**STATE COUNCIL ON MENTAL HEALTH (SCMH) MEETING**

February 11, 2025 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

**APPROVED MINUTES**

*Members Present:* Katherine Aumer, John Betlach, Tianna Celis-Webster, Jon Fujii, Heidi Ilyavi, Jackie Jackson, Kathleen Merriam, Ray Rice, Asianna Saragosa-Torres, Mary Pat Waterhouse, Forrest Wells

*Members Excused:* Naomi Crozier, Lea Dias, Christine Montague-Hicks, Kristin Will

*Staff Present:* Chanel Daluddung, Belinda Danielson, Carolyn Weygan-Hildebrand, Madeleine Hiraga-Nuccio, Mark Linscott, Richalle Patague, Darryl Tanaka, Jocelyn Nazareno, , Valerie Yin

*Guests:* Peter Fritz, Raelyn Yeoman

**I. Call to Order**

Katherine Aumer, chairperson, called the meeting to order at 9:06 am and quorum was established.

**II. Announcements**

K. Aumer welcomed members and guests. She announced the following protocols:

- In case of communication technology-related interruption that could not be restored in 30 minutes, the meeting will automatically be terminated and resume on February 18th, 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.

She also had the following additional announcements:

- Sunshine Law, meetings and agenda. The Office of Information Practice (OIP) advised to cancel the January meeting after a brownout at the meeting's designated physical site. That is because the brownout could potentially exclude members of the public who planned to attend via said site. The OIP also opined on February 7th meeting of the Ad hoc Committee on 2025 Legislation, specifically that the Committee should only consider discussing agenda items that were sufficiently described in the public notice and agenda. Some of the bills were deemed not sufficiently described. The Committee discussed only the bills that could be considered adequately described.
- Membership. There are five nominees whose nominations were up for advise and consent. Three are Council members namely Forrest Wells, TiannaCelis-Webster, and Asianna Saragosa-Torres. The two others are for service area boards namely Jacquie Esser for Oahu SAB and David Litman for Maui SAB . For those on this list, the next announcement will be coming from the Senate Health and Human Services for advice and consent hearings. The

Council vacancies remain the same as last month. An SCMH brochure is in the works to help with applying.

- The 2025 SCMH Report to the Governor and Legislature was submitted but has not been uploaded on the website including the SCMH website.

**III. Approval of Minutes**

The October 14, 2024 minutes was table.
Mary Pat Waterhouse moved to approve the December 10, 2024 minutes. Heidi Ilyavi seconded.
Motion passed.

**IV. Community Input**

Raelyn Yeoman offered the following input (paraphrased):
"Back on October 10, 2023, Dr. Luke from the Hawaii State Hospital (HSH) gave a presentation on HSH to the Council. He expressed his concern that the hospital was again getting overcrowded and having issues. He was around when the Feds came in and investigated the HSH conditions. He was concerned that it was slipping back to where it was then. One of the issues is the Patient Protection Committee, which was put into place at the HSH under the federal consent decree at that time. It is a third-party committee that investigates or hears complaints from people at HSH. (At presentation time), Dr. Luke acknowledged the disbandment of the Patient Protection Committee. I expressed concerns at the State Council meeting that if we are overcrowded again, there is a need to have it put back. Dr. Luke said he would look into it. The Patient Protection Committee is not back. So, I think it needs to be brought to light that we have an overcrowded hospital and a bill in the legislature asking for 8 million dollars to fix issues like molds and dampness. I think a Patient Protection Committee is needed a.s.a.p. So, I just wanted to bring that up because this Council heard it. The October 10, 2023 Council meeting recording is available. I suggest that it be heard. It was eye-opening, and Dr. Luke was very open and informative. I appreciated that when he showed up."

Mark Linscott, the new administrator for HSH, addressed the community inputbut it was actually going to be part of his presentation anyway (paraphrasing): "One of the things we are doing is going back to the basics in terms of making sure that we're providing patient rights and advocacy. One of the areas that the Hospital has been lacking is having the patient rights advocate position filled, so that's in process. Once the position is filled, we intend to bring patient/family-centered care, including the community, into the programming piece. The Hospital does a great job despite the increase in patient census. We achieved our 3-year accreditation from the Joint Commission. We had an auditor review us. There were some findings; some were high, but many were low; there was no pattern, and we will address those. So, from that perspective, we are doing quality care. The areas that we have to get better at are getting back to basics, getting involved in the community, and getting advocacy into the Hospital so people can see that. Overall, we are working on reducing our overcrowding issue partly because we need to do advocacy. We have patients who are frail and elderly who are stable now, and their primary diagnosis is for daily living activities, long-term care, or skilled nursing that don't need behavioral interventions. These are some of the areas that we need to address with our sister hospitals in the State. We are also working with our legislators and other folks in the Department of Health to help with the ACT 26. So, in the

last 2 years, we have increased census by 20% yearly with that specific bill. We have the highest admission level from the previous 2 years partly because of that bill, partly because of the COVID pandemic, where people weren't assessed in the community or at the jail houses. All cases were sent to the Hospital. I think this Council needs to understand that our assets must be utilized appropriately, and that's one of the biggest challenges. So, along with the advocacy with the community, we must ensure we all understand that we are putting costly resources into getting folks the treatment they deserve. That's what we can do here. If they need criminal confinement, we need to support Corrections to ensure they are criminally confined. That's the distinction because not all mentally ill are violent criminals, and the same thing applies to criminals; if they are criminal-minded, they need to be at OCCC."

## V. New Business

### A. Presentation "Meet and Greet, Hawaii State Hospital Update" Mark Linscott

Mr. Mark Linscott is the new administrator for the Hawaii State Hospital.
See summary of presentation via attached slide presentation

Q&A, Discussion.
Q. What can the Council do to advocate or to look at what gaps in the continuum of care need more focus? What do you see as the highest need that we can try to focus on opening up that access to start helping get some of those people out of the hospital and back to the community? Is it a partial hospitalization level of care for adjudicated individuals or an intensive outpatient? What is your view to help that process?
A. The answer to all of that is all of it. Because you need a multiprong approach. We have to focus because we can't do it all the time. What could we do?

1. We had all of the state judges tour the hospital, which is essential because they need to see the patients they ordered to the hospital and how they are doing or not doing. This is step one.
2. Step two is the public defenders because as soon as someone presents to them in the jail cell, they are going to say they are going to say this person is exhibiting mental health issues. Still, they don't understand the rationality behind it. Are they high? Are they intoxicated? Other things need to be taken care of before we can diagnose them and assess the mental illness. The public defenders ultimately go and say that if patients exhibit mental illness, they need to be sent to the state hospital. That door has to change because that may not be true. They could be in detox. We need to do different things in the correction system, and they have the resources to do it; we need to make sure people understand that and get the patient's help. Having more of that crisis team is a mobile repose team, and I think that needs to come back because we have multiple factors here: there is homelessness, there is mental illness, there are medical necessity needs, and you have the complexity of mental health and addict on top of that. So we have to do better there, and I think that's the role of this Council and others, as well as the BHA under Marian and Dr. Fink for the Department of Health. We are here to help our patients and have to do a better job; it's not just corrections. We have to change the way we think about mental health and addiction.

Q. I know preventative is the first step, but we have that 80% there that can ideally start to transition out, so what is the best first step for that population to get back into the community? Would it be partial hospitalization? Would it be intensive outpatient like a hospital stay, doing day treatment 3 days a week? What could help the initial bridge of that gap?
A. The biggest challenge is placement. We have those programs that allow people a second chance; we have IOP. So, what we are battling here is a social stigma that "I was at the State Hospital, oh, what does that come with"? Even the criteria to say this person is stable, non-violent, has been here for years, they are ready to reintegrate, we need to be able to figure out where to place them and have them serve their best life there. And supporting those chances in transitions is the biggest challenge, I would say. We have the programs. We need to extenuate and make it happen. I think IOP is a great program. We have that and SORP; frankly, I would like SORP across the island chain. It's a locked facility, a licensed, and there is programming where you can divert patients from going into the highest level of care to actually being in the community where they came from.

Q. Are you also having problems with finding beds?
A. Yes, part of it is we have a state hospital system. The HSH is more like our state hospital system. Yes, we are a specialty hospital, but we act more like any other medical specialty hospital, and those are areas where we can move some of our patients—especially those in Unit I, where they could be cared for in a long-term skilled nursing facility. We will support people; we have 24/7 psychiatry on campus, doctors on campus, and a host of people willing to help? The other piece to Forrest's point is that a? long-acting injection as appropriate? would be a promising intervention here because you get the stabilization from the mental illness.? After all, they are in treatment, they're taking their meds, and they can be productive.

Q. What kind of regulation is there for individuals sent out of state in terms of a higher level of care? How are they overseen? What is the management approach there?
A. We have a contact on the mainland for some of our challenging (ones); it's interesting because it's all relative. You talk to the actual facility in South Carolina. They think our patients do better, and partly, it is because of the environment that they are in; they can be locked down 23 hours a day. If you think, this is the criminal confinement model. It's not behavioral health. Or through our patients here in Hawaii who are in that institution and are doing better. So, out of all the violent crimes of criminals in mental health from the mainland perspective, or at least that facility, our population tends to do better. And so, when we have to be released and reintegrated, although that's a challenge for us because we got to receive them, they do well in those specialized programs that we couldn't provide as a general psychiatric hospital. We still have to look at those because there will always be a percentage of patients who will not get out of HSH. That's a given. But then, how do we ensure that the right programming for those individuals is done?

**B. "Department of Health Adult Mental Health Division Housing Guide" presented by Belinda Danielson**

Belinda Danielson is the AMHD PIER Community Services Coordinator.
See summary of presentation via attached slide presentation

Q&A, Discussion.
Q. If you had to have look at it and see if it was at the lower level of care or high level of care, where do you think there would be addition need for an extra level? If you were able to add a 4th level of assisted housing, would it be at that lower level of transitioning out or would it be at that higher level maintaining and trying to bridge between inpatient hospitalization or HSH. What side you see the greatest need?
A. I will say all. However, there are special population that we are not meeting the need for right now and that's the level of care between our extended Arch Homes and inpatient. So, it's that Arch level of care that, unfortunately, in our State, only takes private pay. So our health plans aren't paying for that. So, it's the folks that need additional assistance with activities of daily living but have enough independence that they can be in the community in and be active. It's that level of care that we are struggling with. Because if we do the 1147, they are not going to meet the E-Arch level of care and they are not going to have enough money to pay for this private payor or compete with private payors in that Arch level of care. In line with that is our 24 -hour group homes who have those who are struggling with their ADLs. Like, they can't completely do all the activities but we have support from MedQUEST, where they can have chore workers who can step in and help. We don't have that ability to use those folks in our group homes.

Q. The Governor has the push for "Housing as Health Care", Do you think it would be helpful if the Council would look at the possibility of the Legislature being able to identify that those level of care could be covered through Medicare, Medicaid, or other insurance providers?
A. Absolutely, I cannot speak to why there's health plans or even Medicaid or MedQuest that cannot pay for Arch Level. I can't speak to that but just know that's a huge gap.

Q. Is there anything that can be done? Would it take legislative action for something? What would be the appropriate way to help fill that gap?
Discussion from K. Merriam: I do think we should make this a priority. I did mention Supportive Housing to this group before. I would really like to see this as one of our focuses because it takes money. I think it takes legislative movement. I think that the stabilization units also don't house people. We don't use that for housing but it's a place to stay and even those places do not accept people with just a simple walker. I'm just use to places saying no. So, I think if we are going to advocate places that says Yes because they know our people, people with severe mental illness often having a physical problem. We must have more housing and that's going to take funds. So, I would like for us to have a plan for that. One last comment is about the waiting list. I didn't hear about that but the last referral I was a part of, I was told that the client is 79.
A.That is correct. The inventory is an issue. Maybe legislation can help with this. One of the things that we are finding is the higher cost of living and housing. A lot of our providers have had increases in their rents by landlords. That's been the challenge where they cannot stay with the reimbursement that we provide to them. They cannot sustain the leases that they have. So AMHD is trying to find creative ways. like maybe we must go

into the rental business or leasing of these homes and in turn lease it out our providers so we can take the brunt of the cost from our providers.

Q. A lot of the Group homes are not getting paid via contract? I am wondering if they were starting to get paid.
A.The contract issues have been resolved and payment should going out for the contracts.

Q. Do you know what was the delay?
A-We have only one person in our contracts department. So, it was a staffing issue.

Q. Is there a way to provide the Council with the inventory of housing statewide and see the ongoing waiting list?
A. I will work on that inventory. I will have Erin (Snyder) put the information together.

Q.What is the bed rate person for the 3 levels of housing?
A. This will be added to the information.

**A. Nomination – 2025 Officers**

Chair Aumer reminded that the Council Bylaws provide for an annual election of Council Officers. The nomination is open for the four positions and the election will take place next meeting. No nominations were made on the floor. All were encouraged to send their nominations to C. Weygan-Hildebrand before next meeting.

## VI. Old Business

**A. Presentation in December–**

Chair Aumer recalled for all that Dr. Chris Knightsbridge came before the Council last December. He brought to the Council's attention a need for a supporting letter for a grant. K. Aumer offered to get further information about the grant/s from the UH Manoa study proponents. F. Wells moved to support the writing of a thank you letter. H. Ilyavi seconded. The motion passed.

**B. 2025 Legislation Council Agenda**

Before the discussion of bills and resolution proceeded, Committee chair, Mary Pat Waterhouse, requested a motion to create a negotiating Permitted Interaction Group who will work with staff to finalize testimonies based on votes and discussion of the Council. The PIG members will have six members namely K. Aumer, M.P. Waterhouse, Tianna Celis-Webster, Jackie Jackson, Kathleen Merriam, and Heidi Ilyavi. The motion was moved by K. Aumer and seconded by J. Betlach. The recorded votes in favor include K. Aumer, J. Betlach, T. Celis-Webster, J. Fujii, H. Ilyavi, K. Merriam, A. Saragosa- Torres, M. P. Waterhouse and F. Wells.

M. P. Waterhouse introduced the agenda by stating that the bills will be covered along the following priorities: The first set of bills to be prioritized are those that were discussed by the ad hoc committee and still alive at the Legislature. The second to be prioritized are

bills that have not been discussed by the ad Hoc committee but are still alive at the Legislature. Each bill was presented by the assigned ad hoc committee member.

The following were the motions and discussion points on the following bills or their companion bills:

SB1442/HB1123. J. Jackson motioned that the Council provide a testimony in support. H. Ilyavi seconded. The motion passed with no registered objection from any member in attendance.
Discussion:

- The key word is "current" especially as many things have happened impacting mental health. CAMHD works closely with youth, and from a more trauma-informed and coordinated system of care.
- Much of the bills is changing the language, e.g. adolescent instead of youth, addition of trauma-informed care, and others.
- The bill also codifies CAMHD's strategic planning.

HB842 /SB87. K. Aumer motioned in support. J. Betlach seconded. The motion passed with no registered objection from any member in attendance.

SB482/HB700. H. Ilyavi motioned for the Council to provide comments only. T. C Celis-Webster seconded. The motion passed with no registered objection from any member in attendance.
Discussion:

- The Council can support that the measure is in good faith.
- There is concern about the ability to get it done.
- The Council can encourage more education as a way of increasing access rather that mandating the assessment.

SB1448/HB1129. H. Ilyavi motioned for support. J. Betlach seconded. None opposed.

- The problem is with the new building and $8.16M is being asked to remedy deficiencies.

SB361SD1/HB280. J. Betlach motioned for support. F. Wells seconded. None opposed.

- A lot of offenses happen among the homeless. Not having a home address complicates among other things and escalates issues.

HB943/SB1628. J. Betlach motioned for support. F. Wells seconded. None opposed.

- This helps. Any triage that will keep individuals with mental illness from escalating their condition and need for higher level care.

HB212/SB360. K. Aumer motioned to comment only. ___seconded. The votes were 7 ayes, 1 abstain. Three have left the meeting this time.

- The Council appreciates the heart of the bill, but it cannot be a "Send them home" only bill. Families can be complicated. There is a need to know how many stays reunited after initial reunification.
- I.H.S. has this program and send only if they get hold of family.
- It is important to have a soft hand off to family members. There must be something on the other side, not just putting them on the plane.
- Some will say "no". Some of them are newly diagnosed (went missing).
- More information is needed. If they want to be reconnected, it should be decided not only by the legal process if they should be sent back.
- Our local island capacity is beyond overwhelmed. Providers see new faces every winter, but must remember what they are limited in what they can take in.
- Some of the new faces are the lost, confused, and it is good to help make it home again for first-time diagnosis people.
- Aside from the focus on returning among those who have already come here, one also must figure out preventing those coming here.
- This must make sure that we are not replacing one bad situation with another. It is a potential strategy if fully voluntary and with adequate support.
- There is need to see data for efficacy, follow up how to improve.

HB1079/SB1398. J. Jackson/T. Celis-Webster moved to support. J. Betlach seconded. No objection or oppose recorded.

HB1079/SB1398. K. Aumer moved to support. J. Betlach seconded. No objection recorded.

- This is a pilot to gather data. The original target was Maui.

HB1105 /SB1424**.** J. Betlach motioned for support. F. seconded. No objection or oppose recorded.

- This is a pilot. The concerns are about providing funding for pilot then no follow-up.
- A transition plan should be included after the pilot study, including funding for the future if it works.

SB1444/HB1125. F. Wells motioned for support. K. Aumer seconded.

- This sits in line with anything discussed on gaps and needs. We do not know how far it will go.

HB 1462. Members decided to circle back on this and discuss further.

- There is need for one in West Oahu but no data to support.
- There is need for best practices. Most folks in West Oahu go to the Waianae Coast Community Comprehensive Health Center.
- Iwilei BHCC just started. There has been on and off use, and, and not substantially used yet and need a lot of adjustments yet (e.g., There is issue with the HPD/Service Provider not knowing if the patient should go to the BHCC or to the emergency department. It is limited but needed.

At 12:01, Chair Aumer asked if the meeting can be extended to another 10 minutes. No one objected.

SB451. Move to next meeting. There is sentiment for this bill but there is a need to hear more from L. Dias and J. Fujii.

HB1124/SB143.. J. Betlach moved to support. K. Aumer seconded. No objection nor oppose recorded.

- Mark Linscott mentioned this bill. It would help those people under the custody of DOH/HSH.
- Other facilities' rates have increased for a while now at 3x their original rate (e.g., $800 to $2,200, otherwise the facility could not operate).

**VII. Informational Reports by Council Members**

All oral reports tabled.

**VIII. Adjournment**

The meeting was adjourned at 12:10 p.m.

## Handouts