STATE COUNCIL ON MENTAL HEALTH (SCMH) MEETING

November 12, 9:00 a.m. – 12:00 p.m.
Hybrid meeting via Zoom and
in-person at Hale F Conference Room, 2201 Waimano Home Road, Pearl City 96782

DRAFT MINUTES

Members Present: Katherine Aumer, John Betlach, Lea Dias, Heidi Ilyavi, Jackie Jackson, Kathleen Merriam, Christine Montague-Hicks, Ray Rice, Mary Pat Waterhouse, Forrest Wells
Members Absent: Kristin Will
Members Excused: Naomi Crozier, Jon Fujii, Tianna Celis-Webster
Staff Present: Chanel Daluddung, Carolyn Weygan-Hildebrand, Madeleine Hiraga-Nuccio, Valerie Yin, Jocelyn Nazareno
Guest: Sheri Taketa

I. Call to Order

Katherine Aumer, chairperson, called the meeting to order at 9:07 am. The quorum was not immediately established but did at 10:10 am, and until that time, there was only announcement and informational presentation from invited guest.

II. Announcements

Meeting protocol:

- In case of communication technology-related interruption that could not be restored in 30 minutes, the meeting will automatically be terminated and resume on November 19th, at 9 am using the same zoom links used of this meeting.
- Community input will be received in the designated part of the agenda as well as throughout the meeting.
- Meeting is recorded and will be release to the council's website and publicly available.

Others:

- Asianna Saragosa-Torres is the newest council member to come on board.
- There are 5 vacant seats that still needs to be filled.
- November is National Family Caregivers month. Last year, Savy Makalena of Gimme a Break Hawaii joined us. See resources in https://gab808.org/
- SAMHSA-funded Ohana Center for Excellence which has been providing resources through webinars and podcasts, just released its impact report https://aanhpi-ohana.org/coe-impact-report-our-work-our-impact-and-what-weve-learned/

III. Approval of Minutes

Tabled

IV. Community Input

None

V. Old Business

A. Mental Health Block Grant – Planning Council Role

See slide presentation on Draft for 2025 MHBG Report (FY24 Performance)
Carolyn Weygan-Hildebrand, MHBG Planner, said the purpose of the report is not only to look back at FY24 but to engage everyone to start thinking about how to do a better job at planning the next cycle.

Feedback

- It was suggested that the State Chairperson meet with the lead epidemiologist who is helping look at the data.
- It was suggested also to add community tenure, looking at residential services, supported housing, level of care.

B. Presentation in October – Approval of Thank you letter

Thank you letter to Dr. Matsu was reviewed by the Council.
L. Dias moved to approve the letter. J. Betlach seconded. Motion pass

C. SCMH Planning Retreat-Update

The update focused on the subject of recruiting members. For MSAB, it was reported that MSAB chairperson expressed interest in joining the Council in the near future. For KSAB, it was reported again that there is no KSAB but that a member from Kauai should be recruited. For the Big Island, it was reported that HSAB has four members and one member is interested in becoming a member.

D. Member Onboarding - Update

There were two updates:

1. Photos – Members in Maui and the Big Island requested to have their photos taken by a local studio there and get reimbursed. J. Betlach reminded that he already has a photo. For those in Oahu, Carolyn is waiting to hear back from studio as to when members can schedule their photo shoot.
2. Resource- SAMHSA TA crafted a manual for State Councils. Among others, it does identify performance indicators as an area that Councils can help in MHBG planning.

VI. New Business

A. Presentation

"*Overview of the State Department of Human Services' Division of Vocational Rehabilitation Program***"**
Lea Dias, Administrator
(Please see Slide presentation by L. Dias)

Notes:

- DVR helps people with disability with competitive integrated employment

- There are DVR offices in every County. There are 5 offices on Oahu, 1 on Kauai, 2 on Hawaii Island, Hilo and Kona, 1 on Maui and 1 on Molokai.

- **Mission:** VR exists to serve its participants for meaningful employment through timely and individualized vocational rehabilitation services.

- **Vision:** Move forward to work.

- **VALUE: R.I.S.E.**
  R- Respect for the individual
  I-integrity
  S-Service with compassion
  E-Empowerment

- DVR comes Under the Federal Disability Act
  The Funders for DVR is the Federal U.S. Department of Education and the State Department of Human Services

- **DVR Grant – Both the Federal and State**
  - Vocational Rehab Services
  - Older Individual for the Blind
  - Supported Employment Adult and Youth
  - Independent Living Part B
  - Disability Insurance - SSA

- **Partnership**
  - State and Local Agencies
  - UH/Center on Independent Living
  - Centers on Independent Living
  - Community Rehabilitation Programs/Providers
  - Consumer Organizations of persons with disabilities

- **5 things that DVR graded on:**
  - Employment rate 2nd/4th quarter after exit
  - Median Earnings
  - Credential Attainment Rate
  - Measurable Skills
  - New-Effectiveness in Serving Employers

- **DVR Services**
  - VR Counseling and Guidance
  - Vocational & Other training services
  - Job readiness training
  - Job Development and Placement services
  - Supportive Employment
  - Rehab/Assistive Technology
  - Employers Services

- **Services for Students**
  - Pre-Employment Transition services
  - Job Exploration Counseling
  - Work Based Learning Experience
  - Counseling on Post secondary Education Opportunities
  - Workplace Readiness Training
  - Instruction in Self-Advocacy

- Hoopono Service for the Blind
  - New vision programs
  - OIB
  - Blind Vending Program

Question & Answer, Comments.
Q. Has the application process improved and made easier to apply for job?
A. Within the last year the referral and application are online. So, the application is simply to fill. From the time the application is received, the counselors have 2 weeks to see the applicant, and from intake must find applicant eligible within 60 days. If applicant has SSI/SSDI, they are presumed eligible.

Q. How long do you stay with the individual? For example, you training them for a job and then your services drop, or can they stay with you through multiple job changes and get retained in different areas?
A. We have an IPE (individualized plan for employment). We provide services for whatever the individual needs to get ready for a job and until they get to the ultimate job that they want to get too we will close their case. And once they are in that job, we stay with them for 90 days to make sure everything is stable.

Q. Have you considered working with the clulbhouses?
A. Yes, we do work with the clubhouses. So, the consumer, VR counselor and clubhouse staff would work together.

It was suggested that it would be nice to have a statewide initiative for DVR to work with the clubhouses.

B. Presentation

"Department of Education – Behavior Threat Assessment and Management"
Sheri Taketa, Lead – Project HI AWARE2 Behavior Threat Assessment & Management

Basic Principle of Threat Assessment from K-12 Lens.

"My role within this Project High Aware 2 is to roll out threat assessment within all 295 schools within the Department of Education. First, what we're going to do is we're going to roll out to three complex areas. We're collecting data, making sure that we're rolling out to the level of national best practice before we roll out statewide. We are going to be rolling out at Hilo Waikea.

Hawaii Office of Homeland Security targeted violence prevention implementation plan. We are the first state in the entire nation to have a targeted violence prevention implementation plan, which was signed off and enacted by Governor Josh Green. What that means is not just the Department of Education. Homeland Security and its partners are trying to be statewide –hotels, restaurants, and others. We've been rolling out to the Department of Health, the Corrections -- we want a whole state full of level one threat assessment teams so that we can prevent targeted violence all over the state, not just within the Department of Education.

Threat Assessment is:
A preventative approach to determine how likely a person is to carry out a threat of violence. A way to identify, investigation, assess and manage individuals who are on the pathway to violence.

Threat Assessment is not:
Response approach to an act of violences. A vulnerability assessment that focuses on the organizational facility, procedures, and practices.

Five steps:
1. Establish a level threat assessment team, minimal of 6 members.
2. Establish who should lead for threat assessment team.
3. Train all members and train collectively to have common understanding of the threat assessment process.

Required trainings for student of concern cases:
1. Threat Evaluation/Reporting Overview (TERO training)
2. Psychological Risk Assessment
3. The Basic Principles of Threat Assessment from a K-12 Lens

Other Trainings Required:
1. Salem-Keizer Cascade
2. CSTAG Comprehensive School Threat Assessment Guidelines
3. Basic Digital Threat Assessment

Student of Concern Flow Chart - what to do step by step if you do have a student of concern on your campus.

Question & Answer, Comments.
Q. How can you get buy-in from the kids?
A. We are actually working with the state office health education to possibly roll out “See Something, Say Something” through health education. So, they understand the “See something” is not only about threats. it could be other crisis (e.g., suicide attempt).

Q. Do trainings cost anything? And if someone was interested in the trainings what is the procedure?

A. No, trainings are free. Reach out to me by email for the trainings. We do have community trainings and the best training to go to first is the TAROT Training.

Q. You work with Moonshot and Moonshot does a decent job of curating online possibilities for threats. Are there any current reports that are provided either through the Moonshot or in general through your agency with regards to threats?
A. HIDOE, UH West Oahu, Moonshot, and the Governor are creating a draft guidance policies, procedures, and administrative rules informed by legal research. So, UH West Oahu is going to create a level one create policies and procedure, just like the BTAM procedures that we created. They're going to create procedures within its organization.

Q. If things are identified in the schools as being a threat and would that information be given to the public? Would the public be able to go on a posting maybe online or would that be reported essentially or does that get kept as a report privately?
A. It depends because when you go through the threat assessment model training, it could be a student just be saying I want to kill you but really didn't mean it. So, that would be a threat. When you go through the threat assessment model training, it shows you step by step, is this no threat? Is this a transient threat? Is it a very serious substantive threat. So really, it shows you how far along and if it's a credible threat. So, if it's not a threat, nothing is going to be reported. But if it is a much bigger threat then it is reported.

Q.When it comes to these different level one assessment teams, are they going to be roll up to the state, public, private and charter schools, all of those will be part of that as well?
A. Yes

C. 2025 Legislation Council Agenda

M. P. Waterhouse updated that the Ad Hoc Committee met and covered the following:

1. Initial two themes were identified to guide what bills to review/support or not support -workforce, family and children.
2. The committee support the idea of working with other organizations who have the same interest in testifying for a bill.
3. For strategic planning we want start off small and do a resolution and asking different people in the state government and maybe even outside to see what we can do to have this group gathered together to improve or increase the employment of mental health workers within state government and have DRHD get involved and have them identify as being part of that work group.

Other topics for committee to discussed:
Increased mental health workforce development.
Issues or concerns regarding medical insurance

D. Discussion and Response letter from OIP

The Office of Information Practice sent a letter with attachments dated September 26, 2024. It concerns board packets and the time frame for sending them. C. Weygan-Hildebrand relayed that the letter and attachments will be e-mailed to the members after the meeting.

VII. Informational Reports by Council Members

All reports were tabled except for J. Betlach. He reported some good developments from the Big Island (Community Mental Health Center and Crisis Care System as follows:

- A psychiatrist has been hired
- Some vacant positions being filled.
- The (Kona) clubhouse is open four days a week now. There is a new hire but the clubhouse still needs to fill two vacant positions.
- The Crisis Center(?) is being worked on including the issue of getting people to go there.

VIII. Adjournment

The meeting was adjourned at 11:58 a.m.

Handouts

None

Mental Health Block Grant 2025 REPORT

Due December 1, 2024
via WebBGAS

Required Contents

Table 1. Fiscal Year 2024 Performance
Table 3. 2024 Expenditure on Child and Adolescent Mental Health
Table 6. Maintenance of Effort Level

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PURPOSE OF TODAY'S PRESENTATION

1) Present FY24 Result (in Progress)

2) Prepare for FY 26-27 Planning

MHBG Planning Years	**Performance Year**	**Performance Year**
FY22-FY23 Submitted Sept 1, 2021	Year 1	Year 2
FY24-FY25 Submitted Sept 1, 2023	Year 1	Year 2
FY26-FY27 Due Sept 1, 2025	Year 1	Year 2

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Table 1. Performance Measures

- **SAMHSA PRIORITY AREAS**
  - -Community Tenure
  - -Community Based Services
  - -Commitment to Data and Evidence
  - -Promoting Resilience and Emotional Health for Children Youth and Families
  - -Enhancing Access to Suicide Prevention and Crisis Care
  - -Integrating Behavioral Health and Physical Health Care
  - -Strengthening the Behavioral Health Workforce

Table 1. Performance Measures

HAWAII OBJECTIVES

- Decrease the readmission rate of discharged patients of HSH
- Increase the number of clients served by available community-based services
- Data infrastructure improvement to support evidence-based practices, and integrated care involving the HSH, CMHCs, CCBHC, Clubhouses, Contracted Service Providers, and Hawaii Cares 988
- Increase and expand accessibility and reduce health disparities for all youth in need of intensive mental health services.
- Ensure availability of stabilization beds.
- Expand services provided to clients to address both behavioral and physical health needs
- Have the workplace culture and workforce numbers and competencies needed to sustain the public mental health care system.

Table 1. Results

PRIORITY AREA 1. COMMUNITY TENURE

FY24: 30 discharges out of 447 discharges, 7 percent
FY23: 35 readmission our of 534 discharges, 7 percent

Achieved/not achieved FY24 target?
Not achieved. The FY24 target is 5 percent.

The story behind the number

Table 1. Results

PRIORITY 3. COMMITMENT TO DATA AND EVIDENCE

Indicator #1

AMHD is expecting to connect approximately 44 AMHD-contracted providers to AVATAR through Provider Connect NX

Achieved/not achieved FY24 target?

Not achieved. The FY24 goal was 4

The story behind the number

Although there is a delay, AMHD is back on track. As of reporting time, AMHD is expecting to connect approximately 44 AMHD-contracted providers to AVATAR through Provider Connect NX

Table 1. Results

PRIORITY AREA 4. PROMOTING RESILIENCE AND EMOTIONAL HEALTH FOR CHILDREN YOUTH AND FAMILIES

28 clients served by OT-Hawaii

Achieved/not achieved FY24 target?

Achieved. The FY24 goal is 21

The story behind the number

During FY-24, OT-Hawaii has been fully staffed with primary clinicians, a psychiatrist, a supported education and employment specialist, and a youth partner. Being fully staffed has increased opportunity for youth to receive services from OT-Hawaii.

Table 1. Results

PRIORITY AREA 5. ENHANCING ACCESS TO SUICIDE PREVENTION AND CRISIS CARE

Indicator #1

FY24 Three service areas have LCRS services.

Target achieved or not achieved?

Not achieved. FY 24 target was all four service areas.

Narrative behind the number

Oahu, Big Island and Maui had LCRS services, although Maui's eventually closed because of underutilization. Underuse is attributed to two factors – many options were opened after the Maui wildfire disaster and the provider was paid on bed use basis rather than facility basis.

Indicator #2 Being reviewed

Table 1. Results

PRIORITY AREA 6. INTEGRATING BEHAVIORAL HEALTH AND PHYSICAL HEALTH CARE

No certified CCBHC

Target achieved or not achieved?

Not achieved. FY24 target is 1 certified CCBHC.

Narrative for FY24 result

The pilot CCBHC is in Maui. The priority attention during the year was disaster response and recovery. The pilot CCBHC was started during the fiscal year amidst disaster response and recovery after the tragic Maui wildfire. The CCBHC is missing many services that are required to be certified, and these are currently being addressed through contracts and agreements. This target was not worded well. SAMHSA does not give CCBHC certification, rather the State does.

Table 1. Results

PRIORITY AREA 7. STRENGTHENING THE BEHAVIORAL HEALTH WORKFORCE

Indicator #1:
CAMHD vacancy rate is estimated at 20 percent. AMHD's vacancy rate is 36 percent.

Target achieved or not achieved?
CAMHD achieved but not AMHD. FY24 target is 20 percent vacancy rate

Story behind the number
CAMHD has a low vacancy rate because allows its staff to telework. For FY25, CAMHD's objective will be to maintain or reduce the 20% vacancy rate.
AMHD's estimated vacancy rate is in terms of FTE and budgeted positions, and included positions that it was not able to establish during the year. A reorganization is in the works.

Table 1. Results

PRIORITY AREA 7. STRENGTHENING THE BEHAVIORAL HEALTH WORKFORCE

Indicator #2:
being reviewed
Re: SAMHSA Certified TOT Trainers, or similar

Table 1. Results

PRIORITY AREA 7. STRENGTHENING THE BEHAVIORAL HEALTH WORKFORCE

Indicator #3

FY24 54 percent employed or 7 out of 13 successful trainees under AMHD's certified peer specialist program and forensic peer specialist program.

Target achieved or not achieved?

Achieved. FY24 target is 20 percent increase.

Narrative for FY24 result

This is based on seven employed out of the 13 graduates of the AMHD training.

To add to this, CAMHD graduated an entire cohort of certified youth partners. CAMHD's OnTrack Hawaii (OTH) FEP program hired a 0.5 FTE youth peer specialist who successfully completed the course to be certified as a peer specialist.

Table 3 and 6. Results

TABLE 2. CAMHD EXPENSES

FY24 Actual:	$41,726,921
Threshold (1994):	$9,816,784

TABLE 6. MAINTENANCE OF EFFORT

FY24 Actual	$ 141,543,202
Threshold to meet	$ 126,012,164

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OTHER REPORT REQUIREMENT
Uniform Reporting System
Due December 1, 2024

Hawaii 2023 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per 1,000 Population	8,253,780	6.66	24.50	58
Community Utilization per 1,000 Population	8,003,047	6.48	23.75	58
State Hospital Utilization per 1,000 Population	114,039	0.47	0.34	54
Other Psychiatric Inpatient Utilization per 1,000 Population	385,614	0.04	1.33	41

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)*	913,040	34.4%	52.6%	58
Employed (percent with Employment Data)**	913,040	14.8%	28.0%	58

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	65.3%	76.7%	50

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	70.0%	72.3%	47

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	5,594	0.0%	8.0%	44
State Hospital Readmissions: 180 Days	13,652	0.0%	19.6%	49
State Hospital Readmissions: 30 Days: Adults	5,263	0.0%	8.3%	43
State Hospital Readmissions: 180 Days: Adults	12,729	0.0%	20.0%	47
State Hospital Readmissions: 30 Days: Children	330	0.0%	5.7%	15
State Hospital Readmissions: 180 Days: Children	919	0.0%	15.8%	19

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	4,120,281	74.5%	85.3%	57
Homeless/Shelter	210,898	2.3%	4.4%	53
Jail/Correctional Facility	72,952	2.0%	1.5%	52

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	107,274	9.5%	3.3%	34
Supported Employment	77,190	-	2.1%	39
Assertive Community Treatment	86,467	-	2.3%	43
Family Psychoeducation	45,058	-	3.1%	19
Integrated Treatment for Co-occurring Disorders	239,864	25.2%	11.3%	27
Illness Self Management	362,339	-	19.3%	25
Medications Management	528,604	-	27.7%	26

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	5,202	5.6%	0.7%	21
Multisystemic Therapy	32,113	12.4%	3.5%	22
Functional Family Therapy	73,921	10.3%	8.5%	19

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	74.3%	76.5%	49
Child/Family Improved Social Connectedness	84.0%	88.1%	44

*Denominator is the sum of consumers employed and unemployed.
**Denominator is the sum of consumers employed, unemployed, and not in labor force.

What next?