focuses on community tenure with the target outcome of decreasing the percentage of Hawaii State Hospital (HSH) readmissions by 5%. This decrease is applicable to the first six months of hospital discharge. In other words, the goal is to help patients maintain community tenure for at least six month post-hospital discharge and hopefully remain stable in the community a lot longer than six months. • Priority Area #3 focuses on crisis stabilization with the target outcome of decreasing crisis services by 5%. We know that crisis services are offered to the general population regardless of eligibility for AMHD and CAMHD services so the rate of crisis service utilization could also be influenced by economic factors and other community issues such as those we are experiencing now with COVID-19 such as job loss, factors related to being isolated, and limited resources for coping and support. Dr. Curtis shared information about Palekana Leahi and the program design where there are multiple activities built into the program that help the consumer to stabilize and to find coping skills that they can use beyond the program. She emphasized that her thinking is about expanding crisis services rather than decreasing services by 5% so this performance indicator will likely change to reflect a more positive position on how crisis services are utilized especially when looking to divert individuals to stabilization bed units and increasing stabilization bed units for consumers to access on their home island. • Priority Area #4 focuses on peer specialists and forensic specialists with the target outcome of increasing the number of Hawaii Certified Peer Specialists by 5%. Right now, the baseline measurement states that there are 40 Hawaii Certified Peer Specialists so doing simple math, the AMHD is			

	looking to certify an additional two peer specialists in 2022 and two more in 2023. It appears that this is exceptionally low reaching. Is there any consideration to increase this target outcome say by doubling that number for each of the two years so that the goal is to certify an additional four peer specialists in each year? Dr. Curtis confirmed that AMHD should easily be able to increase this percentage because four total seems really low. R. Ries suggested four each year. N. Crozier just completed co-facilitating the recent AMHD Hawaii Peer Specialist Training and six consumers graduated from the training. Dr. Curtis noted there is a forensic peer training coming up in the fall. • Priority Area #5 focuses on access to mental health treatment and support to houseless children and their families. There is a small typo in the priority area but hopefully that can get fixed. There's an "s" missing on the word families. The target outcomes for increasing services by 2% in 2022 and 4% in 2023 is again a very small number when we are looking at a statewide performance indicator. First, this is confusing because the population for this priority area is SED but the description of the priority area seems to redirect to houseless children and their families. There needs to be clarification on the population or revise the population because as written, this performance indicator does not align with the SED population. In regard to the SED population, H. Ilyavi, as a Council member and in her professional role as a parent advocate, has made it very clear that there is a lack of timely access to services and supports for the SED population especially on Hawaii Island. Although Hawaii doesn't want to overpromise on its performance indicators, it's important to address what needs to be address with reasonable target/outcome measures. Regarding the performance indicator as written, is it very low reaching to say the state is working to increase services by two or four houseless children and their families. This			

	is really, really low! Dr. Curtis is encouraged to assist the AMHD and CAMHD to do better with planning around these services. • Lastly, Priority Area #6 focuses on evidence-based practices for children with early serious mental illness (ESMI) with the target outcome of increasing first episode psychosis services by 5% and 10% respectively each of the next two years. Dr. Curtis stated that it was a requirement to have a 10% set aside. There is a plan to increase the age slowly and expand coverage through CAMHD's OnTrack system. Council members had the following feedback on this section: • R. Jackson mentioned that it may be good to emphasize how AMHD has address recidivism. He is advocating for general mental health. • E. Lau-James asked about metrics and whether there are plans to have the metrics available to the public. Dr. Curtis stated plans are being made to provide metrics. For example, the Hawaii Behavioral Health Dashboard is being shared with the public. It doesn't include performance measures yet but that's a good suggestion. • K. Aumer asked whether there is a mutual electronic health record that can be shared and seen by other DOH BHA Divisions. Dr. Curtis stated that there may be parts that are shared but through the Overdose to Action grant, the hope is that there will be clarity for how the systems can share information so data can be used to inform care and budget planning. Integrating data systems is a critical part of this process. • A. Beninato commented that he noticed mental health resources on the UH campus. He observed flyers up on campus and it was great to recognize the information was being shared with students. Moving on to Planning Table #2 on page 79 of our handout which delineates state agency planned expenditures for the next two years. This table has been slightly revised. • What was revised was column B. MHBG funds where there is a total of			

$960,416 allocated to addressing early serious mental illness (ESMI) including first episode psychosis.

- Also, $2,499,750 is allocated to what appears to be 24-hour care. Perhaps Dr. Curtis can share an example of what "Other 24-hour care" looks like as far as services so we know what this activity means and why it's being given $2.499 million in funding. Dr. Curtis stated an example of "Other 24-hour care" is the AMHD's 24-hour group home services.
- A total of $457,542 is allocated to ambulatory and community non-24 hour care. Again, perhaps Dr. Curtis can differentiate for us based on all of the services listed in the service array in Planning Step 1 in this application.
- Lastly $3,270,400 is earmarked for crisis services.
- In total, block grant funding in this application is $7,188,108. This is the amount that the Council is reviewing this evening.

Below is the revised draft table with updated numbers shared via Zoom screen.

	Abuse Block Grant	Health Block Grant	(Federal, State, and Local)	Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)		Funds (excluding local Medicaid)		Relief Funds (MHBG)[A]	Relief Funds (SABG)	(MHBG)[B]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[E]								$0.00		
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[G]		$570,000.00						$90,000.00		
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital					$92,134,019.00					$90,000.00
7. Other 24-Hour Care		$803,000.00			$22,400,000.00					$101,884.00
8. Ambulatory/Community Non-24 Hour Care		$452,536.00			$41,476,350.00			$155,634.00		
9. Administration (excluding program/provider level)[F] MHBG and SABG must be reported separately					$5,670,763.00					
10. Crisis Services (5 percent set-aside)[B]		$2,336,000.00			$4,560,000.00			$1,168,000.00		$817,600.00
11. Total	**$0.00**	**$4,161,536.00**	**$0.00**	**$0.00**	**$166,241,132.00**	**$0.00**	**$0.00**	**$1,413,634.00**	**$0.00**	**$1,009,484.00**

	Dr. Curtis noted that columns B, H and J are applicable to block grant funds. • Column B: Traditional MHBG funds. • Column H: "Trump COVID-19 pandemic response" MHBG funds. • Column J: "Biden COVID-19 pandemic response" MHBG funds; ARP is the acronym for the American Rescue Plan. From previous state plan reviews and MHBG applications, this Table 2 is incomplete. It does not show the full picture of how the state plans to use available MHBG funding from other sources such as Medicaid, other federal funds, and of course state general funds allocated from the legislature. Where is the rest of the money? When will that information be provided to the Council as part of this state plan? R. Ries explained the concern is that of transparency because as a Council, we are tasked with advising the Governor through the DOH about mental health services and it is very concerning that at this late hour in the application process the Council has not been provided with the full scope of funding that this table requires. The table should include all available funds. We should know how funds are being spent to provide the services that are indicated in Planning Step 1 of this application. Table 6 on page 94 outlines the non-direct services and administrative funding for mental health services. The Council was provided with a blank table. As of this evening, this table is still blank but it really should not be. The Council should see funding numbers here for various areas of system support. The Council has a direct stake in this table as the Council is listed as item #4. When will this table be updated with the budget information so that the Council may review it and offer comments? Dr. Curtis noted this table is being worked on and will include planned amounts to be spent. For the Council, Dr. Curtis states the usual allocation is $10,000 per year. There are also discussions about funding the Clubhouse and health centers to upgrade Wi-Fi to expand technology access. Training of peers and partnering			

with nursing education programs will also be included in this table. There is also a need to hire a statistician to assist with data reporting and analysis.

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems						
2. Infrastructure Support						
3. Partnerships, community outreach, and needs assessment						
4. Planning Council Activities (MHBG required, SABG optional)						
5. Quality Assurance and Improvement						
6. Research and Evaluation						
7. Training and Education						
8. Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Additionally, Dr. Curtis mentioned for Information Systems, there is a budget of $139,000 to pay for an epidemiologist. For Infrastructure Support, there is a budget of approximately $780 for PPE and $32,000 for Wi-Fi and tablets. For Partnerships, Community Outreach and Needs Assessment, there is a budget of $50,000 for locum tenens and $56,000 for cellblock nursing services. For Quality Assurance and Improvement, there is a budget of zero for right now. For Research and Evaluation, there is a budget for $55,000 for a research statistician for federal reporting. For Training and Education, there is a budget of $260 for training of peer specialists when it is long distance.

R. Ries noted it is way better to have this table filled out rather than have it shared orally without time to really review and see the numbers to think about the funding and offer advice.

At this time, it makes for a challenging decision for the Council to write a letter of support for this state plan and application as there are many important and critical parts missing for review and for the Council to take under consideration.

	Council members shared the following comments: • K. Aumer expressed concerns for sustainability. For example, ARP MHBG funds are short-term and not meant to continue to be available. Therefore, services being funded by this ARP MHBG funding need to be sustained over time. What is the plan for sustaining these ARP funded programs? • Dr. Curtis noted issues with the DHS MQD contractor for its Community Care Services (CCS) contract where it is required that providers use CellTrack and billing is based on entries that match CPT billing. • E. Lau-James noted the required 10% set aside for early serious mental illness and first episode psychosis. Most of the programs are focused on CAMHD services. Dr. Curtis noted that there is only one service which is now being run by CAMHD staff who are working with youth. The plan is to expand this program to ages 18-24 and then work with an adult coordinator to plan for adult services in this specific areas of care. We all agree that this program needs to expand to increase participation. <u>Environmental Factors Plan (starting on page 95)</u> There have been updates to various parts in this last section. S. Haitsuka will share updates on the Zoom screen as she is able to. Section 1 on pages 95 through 98 asks about the health care system, parity and integration. This section appears to have the same narrative content as the previous application. • Required responses to questions 1 and 2, were blank but have since been updated. • Generally speaking, we hope to see broader integration that is representative of Neighbor Islands and rural communities. • For example, it is highlighted in the updated response to question 1 that the AMHD continues to implement the Living Well Hawaii project which began as a pilot project in 2013 in partnership with the health department, West Honolulu Mental Health Treatment Services Section, Primary Care Association of Hawaii and Kalihi-Palama Health Center and was designed to demonstrate integration of physical and mental health care using a			

	patient-centered medical home model. There was an opportunity to expand to the Central Leeward Treatment Service Section in Pearl City but beyond these Oahu locations, again, the Council serves to advocate for parity where mental health service recipients may access care and services similarly from any location where services are provided, and not have to wish they could or hope one day they will. We want the mental health system to do better across the board to ensure equity as well as equality for all who need services, when they need it, and where they need it. Additionally, for consideration, this question is answered heavily by the AMHD adult perspective and does not include how the child mental health system integrates with primary health care. We are sure that youth integrated services are provided; but we're not seeing it acknowledged here in this response. Dr. Curtis commented that she would like to work more with the Federally Qualified Health Centers (FQHCs) statewide because a significant amount of AMHD consumers receive services from FQHCs. Regarding question 2, this question has now been answered but again it seems like the response lacks full transparency but more from the angle of giving credit to parts of the system that are helping to address integrated systems of care. • For example, it's disappointing to see limited acknowledgements for the entities and agency partners who help to address crisis and requests for MH-1 determinations whether that be the various county police departments or the designated MHEWs coordinated through the Queen's Health Systems. • Additionally, it seems like this would be a good place to also elaborate on the multiple Palekana stabilization bed locations that were mentioned to us at previous Council meetings. • Perhaps even take a step to narrate the process by which someone enters the AMHD and CAMHD systems of care. This question was not only for the adult system but it makes no mention about youth the adult transitions or			

	how youth and their families are provided with integrated care. Questions 3 through 8 all are yes affirmative responses with question 4 confirming that the Department of Human Services (DHS) MedQUEST Division (MQD) is responsible for monitoring access to mental health and substance use disorder services offered through QUEST health plans. Moving down to question 9, it's interesting that the mental health and substance abuse parity work group identified 11 elements. These are all issues that I think other states can relate to and perhaps other states have been able to overcome. • As a Council and as the Council representative for mental health service providers, R. Ries can attest that many, if not all of these 11 elements have been brought to this Council's attention as well. • The Mental Health Parity and Addiction Equity Act of 2008 essentially required insurers to offer coverage for mental health and substance use disorders that are comparable to general medical coverage including treatment limitations and requirements for mental health and substance use disorders must not be more restrictive than the same requirements or benefits offered for other medical care. J. Fujii mentioned this topic during our meeting with M. Gleason and H. Sabre and we received a report handout from him for our last meeting on August 10, 2021 that summarized the 2018 Medicaid mental health parity and addiction equity act. For a future meeting when we invite Dr. Curtis back to present an update, we'd appreciate sharing more about the work of this parity group to help us to know what the group's recommendations were for action steps to address these 11 elements, what progress has been made and in what ways the Council could be helpful with future progress. The Council is in a position to be a conduit for updating the legislature and the Governor on this 2019 Senate Concurrent Resolution and other areas of the state mental health system. We don't know the SCR number referenced in question 2, but if you could please provide that information to Stacy, she in turn can share the legislative document with us as a future meeting handout.	Provide SCR number for distribution of bill to the Council.	A. Curtis/ S. Haitsuka	9/28/21

	Question 10 asks the state to highlight any activities related to this section; however, no highlights are provided in this section. We encourage the state to take the opportunity to be transparent about its efforts both in progress and planned for the future with regards to efforts to parity and integration. In this transparency, we are referring to the information shared orally during tonight's meeting being included in the written MHBG application. If it is not written there, and only orally shared, it should not count towards MHBG application information. As a general rule of thumb, so as not to appear shady or secretive or appearing to hide information, it's best to have the draft application available in a fuller and more complete status. This would greatly help the Council to do its part to review the application and be posed to submit a letter of support. Perhaps as a suggestion for future applications, these questions could maybe be delegated out to the community at large and specifically delegated to mental health stakeholders who may have input that can be included in a response to this question. Moving on to Section 2 on pages 99 through 102 focuses on health disparities. • Looks like responses to this set of questions is the same as the last application with regards to tracking access and enrollment with demographic information. • Again, it may be worth considering elaborating within question seven which asks the state to highlight activities such as describing the data-driven plan to address and reduce disparities and how the state address linguistic and language barriers. For example, question six is answered as a yes for budgeting to identify and remediate disparities and it may be appropriate here in question seven to elaborate on what exactly is budgeted for this. Constructively, the transparency here could help with educating Council members as well as the SAMHSA funding authorities. • We know excellent work is being done but many times a simple yes/no answer to a closed question doesn't highlight efforts by our community			

	and within the state mental health authority and leadership. Moving on to Section 3 on pages 102 and 103 focuses on innovation in purchasing decisions. • Looks like the check boxes were marked the same as the last application with boxes b, f, and h checked off. • We recommend boxes a and c should also be checked off. • Additionally, have there been other purchasing strategies used such as when AMHD arranges for small non-cash incentives? SAMHSA does allow non-case incentives to be given to mental health service recipients for wrap around non-clinical support services that are tied to meeting program goals, meeting abstinence benchmarks and retaining participation throughout the duration of the program. • Dr. Curtis mentioned about incentives with one of the Palekana programs, possibly at the Leahi Hospital in Diamond Head on Oahu and also at the East Hawaii Palekana location on Hawaii Island. • Would these qualify for checking box c. use of financial and non-financial incentives for providers or consumers? • If there is a way to also highlight, possibly in question 3, the efforts to use an electronic health record system across CAMHD and AMHD, there was a proposed plan for a statewide community-based master services agreement under the BHA led by former deputy director Eddie Mersereau. While that larger contract has since been shelved, with contracts being issued as they previously were (standalone vs a master contract agreement), the AMHD and CAMHD continue to work on a smaller record management project with contractor BerryDunn. We are unsure if it's appropriate to check off box a. leadership support, including investment of human and financial resources. Moving on to Section 4 on pages 104 and 105 focuses on evidence based practices for early interventions to address early serious mental illness. • Primarily for the CAMHD to respond to this set of questions; It looks like from the update that they have sufficiently answered and described the evidence-based practices for intervention of early serious mental illness.			

	• Possibly for our Council members who are mental health service recipients, our youth and student advocate representative, and family members and parent of a child receiving services, perhaps these Council members and other Council members have feedback to offer regarding Section 4? • K. Aumer inquired about adding information about how the DOH and CAMHD are integrating with DOE services? This information may be provided in Section 20 (partner section). R. Ries suggests that this information be made more prominent. Moving on to Section 5 on page 106 which focuses on person centered planning. • It appears that these questions have updated responses that adequately answer the questions. • On page 105, it asks to list diagnostic categories and those are now listed. Moving on to Section 6 on pages 107 and 108 which focuses on program integrity. • This is another section that has been significantly revised with highlighted activities written out inclusive of AMHD and CAMHD initiatives that assure adherence to federal program requirements and to monitor the use of funds. • Perhaps in the future, the Council may hear from both CAMHD and AMHD regarding the outcome of their monitoring efforts such as auditing outcomes, fiscal and program monitoring, and business compliance and performance measurements. We are going to skip Section 7 on page 109 because this section on tribes does not apply to Hawaii at this time. We are also going to skip Section 8 on pages 110 through page 117 because this section is for another block grant specific to substance abuse which was inadvertently included in this block grant by mistake. Responses will be entered at a later time. Moving on to Section 9 on pages 118 to page 128 which focuses on statutory criterion for the mental health block grant.			

	This section is broken into 5 criterion subsections. • Page 118 has a typo in the word psychosocial. • The first criterion asks the state to describe current services and resources and to describe case management services that are offered. • The second criterion asks for the prevalence and incidence rates for adults with SMI and children with SED. There was a significant decrease in the statewide prevalence from the previous application which indicated 76,770 compared to page 122 which lists 44,000. The prevalence for children with SED decreased slightly from 12,300 to 11,726. An addendum for criterion 2 was added which provides additional data on Hawaii's prevalence as a state, by County and by race and ethnicity. Previously, SAMHSA's recommended estimated prevalence rate for SMI was 5.4 percent based on the federal register. Taking last application's 2017 adult population of 1,421,658 and multiplying by the 5.4 recommended estimated prevalence rate equals to an estimated 76,770. It appears for this application, the calculation was done differently by taking the 44,000 indicated by the NSDUH report and dividing it by the estimated 2020 population of 1,119,689 to come up with the new estimated prevalence of 3.7 percent. Dr. Curtis stated she will review and confirm the prevalence data was calculated correctly. She will also check with M. Gleason whether there is a need to keep using the 1999 data. The Council defers to the AMHD for confirmation and accuracy of determining prevalence. It just seems to be different in interpretation of how to identify prevalence compared with previous years and may not align with the guidance for criterion 2 which states, on page 122 of our handout, "In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the population of focus." If the number needs to be revised, then the AMHD can do that and the Council can review the changes when we receive the final application post-			

	submission. Dr. Curtis explained the large decrease in prevalence was due to using old data from 1999. She decided to use updated numbers provided by The National Survey on Drug Use and Health (acronym pronounced: Nuz-Duh) with data that does indicate 44,000 as Hawaii's annual average for 18 years and older. This is how the prevalence number shows a decrease. R. Ries suggested that there needs to be a better explanation maybe to say that Hawaii changed from using the 1999 reference to the more current survey data reference. R. Ries stated that the Council did not receive this information in our meeting handout and it is a lot of information which is great. Council members would have wanted to have this available much earlier as it is late this evening and we are needing to keep moving on with this review. • The third criterion asks for confirmation of the six areas of services which have all been checked as yes. • The fourth criterion asks about the state's services for rural populations, homeless populations and older adult populations. Part a looks to be the exact same as the previous application. Part b looks to have updated 2020 Point-in-Time homeless count data but does not appear to include any analysis or comparison to prior years and whether targeted service for the homeless population are making a positive difference and in what measurable ways. It looks like there are some formatting issues with response to b. in the 5th and 6th line but that can easily be fixed. The information for CAMHD and the trauma-trained social worker appear to the exact same as the previous application. Part c looks to be the exact same as the previous application as well. These sections have since been updated with PIT information but having to review it on the Zoom screen is visually challenging.			

- The fifth criterion asks about the state's management systems. It appears that all of what is written is the exact same as the previous application.

  The AMHD expenditures for fiscal year 2019 and fiscal year 2020 are not included in Criterion 5. The expenditure tables would show the total funding, inclusive of general funds, special funds and federal funds for each community mental health center, contracted services, court evaluation and the Hawaii State Hospital (HSH). This information is missing. Roughly, each of these years totaled $140 million dollars.

MENTAL HEALTH BLOCK GRANT ACTIVITIES/EXPENDITURES - Cycle 39

Activity	Block Grant Categories	Person Responsible/Program Expenses	Mental Health Block Grant	Obligated	Expended	Balance	MHBG Cycle 39 10/1/2019 - 9/30/2021
Other 24 Hour Care	24-Hour Group Home	Mental Health Kokua	$500,000.00			$500,000.00	Direct Services, to be encumbered
Ambulatory/Community Non-24 Hour Care	Day Treatment Program	Queen's	$250,000.00			$250,000.00	Outpatient Services, to be encumbered
Administrative/Leadership Cost	Training (Staff Development)	Staff Training	$90,000.00		$18,805.50	$71,194.50	
		TOTAL	$840,000.00	$0.00	$18,805.50	$821,194.50	
Table 6b: Non-Direct Service Activities	State Council on Mental Health	Council Activities	$20,000.00	$8,100.00		$11,900.00	Retreat $8,100
	Information Systems	Epidemiologist	$139,782.00		$36,791.07	$102,990.93	Salary, fringe, taxes, cell phone
	Infrastructure Support	PPE	$780.00		$777.60	$2.40	Postage for PPE
	Infrastructure Support	Chromebooks, Ipads	$32,000.00	$31,833.59		$166.41	
	Partnerships - Community	Locum Tenens Program	$50,000.00	$360.00	$48,240.00	$1,400.00	
		CRD Nursing Services	$56,000.00		$55,350.50	$649.50	
		Women's Prison Re-Entry Program	$0.00			$0.00	
	Quality Assurance		$0.00			$0.00	
	Research & Evaluation	Report statistician	$55,000.00	$19,000.00	$36,000.00	$0.00	
	Training & Education	HCPS	$261.30		$261.30	$0.00	
	TOTAL FOR NON-DIRECT ACTIVITIES		$353,823.30	$59,293.59	$177,420.47	$117,109.24	
	AMHD ALLOCATION GRAND TOTAL		$1,976,102.00				
	BALANCE		$782,278.70				
updated 6/26/20 - allocation							
updated 6/28/21 - obligations, expenditures							

  There is also another table that would tell us about the fiscal year 2022 and fiscal year 2023 planned expenditures for 24 hour care, ambulatory and non-24-hour care as well as administrative and non-direct care activities. Roughly, the two year planned expenditures totaled $1.87 million dollars.

  There is also no update on staffing and trainings which are indicated as part of criterion 5 for financial resources, staffing and training for mental

	health service providers. For example, staff have been approved for training on topics such as suicide prevention and quality management. We are skipping Section 10 on pages 129 through page 138 because this section was inadvertently included by mistake. Section 11 on page 139 focuses on the Continuous Quality Improvement (CQI) plan and the state's responses is no, because Hawaii does not currently have a CQI plan for federal fiscal year 2020 to 2021. R. Ries noted that the instructions in the narrative section note "stakeholder input" which the Council is a significant source. R. Ries asked Dr. Curtis and she agreed, that future state mental health authority initiatives could include the Council for stakeholder input. Sections 12 and 13 on pages 140 to 143 focuses on trauma and criminal and juvenile justice. • All questions have been answered yes. • Question 5 for both of these sections do not have any responses highlighting how Hawaii has addressed trauma or developing trauma-informed organizations. Again, the comment here is that we know Hawaii is making progress but without any narrative comments it is really hard to recognize any of the partnerships and work being done. • For example, the legislature has prioritized the passing of a bill related to trauma informed education. This is a bill that the Council testified on and that we included a copy of our testimony for in our section of this application. I'm sure there are other examples. • It would be great if this question 5 were delegated out to others who could possibly share input and help with highlighting the great work that is being done in the area of trauma. We are skipping over Section 14 on pages 144 and 145 because that section is for the substance abuse block grant. Section 15 on pages 146 to 147 focuses on crisis services. • Applicable crisis services are checked off and highlighted examples of crisis			

	services are included in the response to question 4. • It may be good to also include work done to expand the Mental Health Emergency Worker (MHEW) contract to include other neighbor islands to highlight how MHEWs have helped with crisis response. Section 16 on pages 148 to 149 focuses on recovery. • The revised response to this section is on the Zoom screen. It is very hard to read all of this in this way. • All of the responses are yes. • Details about how Hawaii applies the concept of recovery to adults with SMI and children with SED is explained. • It appears that there is only recovery information for adults with SMI. The response to question 3 about children with SED is missing. • For question 4, to be consistent, it's probably a good idea to change dual diagnosis to co-occurring. • Additionally, it may be worth adding to the response how information obtained at intake is used to develop the treatment plan or the mental health service recipients master recovery plan, also perhaps noting how treatment is ordered by the court or through other referral streams. Section 17 on pages 150 which focuses on community living the implementation of Olmstead. • Hawaii does have an Olmstead plan. In terms of background, the Olmstead decision came in 1999 from the Supreme Court which basically affirmed that the unjustified segregation of individuals who live with a disability is a form of unlawful discrimination under the Americans with Disabilities Act. This meant that states had to address segregation based on a person being disabled and states needed to protect these individuals from discrimination on the basis of disability in the services, programs and activities that are provided by state and local government agencies. It was really and is still one of the most important civil rights decisions made by the court in favor of people with disabilities. • All questions are answered with a yes here.			

	We are skipping over Section 18 on page 151 through 154 because they do not apply to use for our review. Section 19 on page 154 focuses on suicide prevention. • This section has been updated with most current available suicide rates and state suicide plan information available from the Hawaii State Department of Health, Emergency Medical Services and Injury Prevention System Branch (EMSIPSB) as well as planning information from the Prevent Suicide Hawaii Task Force. • K. Merriam may have additional suicide related data not only in her role as the DOH representative to the Council but also in her role as co-Chair of the American Foundation for Suicide Prevention (AFSP) Hawaii Chapter. K. Merriam concurred that information shared in the draft application is sufficient and thanked the group for inclusion of AFSP and suicide statistics, specifically reducing suicide by 25% by 2025. Section 20 on page 155 focuses on support from State partners. • It appears this section has been updated with information about ways the CAMHD and AMHD have partnered with other entities to meet the needs of individuals with SMI or children and youth with SED and behavioral health needs. • What may be particularly helpful in preparing future application content for this section is for question 2 to be delegated out to various partners indicated at the top of this section in the narrative question examples. Asking for input from, for example, community hospitals, Hawaii Public Housing Authority (HPHA) which Council member K. Martinez is an employee and Council representative for as well as the Child Welfare Services (CWS) section where Council member D. Koyanagi is an employee and Council representative for and others who are not members but who have a stake in this question. It could be helpful to have their input here as there are always opportunities and a need to develop new partnerships and to renew existing partnerships by expanding them to other areas where help to serve individual with mental health needs is identified.			

	The State Council Section 21 on pages 156-164. • We previewed these pages as a working handout at our August 10, 2021 Council meeting and provided S. Haitsuka with our input and direction for completing the narrative responses. • Pages 156-164 offer our information and it can be updated with any feedback members have for edits and additions. Section 22 on page 165 focuses on the public comment opportunities for this state plan and application. • This section has been updated and it's obvious there is no time for the public posting and comment period of this application but hopefully the final application can be posted on the AMHD website and the State Council's website for review and post-submission public comments. Section 23 on pages 166-169 are not applicable so we will skip over it. This is the end of the application review. R. Ries thanked Dr. Curtis for attending this evening's meeting and for all the additional feedback to help finalize the Council's letter of support.			
V. Finalize Draft of the State Council Letter of Support for the Hawaii SAMHSA Community Mental Health Block Grant Application	R. Ries asked Council members to comment on the status of the letter with the current incomplete application that was presented to the Council. He expressed concerns about the Council's accountability and responsibility to review the application but also to recognize that it may not be the right place to share concerns about timeliness with the completion of the application. On the one hand, it's important to share what the Council's experience is but on the other hand, it is important to be professional and share concerns appropriately where it is best communicated. He asked Council members to share some of the strengths that we see in the application. In other words, what are areas of the application content where we feel Hawaii's mental health system is strongly prepared for or is currently doing a good job with providing or arranging for mental health services?			

	He also asked Council members to identify what are areas where we agree are in need of being addressed? In other words, what do we see as unmet needs? What do we see as critical service gaps? He noted that perhaps these are already included in the application; perhaps they were left out of the application and we want to bring attention to these needs. As a Council we are tasked to consider service gaps and needs and to take into consideration issues that affect more than one service area or more than one County. We would want to mention these strengths and areas of unmet needs in our support letter. R. Ries asked Council members to share how they feel about articulating our concerns about timeliness of this application and lack of completeness of the draft application that was received. • R. Ries noted that it's clear the timeline in the AMHD policy and procedure for state and county plans was not followed and there are areas of the application that we should have been able to review because the information is for past fiscal years 2019 and 2020. We are responsible for reviewing this information as part of our advisory capacity. Dr. Curtis brought up good points about why there was a delay; however, it is also clear that the deadline is not flexible per Dr. Curtis and funding is at risk if information is not provided in the application. She provided a lot of information verbally this evening which is great but it is not included in the application so it will not be shared where it needs to be shared. R. Ries asked if our letter should also include a mention about this area of concern and that we were not fully able to review the application due to lack of timely completion and budget information for past projected expenditures not being provided to us. • C. Knightsbridge noted that the Council can make a healthy compromise where our voice is still heard on both our support of funding for Hawaii's mental health system and our concerns about the timeliness and composition issues with the application.			

	• R. Ries noted he is not super comfortable with rushing in haste of fatigue from tonight's application review. He has reservations about submitting a letter of support where the Council has not actually seen the contents of the finalized application. E. Lau-James made a motion to vote on (1) writing a letter of support without contingencies for the mental health block grant and (2) separately write a letter to DOH Deputy Director M. Tsuji stating our concerns about the application being untimely for proper review. C. Knightsbridge seconded the motion.	Motion passed unanimously.		
VI. Wrap Up/ Next Steps	R. Ries expressed his deepest appreciation to all Council members for being present and participating tonight. Reviewing this application was as thorough a job as we could do and he believes the Council met its obligation with respect to our responsibility for reviewing the SCISP state plan and the MHBG application. Last time the application was reviewed, the Council formed a PIG which was responsible for reviewing the entire application. On one hand, the application they reviewed was complete and they did not have to toggle between a rough draft and updated information. On the other hand, feedback from some members was that they were not members of the PIG and they had equal responsibility to review the state plan as all Council members should share in doing so. This year, we are fortunate to have the majority of our Council membership seats filled and this time to review the application may be the first and only time Council members formally participate. In this view, R. Ries commented that the Council is on the right track as far as performing its roles and responsibilities as noted in our Bylaws. We made the commitment to do the best job we can as an advisory council to the governor through the DOH. R. Ries invited Council members to share any final thoughts about this process and any positive feedback on the meeting. • R. Jackson stated R. Ries did an outstanding job with the structured application review and thanked everyone for their participation.	For information only.		

	• K. Aumer thanked R. Ries and everyone for the thorough discussion. • E. Lau-James thanked everyone for attending and participating.			
VII. Closing Announcements	Council members shared the following announcements: • None. The next Council meeting is scheduled for Tuesday, September 14, 2021 from 9:00 a.m. to 12:00 p.m.	For information only.		
IX. Adjournment	The meeting was adjourned at 9:25 p.m.	For information only.		
Electronic Mail Outs	The following handouts were e-mailed to SCMH members and individuals on the SCMH e-mail distribution list: E-mail (1 of 1) with handouts (total of 2 handouts) 1. August 2021 Executive Meeting – Agenda 2. Hawaii SAMHSA Community Mental Health Block Grant Application (Draft 8/26/21, 12:40am)	For information only.		