STATE COUNCIL ON MENTAL HEALTH (SCMH) MEETING

November 15, 2022

9:00 a.m. – 12:00 p.m.

APPROVED MINUTES

Members Present:	Katherine Aumer, John Betlach, Jon Fujii, Heidi Ilyavi, Jackie Jackson, Eileen Lau-James, Kathleen Merriam, Ray Rice, Mary Pat Waterhouse, Kristin Will, Marian Tsuji (ex-officio)
Members Absent:	
Members Excused:	Antonino Beninato, Naomi Crozier, Lea Dias, Chris Knightsbridge, Richard Ries, Kau`i Seguancia
Guests Present:	Ellen Carson, Cindi Dang, Andrea Kimura, Izeah Garcia, Connie Mitchell, Maile Murray, Melissa Ring, Sunshine Kuhia Smith, Tami Swonigan, and Darah Wallstein
AMHD and CAMHD Staff Present:	Jocelyn Nazareno, Carolyn Weygan-Hildebrand, Scott Shimabukuro, and Valerie Yin

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS
I. Call to Order	Katherine Aumer, 1st. Vice-Chairperson, called the meeting to order at 9:03 a.m. Eileen James-Lau call the roll and quorum was established with eight members out of 14 current ones. K. Aumer requested to be excused at 11:00 a.m. and announced that Kathleen Merriam, 2nd Vice Chairperson, will take over the meeting.	For information only
II. Meeting Announcements	Katherine Aumer welcomed members and guests. Announcements covered: *Membership* • There are three official resignations and four appointments. K. Aumer led in thanking Jennifer Renfro, Jeff Galon Jr. and Tara Reed for their service. She recognized that all three were active as members. She also thanked Governor Ige and his staff for acting on four interim appointments. The first of the recent appointments is Heidi Ilyavi who is continuing on. The three new ones are John Betlach, Jean Okuda, and Kristin Will. All three new ones will be full-fledged members as soon as they sign and submit their respective oath of office documents.	For Information only

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	K. Aumer welcomed the two new members in attendance and requested them to introduce themselves and say a few words: • J. Betlach will be the representative for the Hawaii Service Area Board. He says that it is an honor to be part of helping out. He shared that he is a professional in mental health care and also had family members and friends who have had challenges. He said further, "And I just care about our community. And I'm just really stoked to be able to work with a bunch of folks that also care. And I'm just really looking forward to working with everyone." • K. Will takes over J. Galon Jr. as representative of the criminal justice sector. She said, "I'm the temporary specialty court administrator but my real position is the mental health court coordinator. I'm in charge of and I supervise the mental health unit. We are in charge of people on conditional release and we supervise a mental health part. I'm just here to learn more about what you guys do." • K. Aumer asked what staff found on whether ex-officio is counted for quorum. Staff reported that, per Roberts Rule, ex-officio is not counted. *Meeting protocol* • In case there is a breakdown in communication that cannot be restored within 30 minutes after interruption, the meeting will automatically be terminated, and the Council will meet again on Tuesday, October 18 at 9 a.m. using the same links provided for this meeting. • Community input will be received in the designated part of the agenda as well as throughout the meeting. *Handouts* • Copies of the Council thank you letters sent to Sgt. J. Pontanilla and J. Oliver can be found in the handouts. • The Child and Adolescent Mental Health Division (CAMHD) is inviting all to the public hearings for its Strategic Plan. Dates and links are provided in the flyer.	

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	• The DOH also shared an infographic of results of the survey on the Red Hill Water Contamination Impact. • The SAMHSA released its interim strategic plan.	
III. Consideration and Approval of Review Minutes • October 11, 2022	The draft minutes for October 11, 2022 were reviewed.	Action Eileen Lau-James moved to approve the October 11, 2022 minutes. Mary Pat Waterhouse seconded. The motion passed unanimously.
IV. Community Input	Several attendees provided community input in connection with the ongoing strike of Kaiser Hawaii mental health care workers (Below are a transcript of the testimonies. There are minor edits for clarity). Oral testimony from Andrea Camorra: "My name is Andrea Camorra and I've been a licensed clinical social worker for a total of 28 years, and I've been working at Kaiser's integrated behavioral health clinic in YPO for 16 years. I'm one of the Kaiser clinicians on strike for 12 weeks now. I'd like to share how we got to this point. So, in my 16 years at Kaiser, we've been understaffed for over 10 years. This understaffing is not a COVID problem but a long-standing one. I've been the only keiki therapist on Leeward side. Currently, there are only 2.5 therapists to see all the keiki on the Leeward side, North Shore, and Central Oahu. Our keiki have to wait two to three months for an intake appointment and another two to three months for a return visit to start treatment. Once they're in our system, they are not seen for weekly appointments, which is the standard of care for depression, anxiety, eating disorders, substance abuse and many other mental health diagnoses. They cannot be seen easily because there are not enough therapists and appointments to go around. Our keiki become sicker because they've had to wait and stay sick longer because they cannot get the proper treatment. Seeking mental health care should not take four to six months. But that's the reality at Kaiser. We've taken multiple actions to try to correct this problem. We filed the complaint in November of 2021 with the Hawaii Department of Commerce and Consumer Affairs, which oversees insurance plans in Hawaii.	For information only

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	It's been more than a year and they have yet to rule, and I've given Kaiser multiple extensions to respond to the complaint. This January, we also filed a complaint with the National Committee for Quality Assurance, or NCQA for short, which is an independent national organization that rate insurance plans. The NCQA has put Kaiser on a corrective action plan due to their mental health services, stating," lack of access to behavioral health for Kaiser members poses a potential patient safety risk, and that Kaiser's prior efforts to improve access to behavioral health have largely been ineffective.". As of this writing, Kaiser has not met its goals laid out in the corrective action plan. Kaiser has also not shown any interest in trying to retain or attract new therapists via a fair and reasonable contract. But what does this have to do with state services? Well, due to the short staffing at Kaiser, we offload our QUEST patients to state services such as SCBD, or CCS because we cannot see them at the frequency that these patients require. Parents are then appalled to find out that I can only see them once a month after transitioning from SCBD services. Parents are encouraged to put their keiki on IEP s because in doing so they can access SCBD services, even with being a commercial Kaiser member. And I also hear parents being told to get their kids on QUEST, so they can get care via SCBD due to the lack of appointments in our department. These families pick Kaiser as their QUEST provider, and Kaiser is not giving them the treatment they need due to understaffing. Kaiser is burdening already taxed state resources due to their failure to address their own lack of providers. Thank you for the opportunity to share my story. And it's my hope that this Council will be able to improve the mental health care, not just for Kaiser keiki. But for all the keiki of Hawaii. Thank you. Oral Testimony from Melissa Ring: I'm a licensed clinical psychologist for 40 years. Most recently, I worked at Kaiser Permanente Moilani Clinic until I retired in September 2020. And then I came back to work in the call center for Kaiser. Call center staff screen Kaiser members to determine their level of need, including whether they're in crisis and then schedule appointments or make referrals to contracted practitioners. We hear the problems and the anxiety, worry pain, grief, all the reasons they seek care. I'm here today to describe the impacts of Kaiser's inadequate	

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	staffing, and their unwillingness to provide sufficient compensation benefits and working conditions to recruit and retain staff. These deficiencies adversely impact the state's system of care and provision of mental health treatment. I will note that I am a member of the National Union for Health Care Workers. We have been on strike for 12 weeks trying to make a difference in getting these rectified along model of cares to provide integrated services. Within behavior health, we try to keep the most difficult patients being provided by salaried employees of Kaiser and then we contract the less complicated cases to private practitioners. Our staffing situation has led to long delays in obtaining initial appointments, as well as significant time between sessions. This has led to external referrals regardless of need, and the external providers are also overwhelmed. Also, external providers often do not accept Kaiser Medicare or Kaiser QUEST. So, these individuals are adversely impacted. Persons with serious mental health conditions who might appropriately have been cared for within Kaiser are referred to Community Care Services. Children and adolescents with emerging disorders are not provided initial care that might prevent development of serious emotional disturbances. So, these same children are referred to the overburden Family Guidance Centers. Individuals with serious mental health issues such as those with suicidal impulses and psychotic symptoms, who call Hawaii CARES also have significant delays accessing care and are told to call from a contracted list of contracted providers. Individuals with recent hospitalization or serious suicide attempts might get timely psychiatry appointments, but they don't get the needed therapy. Kaiser has been encouraging contracted providers by increasing their rates. But they have been unwilling to consider our modest proposals which are significantly less than salaries provided in California. Kaiser will not recruit and retain mental health professionals without sufficient compensation. And this again, lack of a lack of providers directly impacts the state and what the state provides. In some, Kaiser's inadequacies are impacting the mental health system throughout the state and the public private balance of the system of care. I request your support to urge DCCA to complete their investigation into Kaiser and make their findings public. We would ask that your annual Report referenced the impacts of Kaiser staffing crisis and that of our current strike on the mental health needs of Hawaii residents. Thank you.	

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	Questions from Council members: Q. I was wondering, is this a recent phenomenon in terms of like the staffing shortages and/or how you described it as a lack of reimbursement, or lack of pay for the staff or providers? Is this related to the sort of, shuffling of assignment to the Southern California district or is it sort of something that persisted before? A. It's been going on for many, many years, but has gotten worse in the last few years. Kaiser is able to recruit some new therapists, but we lose therapists on as you know, we get someone in and someone quits, we get someone in and they only last three months, six months, maybe a year. So those problems did go on before the administrative change. And we do have some problems related to add, it seems like when we unionized there seems to be actual pushback on that with takeaways rather than any negotiation for improvements. Oral Testimony from Dr. Darah Wallstein: My name is Dr. Dara Wallstein. I'm both a clinical social worker and licensed clinical psychologist. I've been employed by Kaiser Permanente since 2014 and I work in the Hilo Clinic on the Big Island. I have about over 35 years (of professional service). For most of my tenure with Kaiser and I've been the only therapist on the Hilo side of the Big Island that works directly for Kaiser, behavioral health staffing throughout Hawaii is very poor. But on Hawaii Island, it's even worse. Kaiser is only slotting four therapy positions on the Big Island , and of these four positions, Kaiser only permits three of us to exclusively provide care for Big Island patients. This translates up to a ratio of one therapist for every 10,000 members on the Big Island. Alarmingly, we only have one Big Island Kaiser therapist that sees children under 13. Kaiser contracts private practice therapists on the Big Island, but most of them are not accepting new Kaiser patients and only a fraction of these treat children for the last one to two years. The wait times for initial and follow up appointments for Kaiser Big Island patients is two to three months prior to going out on strike. Twice as everybody's talked about three weeks ago. Three months ago, I	

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	had a wait list of 83 patients that were established patients, many with very serious mental health issues that needed more frequent follow up appointments. We can't cap per caseload; they just keep on piling on. Kaiser claims there's a mental health shortage in Hawaii. However, there are over 2,700 people in Hawaii that have active psychology and clinical social work licenses. And this includes over 220 who reside on the Big Island. The fact is, there are enough therapists in Hawaii available for Kaiser to recruit. Therefore, the reason Kaiser does not have more mental health staff is despite the growth of their membership, they have not increased positions and have been able to retain their current staff at the end of the year cut. Last year, Kaiser had over 56 billion in assets and paid its CEO an annual salary of 17 million. Given its vast resources, Kaiser can easily offer competitive wages and benefits to attract and retain a mental health workforce to provide for the over 260,000 Hawaii residents. I encourage you to please support our efforts to have Kaiser come up, come to the bargaining table, and agree to a contract that makes them accountable to provide mental health parity for those they are insuring. Thank you so much for your time. Oral Testimony from Dr. Tami Swonigan: I have been in Hawaii for 23 years. I started as an intern with the V.A. After that, I worked for a private company and we consulted with Department of Education, Department of Health, and Department of Human Services. I did that for about seven or eight years before I came to Kaiser as a clinical psychologist, and I've been with Kaiser for 15 and a half years. I initially was a therapist, psychologist, and I saw the entire range. So, I saw keiki to our kupuna and did individual and groups, family therapy, the whole gamut. In 2014 I shifted, and I started to be a behavioral health consultant. We call it mental health integration in primary care. I work out at the YPO clinic. And my responsibility is to be available to all of the physicians in the clinic to address those issues that present themselves in primary care and that are able to be addressed by changing lifestyle, better understanding what's going on, helping people to adjust to new diagnoses, people who aren't compliant with their medication. So, I'm kind of everywhere in the clinic and my schedule varies per day depending on which physicians are requesting my assistance - whether	

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	that is someone adjusting to a diabetes diagnosis, someone with hypertension, other stress related health issues, chronic pain, migraines, postpartum depression OB GYN, frequent anxiety, panic attacks. So that is my primary job. What's happened, however, is I've not been able to do that job, because I keep having to intervene and do more typical therapy work because there's insufficient number of therapists. We've been talking about this. Again, it's been well over a decade. So, I know Kaiser keeps insisting in their media that this is due to the shortage nationally, due to the pandemic, those things worsened. It's a choice not to staff more than three or four people on an entire island, that's a choice not to do that. And they've made that choice over and over. When I'm not available, because I'm doing more traditional therapy, those patients presenting in primary care burden physician schedules, and they (physicians) start to feel more burnout addressing issues that they're not typically trained to do. And so again, it's this ripple effect. And it's so important, because again, and you'll see in a Kaiser commercial, now we treat the entire body, we know that if you're anxious, it affects you know, absenteeism, your ability to be a partner, parent, a family member, to work be part of the community. And again, it drives up prices, because people presently go to the ER, they get sicker. And that's their entire health and well-being. And again, that ripples through children with diabetes, etc., not complying, not wanting to go to school. So, it affects the entire education system, teachers dealing with things that are not being addressed through proper treatment. So again, we've been out and not because we want it to be out. We're clinicians, we trained to help people. That's what we want to do with our patients. We're not trying to get rich off of it, although we keep getting presented that way. As a clinician who misses seeing patients and misses collaborating with our physicians, we ask that you ask DCCA and look at what's holding things up. This is not, again, about a bunch of clinicians that are out. This is about patients who are suffering and who are struggling coming off of a pandemic, It's about the first responders, again, everybody, it's a ripple effect. And people seem to be taking their time as if this is just some kind of business deal. These are people's lives. And so whatever support that you're able to give us, we would very much appreciate it.	

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	Questions/Clarifications from council members: Q. I'm asking the Council members because this has been brought up before in the past I know. And, specifically, I've asked this because of my personal experiences with difficulty getting treatment for my husband. It seems like many of the services that the State the state funds provide. Many of the programs aren't available to people that have insurance plans from their employers. I wanted to ask the Council members specifically what you know, like what we can do to specifically help the Kaiser patients, Kaiser members and other people with private insurance instead of state funded programs. A. K. Aumer commented that there are a variety of options open to the Council, and think legislation can be part of it. She asked for opinion from some action items that the Council could take, specifically in regards to just being aware of what is going on? A. Izeah Garcia said that folks can give their email addresses or reach out to him and he can keep folks in the loop. He repeated that they are on strike for about three months now and asserted that it is the longest mental health workers strike in US history. He said that all of this is to improve recruitment and retention measures at Kaiser Permanente improve patient access, wait times as well. He said that for right now, they have a complaint with the Department of Commerce and Consumer Affairs that was submitted in November of 2021, outlining issues with regards to access and amount of external providers. He pointed out that asking the DCCA about this is something that the Council can do if interested. He also asked to include this fight in the Council's annual report to talk about how conditions at Kaiser affect patients across Hawaii. He added that they are on the line and so folks can come out. Support and share the picket line information. He explained that that they do not want to go back to work with conditions that take away their pensions and their wages. He shared via chat a fact sheet with a comparison of wage proposals in Hawaii, versus what they settled in Northern California. K. Aumer thanked everyone and made it clear that the Council, as a body, cannot do anything immediately and need to take things up as an agenda item	

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	and deliberate as a group. This could be something that the Council can put on next month's meeting agenda to discuss. She expressed hope that the strike won't last that long and are resolved before then. She added that Council members, in their individual capacity, can advocate on their own (or not). K. Aumer recognized Dr. Wallstein who said that California passed legislation that strengthens parity laws as well as accountability. K. Aumer recognized Dr. Swonigan who pointed out that adding fines, like in the California law, seem to get Kaiser to respond. So, she said that the Council might want to check legislations later. K. Aumer recognized I. Garcia who identified the California bills as Senate Bill 855 and Senate Bill 221. He said that there is increase in insurance coverage for behavioral health care and is explicitly codified, requiring providers to provide behavioral health care follow up appointments within 10 business days, as is clinically required or clinically recommended. K. Aumer thanked everyone for their powerful testimonies and thought it said a lot about what community members are experiencing. E. Lau-James asked whether it was possible for the Council to request, specifically someone representing Kaiser to present about their explanation for the shortages. K. Aumer concluded that this topic will be in a future agenda.	
V. Old Business	A. Youth Survey – PIG Update. B. Advocacy – PIG Legislation 2023 Update K. Aumer asked for comments on the staff's recommendation that the Council give power to its Executive Committee (Chairperson, Vice Chairpersons, and Secretary) to act on its behalf in approving its annual report to the Governor and Legislature. This request ensures that there is a formal way to do so in case there is no quorum next month. Carolyn Weygan-Hildebrand added that the report will be submitted to DOH on December 20 to be compiled with other reports. An executive committee meeting will be publicly- noticed and a draft report will be uploaded for everyone to comment. E. Lau-James commented that the Council had	Tabled <u>Action</u> E. Lau-James moved that the Council give power to its Executive Committee to approve the Council's annual report in the event that the Council does not have quorum in December. Mary Pat Waterhouse seconded. The motion passed unanimously.

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	been meeting quorum so it will be able to approve the report. So, there may not be a need for said executive meeting. M. P. Waterhouse reported that the PIG agreed that Carolyn Weygan-Hildebrand, as staff of the Council, will take the lead in drafting the report. She updated that a PIG meeting will be set up to decide how the Council will handle the 2023 bills, either doing it the way it was done last year or just getting the first hearing first and have fewer bills to review and testify to. She said that she would rather not be the chair this PIG because she is a new member. Instead, she would be very happy to work real closely with someone who has worked last year and familiar with Council's system. K. Aumer asked for any volunteer to chair the PIG and no one volunteered. She requested for more members and the following confirmed: Valerie Yin (CAMHD planner), Jon Betlach, and Jackie Jackson. C. Planning – Staff Update on Mental Health Block Grant C Weygan-Hildebrand reported that a report outline will be proposed to the PIG.	
VI. New Business VI. New Business…Con't	A. Assisted Community Treatment: What it is, and the existing Hawaii Law. M. P. Waterhouse introduced the invited presenter. "Connie Mitchell is head of Institute for Human Services, the largest homeless shelter in the State. Before HIS, Connie was also in charge of the nurses at the Hawaii State Hospital. She's got a wealth of information regarding mental health. She worked in rural communities as well. The other person that is going to be speaking with her is Ellen Carson." Connie Mitchell introduced Ellen Carson. "Ellen is a retired attorney who has had a long history of advocacy in our state for many different areas, among them for women's rights, civil rights, health, reforming some of the health rights that we have. She was also largely responsible for the Harmonization Act which allows us to share information more readily when we have so many privacy laws that was	For information only

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	preventing us from being able to really share information for the good of our patients and the people that we're serving." Connie Mitchell introduced I.H.S. and what it has been doing especially in the mental health arena. She said that I.H.S. helps a lot of families who are kind of stuck and not knowing what do you know, in terms of having a mentally ill loved one and having difficulty because they can't get treatment. She talked about the system relative to where there are as a service provider and where they run into problems when trying to help people access mental health treatment. She said that Ellen will be going to share some of the proposed statutory amendments that they want to bring up in the next legislative session. She said she hope that the Council will support but also give input and help shape these bills. Please see attached presentation slides by C. Mitchell. Ellen Carson talked about three current tools in the Hawaii's toolbox for helping individuals with mental illness or substance abuse who have severe capacity limitations. She said they feel bulky, cumbersome and time consuming. They can be improved. (1) Assisted outpatient community treatment or ACT in Hawaii. It also goes by Assisted Outpatient Treatment (AOT) in the US Mainland. The purpose of this tool is to get treatment to people while they're still in the community without having to hospitalize them. They get effective treatment so that they will not do harm to themselves or others, and hopefully can start stabilizing and having a more functional life. The standards for assisted community treatment require either a psychiatrist or an APRN (Advanced Practice Nurse) with a psychiatric specialty, to say that the person's mentally ill or suffering from severe substance abuse, and are unlikely to be able to live safely in the community that they are in danger of imminent harm to themselves, or others of deteriorating to a point where they would be an imminent harm to themselves or others, and that there's a history of a lack of proper treatment or adherence to treatment schedules for them. Considering the less restrictive alternatives, the best thing to do would be to provide	

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	appropriately medical treatment while in the community. This is in the person's best medical interests. To invoke this particular tool, one needs to have an interested party, which could be a family member or it could be a psychiatrist, that needs to individually petition to the family court with sworn evidence that attests to these various standards and needs to say that those standards are met. It becomes quite a burden to try to do this. There is a need for an appointed guardian to be able to represent the best interests of the individual involved. There's at least two court hearings- one's an initial one just to make sure everybody's on and get a court date and the other on evidentiary proceeding. She continues, "This latter one looks somewhat like what you see on TV in terms of formal witnesses under oath, with cross examination documents being submitted or other evidence. However, because of the changes with COVID, and more online proceedings, the family court is getting more receptive to being able to hold some of these testimonies online. So, an individual out in the community might have their outreach worker come up to them with a laptop, or cell phone or whatever works to have them be in attendance at the meeting. And the same, hopefully for the psychiatric provider, so that they don't need to travel to Kapolei and wait for a long time to have the hearing and their testimony. Nevertheless, that takes a while and the time from the filing of a petition to the time of being able to get an order that says this treatment can now be rendered to the patient. And here's a treatment plan that the court stands behind an order to be enforced. Well, that can take two months, at a minimum four months, sometimes it's taken six or eight months, or longer. So often, the person by that time might have already deteriorated, most of them died, committed crime, other things that just create havoc, for them and for the system." (2) Orders to Treat or OTT. Orders to treat right now are currently restricted to folks that are in the Hawaii State Hospital. This allows the Director of the Department of Health to seek an order to treat over a patient's objection. Patients objecting to treatment may needs treatment because they are still imminently in danger of hurting themselves or someone else as a result of their mental illness or their substance abuse issues. So, the order to treat is one of the options that's there.	

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	(3) Guardianship. A guardianship can be done where the person totally lacks own legal capacity to act because their thought process, whether it's delusional or simply dementia, or other things may render them unable to form informed consent or to make decisions in any type of rational way. When that occurs, the court, again upon a petition being filed and a lengthy process can appoint a guardian a full guardian to act in that person's stead, either just for healthcare decisions, or for health care, plus financial matters, and the whole ball of wax that may be needed for that. Ellen expressed that the wish of I.H.S. and others is to try to make each of those to be more amenable to what the community's real needs are, and to make them more responsive to the individuals help, and also to the families and communities that are trying to support these individuals. For example, with Assisted Community Treatment, orders can be issued within 30 days of the petition being filed and enable to get faster to treatment and not have people deteriorate further. The court can be encouraged to have greater use of the online hearings for providers. The next is called stipulated on consent order, where an ACT petition is sought, and the subject doesn't contest the proposed ACT order, which happens in maybe a third of the cases, that once notified a petition has been file and the treatment request is seen, they can go ahead and consent and help speed things along as well. Also, one can take the onus off of the individuals who are the ones currently having to do these petitions, and to simply ask the Department of Health Director to file these and to give the director the information needed to show that the person meets the standards and then cooperate with the director and the filing and being witness for this proceeding. These are essentially the wish list items for the Assisted Community Treatment. On the OTT side, where somebody's already in custody and is imminently dangerous to self or others within the next 45 days, what can change is to have 30 days from petition to final order instead of months and months. One can have the DOH Director be the one that files the petition or that can be requested to file the petition, and allow others to help support that but not have to bear the burden of it and expand this particular part of the toolbox to include community hospitals,	

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	private hospitals, psychiatric facilities, so that it could be something where people other than those who are in the State Hospital could be helped by in order to treat over objection. For MH4 evaluation occurs, what is sought also is for the psychiatric facility or hospital where that individual is to be able to petition the DOH Director to file an order to treat, to be able to get stabilizing treatment and long-acting medication if appropriate for the individual so that perhaps they can avoid hospitalization altogether. For, MH6 proceeding, to allow for simultaneous filings of petitions that includes all of the orders to treat that are known at that time so that there can be proper treatment when the person gets hospital while they're still held in say a psychiatric bed in a private sector. Ellen Carson added other critical issue. Some facilities do have the capability to go ahead and hospitalize someone in a secure lockdown ward within their own facility, but very little incentive to do so if they can't actively treat the person, then what are they doing to really help that person? Finally on the guardianship tool, there is an emergency guardianship procedure that can work much more quickly say, to be able to extend the maximum length of the emergency guardianship 220 days instead of 90 days. *Discussions, Q&A* K. Aumer asked Council member Kristin Will if she has any comments. K. Will responded that they see the issue on the court side also, with the orders to treat and more. If the client is not willing to take meds, they're not going to be treated unless they're violent. It is much harder to get a judge to sign an order to treat if they're not even forensically committed in a sense, where they've done a crime to get CR (Court Order). So, in the community, it would be a lot even harder to do that. Q. (Directed to K. Will) Does the individual need to be present for court proceedings for ACT or can their advocate be present for them? A. “The JAL is always there and we take the JAL to go see the person. In more recent times, we've brought the person in through tele-video if the person is willing. So, we've brought somebody in through the hospital	

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	when they were hospitalized. And we brought somebody in through the street when they were on the street, but many of them don't want to participate, but we we're able to proceed without them being present. We do serve them on every case, so they've been served and then they don't show up or we try to facilitate it, but they don't show up." B. DOH Children and Adolescent Mental Health Division update on CAMHD Plan, Evaluation Report and Related Legislation presented Dr. Scott Shimabukuro, CAMHD Administrator reported that the Division is in the midst of strategic planning development. He said: "CAMHD Planner, Valerie Yin, has been able to develop and facilitate a process of the strategic planning that has been a meaningful for CAMHD. It's clarifying for CAMHD's vision, direction, intention, and what we want to accomplish. A big part of is 'prevention.' CAMHD has been very active in prevention activities. We want to increase that, and we want to further those efforts. Marian Tsuji has been a very huge champion of prevention efforts. With the idea that we're not going to treat our way out of the problems we're seeing in our communities, we have to provide treatment. But treatment isn't enough, we need to do a variety of prevention efforts. And so that's what we have. Historically, CAMHD has been less about prevention, but moving forward, we're going to be more about prevention, preventative, as opposed to just solely treatment." *Discussion, Q&A* Q. Often funding can be an issue with preventative methods because treatment often gets more funding in many ways. Do you already have identified specific targeted funding sources for those primitive methods? A. We're going to use general funds. We can use block grant funding in some ways that promote our prevention efforts. V. Yin put in the chat that there will be public hearings to obtain feedback from the public on its strategic plan. We have done Oahu and Kaui hearings and we are going to	

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	the other counties. We take the feedback that we received from people very seriously. And I'm super appreciative that people are willing to speak up and contribute to our strategic plan. People can also join in via zoom for the public hearings. The next hearing November 22, 2022 on Maui at 8:30 a.m. to 9:30 a.m. K. Aumer thanked all the speakers and she asked for any final question. E. Lau-James wanted to make a motion for the Council to write a letter to the Governor in response to the community input today from Kaiser. K. Aumer commented the goal is that we receive those testimonies, and then we put on the agenda for the next meeting. That way, it is public and the Council can receive more input at that point. Then when the Council writes the letter, it can be more informed. The point of making that public is to ensure everyone has input. The meeting was handed over to Kathleen Merriam, 2nd Vice-Chairperson.	
VII. Informational Reports	Island Representative Reports • Oahu Service Area Board (OSAB) – Jackie Jackson o C. Weygan-Hildebrand reported that the last meeting of OSAB was canceled due to technical issues over a few words in the public notice. • Maui Service Area Board (MSAB) – None (Representative T. Reed stepped down and there is no longer a representative for Maui). State Agency Representative Reports • Health (DOH) Update by K. Merriam shared a written report. See attached. • Med-Quest Medicaid Program (MQD) Jon Fujii provided 2 updates. He said, "(1) the 1115 waiver renewals are coming up. There are five-year renewals with CMS to conduct our managed care plans and service delivery. The current 1115 waiver expires beginning of August of 2024. And we have generally a year before that to submit to CMS. Like what our waiver is going to look like	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS
	for the next five years. We have continued to focus on behavioral integration in all the things that we're doing across the board, including a lot of mental health services and a lot of primary care services, integrated primary care from the mental health perspective. So, some of the things that Kaiser was talking about earlier, and this is some of the stuff that we're really sort of keen on in terms of how do we look at promoting that through our contract with their health plans. (2) A lot of folks are doing a lot of things around getting public input and Med-Quest Division are also doing something similar. We have a behavioral assessment to get input from folks in the community. We shared out the link to that. The survey is done by our contractor with our University of Hawaii team to help us with that survey. The deadline is November 18, 2022." • Social Service. No updates. * Note: VocRehab, DOE, Judiciary, Housing reports-Tabled Specialty Area Representative Reports • Hawaii Advisory Committee on Drug and Abuse and Controlled Substances (HACDACS). J. Fujii reported that HACDACS in the process of doing two things right now. That is the agenda for 2023 in terms of the topics we're going to be looking at and the speakers we're going to be bringing in. The second big thing is we're working on our 23 legislative record and recommendations. He said further, "I already submitted some information for a piece that I had to put together, which was the Behavioral Health Advisory Committee. There's a Vimeo around Captain Williams from SAMHSA talking about her experience with as being involved in different states with what we're looking into stepping into here. She made some really good points." • Parents and Family Members of Mental Health Service Recipients –	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS
	E. Lau-James gave an outline of the definitions for all of the MHs. She asked Kristin Will if she feels that people in the judiciary are pretty aware of health risk of the situation in the hospital and that people are being released without treatment, and that it's a risk to the community? K. Will responded that she is aware of this. She said she works for the Judiciary; the State Hospital is under the Department of Health and OCCC is under the Department of Public Safety. She said further, "So, the three don't always seem to connect like what our thoughts are. In the long run this is stuff that needs to be addressed because the mental health issues just exploding. And it does not necessarily mean that when you have mental health issues, you are a criminal." K. Merriam requested for an infographic that could help everybody be on the same page because there's so much different knowledge. She said further, "We have people that are on the ground doing this work every day. And then we have a family member, people served that's one perspective. And then we have people that might be trying to figure out how to implement some of this." M. P. Waterhouse reported that she is working with C. Mitchell and E. Carson on 2 bills and ask Kristin if she is interested in working with them. K. Will said yes and to please send her an e-mail.	
VIII. Meeting Evaluation/Future Agenda Items	Agenda for next/ future meetings: • Legislative agenda presentation from Brian Talisayan • Create some type of infographic /flowchart to help navigate all of these silos • Form PIG for new council members to welcome them onboard. • Kaiser issue • J. Betlach reported that there's not a representative from ADAD to help the police with some of the challenges that come up, and Hawaii doesn't have the same structure that they have on Oahu. There's a	Information only

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/CONCLUSIONS
	certain special position that hasn't been created. This is a challenge that there's no one for the police to work with.	
XIV. Adjournment	The meeting was adjourned at 11:55 a.m.	For information only
Electronic Mail Outs	The following handouts were e-mailed to SCMH members and individuals the SCMH e-mail distribution list: AGENDA November 2022 Meeting FINAL 1. MINUTES October 2022 Meeting DRAFT (includes SCISP slides and DOH Report) 2. ATTENDANCE log October 2022 Meeting_FY23 3. Announcement _Copies of Council Thank You letters Signed and Sent 4. Announcement _Copies of Approved Minutes of HACDACS and SAB Meetings 5. Announcement _CAMHD Flyer on Public Hearings for CAMHD Strategic Plan 6. Announcement _Red Hill Water Contamination Survey Results 7. Announcement _SAMHSA Interim Strategic Plan 2023-2026	For information only

Proposed MH Treatment Advocacy to 2023 Legislature

Ellen Carson
Connie Mitchell
IHS, The Institute for Human Services

COMPLEXITY of Hawaii's Homelessness

G-A-P between **INCOME** and **RENTS/MORTGAGES**

FALLOUT FROM **CHRONIC DRUG USE**

BEHAVIORAL HEALTH and **LEGAL SYSTEMS NOT ALIGNED**

GENERATIONAL POVERTY

LONGEST PERIOD of MILITARY deployment in U.S. history

IMMIGRATION & DISINTEGRATION of FAMILIES

CULTURAL TRAUMA of Hawaii's overthrow

MARKETING OF HAWAII as **PARADISE**

State's **UNIQUE GEOPOLITICAL ECONOMIC VALUE**

IHS, The Institute for Human Services

Mission

To create and offer tailored solutions for those in crisis, and nurture homeless people toward greater self-direction and responsibility.

Vision

A community where homeless people are empowered with hope, dignity and confidence to quickly access and sustain a safe, decent and affordable home.

Emergency Shelters

Specialty Shelters

Outreach Programs Focused on Mental illness by IHS, Institute for Human Services

Homeless ICM

Program Manager: Lawrence Antolin
(808) 321-3296

- Those who are frequently arrested & MH'd
- Capital coalition specifically for persons within 1-mile radius of the Capital

Outreach Navigation Program

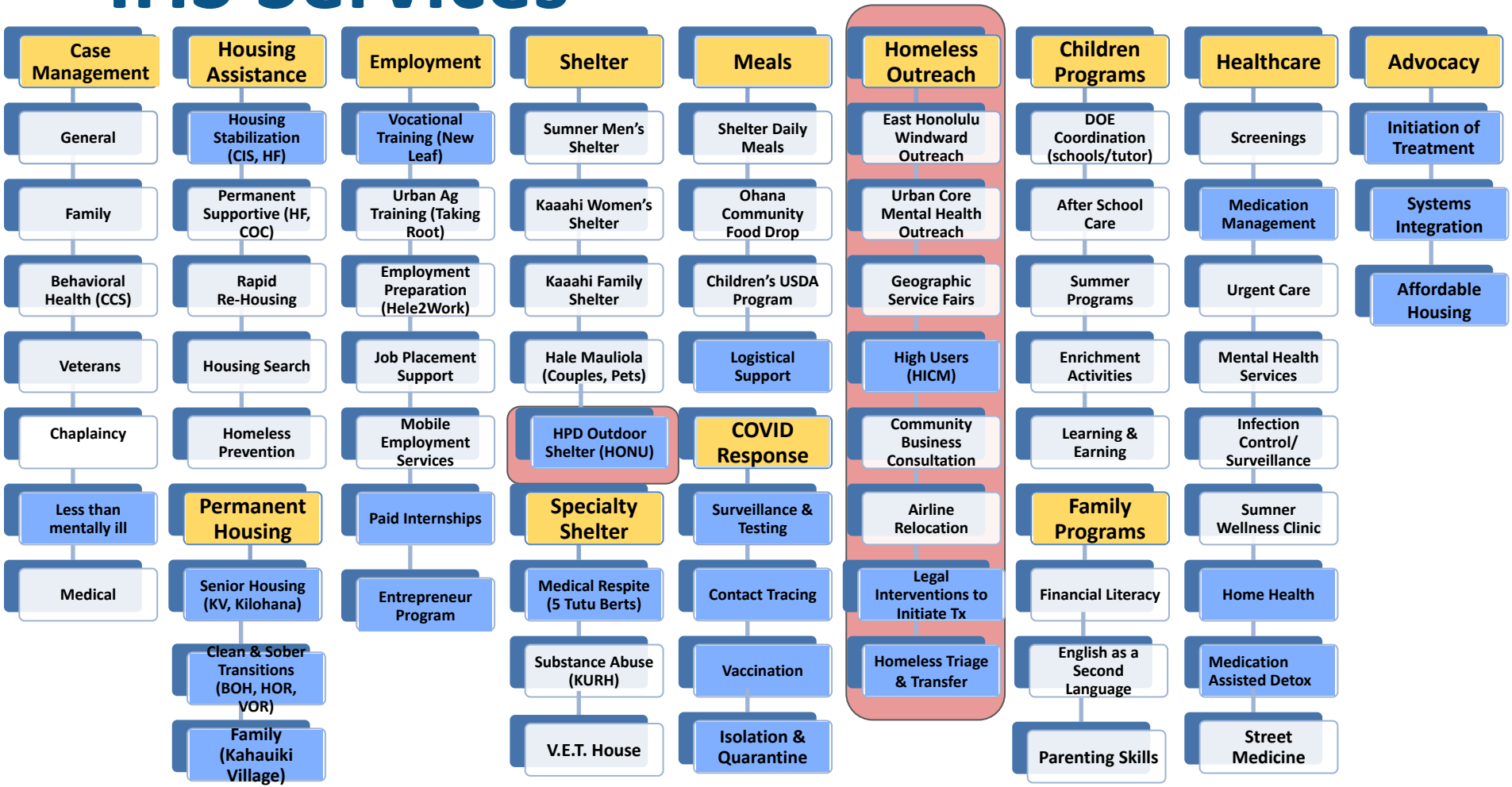
Program Manager: David Warman
(808) 450-8343

- Those who appear to need court orders for treatment

AMHD Outreach and LMI - Less Mentally Ill

Program Manager: Lawrence Antolin
(808) 321-3296

IHS Services



Our Premise

Substance abuse and mental illness are public health and economic crises based on the cost of related care, the loss of workforce & the contribution to the increase of crime. Chronic unsheltered homelessness is often the result of these two conditions Therefore, we need more assertive interventions to address the crisis.

Core to intervention is Diversion to HSH and mandating treatment in lieu of prosecution.

IHS Outreach Navigation Program

Outreach Navigation Program

GOAL: Initiate or reinstate treatment for serious mental illness with homeless individuals

INTERVENTIONS:

- Assertive outreach, including contingency management
- On the street psychiatric assessment, medical interventions
- Coordinating with homeless intensive case management
- File petitions for guardianship
- File petitions for Assisted Community Treatment
- Implementing treatment through coordination with HPD, emergency rooms
- Coordinating with Prosecutor’s office, HSH, Courts

COMING SOON (Early 2023)

‘Imi Ola Piha

Triage Center
551 Dillingham Blvd.

Hygiene Center, Ample Storage

TARGET OUTCOMES:

1. Expand treatment access for vulnerable homeless w/ MH & AOD disorders
2. ⇧ access to:
   a) Detox - MAT
   b) Mental health Treatment
   c) Urgent care
3. Workforce development
4. Treatment Algorithms
5. GPRA Government Performance and Results Act of 1993

Geography: Oahu with emphasis on urban CORE
Pilot: Chinatown & **Waikiki** CPT Collaboration

An effective mental health system would…

- Be comprehensive with a full spectrum of mental health services to meet the needs of most vulnerable including outreach, crisis stabilization outpatient treatment, inpatient, continued treatment/stepdown services, psychosocial rehabilitation, housing and employment support
- Attend to prevention, provide responsive assessment and triage at multiple intercept points in the system, deliver effective treatment supported by competent and responsive case management
- Integrate efforts of multiple systems of service (Behavioral health, general health care, DD, public safety, judiciary, homeless services, Medicaid/other health plans etc.)

Treatment Opportunity Missed at Intercept Points

- Community Services (Crisis Lines, Crisis Care, Intensive case management)
  - Few CMs petition for Assisted Outpatient treatment (AOT) when appropriate, no legal support
- Law Enforcement (911, local Police)
  - MH1s often are released by hospital ERs due to treatment refusal or diagnosed primarily with SUD
- Emergency Departments, Hospital
  - Limited psych support
  - Current statute does not support treatment over objection for core mental illness under a MH4 hold
  - Civil commitment petition requires separate petition for OTT,
  - Hawaii Staet Hospital does not file AOT prior to release
-

Missed Opportunities (continued)

- Initial Court Hearings and Initial Detention (arrest, cellblock, court appearance)
  - Arrests often result in nothing more than time served due to less severe criminal charges
  - Diversion to HSH under Act 26 to assess fitness to stand trial; Often released within 5 days due to lack of understanding of the severity of community behaviors.
  - Assisted Community Treatment order not petitioned with court
- Jail or Court (Specialty Court, Jail, dispositional court)
  - MH Court only serves those already adjudicated?
  - Treatment in jail is difficult to initiate or maintain upon detention
- Re-Entry (from jail or prison)
  - Often homeless,
  - Often with no mandate to remain on medications
- Community Corrections (parole, probation)

Mahalo!

Connie Mitchell
Executive Director

State Mental Health Council

DOH Report - 11/15/2022

Alcohol & Drug Abuse Division

- Your comments are welcome for the State Plan 2022 Revision as we are in a "public dissemination phase."
    - The website is now available: https://health.hawaii.gov/substance-abuse/state-plan/
    - The System of Care chapters are also now available as a Review PDF Copy.
    - The Statistical Report which was the subject of the first webinar series is also available.
    - Historical full plans also available.
    - Coming soon: A "comprehensive chapter" with overall themes for the next 5 years with a near-term action plan, and updated data dashboard.
- Working with our Attorney General to convene an advisory committee and prepare a needs assessment for the upcoming Opioid Settlement Project.
- Challenges with trying to fill vacant positions for procurement, contracting and monitoring functions. In the meantime, maximizing use of 89-day appointments, and training new staff.
- Conducted first substance use primary prevention provider conference in last August to kick-off expanded prevention efforts. Will encourage them to learn more about the SCMH.

Adult Mental Health Division

- Continue to work to implement the first Certified Community Behavioral Health Center in our state at our Maui Community Mental Health Center. AMHD was awarded a SAMHSA grant for this work.
- Working with our State and community partners on rolling out the Asian American and Native Hawaiian/Pacific Islander (AANHPI) National Center for Behavioral Health Excellence since our award this fall from SAMHSA. We are working with San Jose State University and Papa Ola Lokahi among other organizations in conducting this important work.
- We hosted 4 county-wide summits related to mental health reform this fall. We continue to work with our judiciary and criminal justice partners on efforts to decriminalize mental health and enhance jail diversion efforts across the state. See https://health.hawaii.gov/amhd/jail-diversion/ to see Judge Steven Leifman's opening remarks at the Oahu summit.
- We continue to focus on training peer specialists and forensic peer specialists and any interested applicants should contact: https://health.hawaii.gov/amhd/consumer/hcps/ https://health.hawaii.gov/amhd/consumer/hfps/.
- The Hawaii Cares line has been rolling out text and chat functions for the crisis/988 line this fall to enhance services.
- We oversee the Overdose to Action grant and funding from the grant has led to a new behavioral health dashboard (designed by Data Science Institute at University of Hawaii in collaboration with staff from AMHD, CAMHD and ADAD as well as the Thompson School of Social Work at UH). This site includes tabs for substance use, mental health, co-occurring substance use and mental health, as well as crisis care data for our state. Please go see the beta site and give feedback. More data sources will be added soon as well. https://bh808.hawaii.gov/

Child & Adolescent Mental Health Division

- We are currently working on our strategic plan which includes community in-person/Zoom meetings in the various counties. The overarching goals of accessibility, data informed decision making, and prevention are not dramatically different from past plans. However, the level of effort in these areas will be, and have already been considerably elevated.
- CAMHD and ADAD are entering into a rate study which should have both near future impacts as well as long term impacts with the inclusion of performance-based incentives. Additionally, CAMHD is seeking an increased budget and is exploring all options to further resource the provider network.
- We have been and continue to provide Crisis Intervention Training (CIT) training to law enforcement and it has now extended to three islands (counties).
- Regarding the recently passed bill to establish the Office of Wellness and Resilience which currently resides under DHS, CAMHD in collaboration with Harvard Medical School's Baker Center for Children and Families is pursuing a grant to evaluate the outcomes of the office.

Developmental Disabilities Division

- We are implementing its initiatives made possible through §9817 of the American Rescue Plan Act (ARPA).
    - Trainings are underway for several core initiatives including Quality Management, Competitive Integrated Employment, and Community Navigator Practice Development.
    - Trainings will begin in January for the Positive Approaches/Trauma-informed Care initiative.
    - Design is underway for new waiver services for Peer-to-Peer Support and Residential Support for People with Behavioral Challenges.
    - A Workforce Development advisory group has been established and a study has been completed by the University of Minnesota that in informing selection of a curriculum for certification of Direct Support Professionals. DDD will launch a grant program for providers and individuals to incentivize enrollment in a certification program. Overall, this initiative has a goal of increasing recruitment and retention of DSPs.
    - An evaluation of the DDD program and impact of changes made since the 2016 Waiver is underway.
- We are conducting analysis and planning for a temporary rate increase for certain waiver services during FY23 to address the increase in the minimum wage that became effective October 1, 2022.
- We are developing an "unwinding plan" as flexibilities allowed by CMS for the 1915(c) waiver during the Public Health Emergency (PHE) will sunset six months after the end of the PHE. The current PHE will end January 11, 2023.