**STATE COUNCIL ON MENTAL HEALTH MEETING**
**DRAFT MEETING MINUTES**
**Tuesday, February 10, 2026, 9:00 a.m. to 12:00 noon**
**Via Zoom with in-person location at**
**Hale F Conference Room, 2201 Waimano Home Road, Pearl City, 96782**

*Members Present:* Katherine Aumer (Chairperson), Kathleen Merriam, Forrest Wells, Mary Pat Waterhouse, John Betlach, Jon Fujii, Heidi Ilyavi*, Jackie Jackson, Christine Montague- Hicks, Kristin Wills, Tianna Celis-Webster.

*Members Excused*: Lea Dias, Ray Rice, Marian Tsuji (ex officio)

*Member Absent*: Asianna Torres-Zaragosa

*AMHD staff:* Carolyn Weygan-Hildebrand, Courtenay Matsu

*Guests:* Raelyn Reyno, Cindi Dang, M. Squirrel Celeste, Judy Steinman.

## I. Call to Order

Katherine Aumer, Chairperson, called the meeting to order at 9:07 am. Quorum was reached at 9:17 a.m.

## II. Announcements

- Meeting protocol – The Council will meet on February 17 if an audiovisual communication break cannot be resolved within 30 minutes.
- Events – The National Council for Mental Wellbeing National Conference (NATCON) will be April 27-29, 2026, in Denver, Colorado (nationalcouncil.org). As Hawaii moves toward the Certified Community Behavioral Health Clinic (CCBHC) model, this conference is relevant to the state planning council.
- Membership – No changes, but the Governor is expected to nominate for the upcoming Senate advice and consent.
- Ex officio message – Courtenay Matsu, acting ex officio member, reported that many legislative bills are being tracked.

## III. Community Input

## IV. Approval of Minutes

Tabled

## V. New Business

### *A. Presentation*

"*Mental Health Holds and the Mental Health Court*"
By Kristin Will, Hawaii Mental Health Court Coordinator
Please refer also to the PowerPoint Slides and the List of MH codes.
This presentation covers the Mental Health Court and the process for mental health holds in the specialty court system. K. Will explained that the program serves individuals with mental illness in the criminal justice system by emphasizing treatment, structured supervision, and collaboration with service providers instead of incarceration. Participants appear in court regularly and work with probation officers, case managers, and treatment teams to follow individualized plans for stabilization and recovery. The program maintains smaller caseloads (about 35–40 participants) due to the intensive supervision and engagement required. The court prioritizes community and participant safety, working closely with providers and families to stabilize individuals in the community whenever possible. Hospitalization may be considered if individuals stop taking medication or engage in behaviors that pose safety risks, but it usually involves judicial review and is used only when necessary. MH provisions allow authorized stakeholders such as probation officers, treatment providers, and attorneys to request psychiatric evaluation or hospitalization for individuals on Conditional Release (CR) when they appear dangerous or are experiencing significant mental health decompensation. The process usually begins with a treatment team letter or affidavit, signed by a licensed prescribing mental health professional, which triggers a court review. Probation officers collect verified information from treatment providers and present it to the judge, who decides whether to authorize hospitalization or further evaluation. Wills also described the different tracks in the mental health court program, which categorize participants by legal status and pathway into the program. Track 4: Individuals facing probation revocation, often considered a final opportunity for treatment through specialty court before possible incarceration. Track 2: Previously used for jail diversion cases involving first felony offenses with a possible deferred acceptance of guilty plea (DAG), now largely redirected to other diversion programs. Track 1: Rarely used, generally associated with misdemeanor-level cases that may also qualify for jail diversion.

Q. Of the program census of approximately 35–40 participants, about five are currently in jail, and two are on the run.
A. The program census fluctuates, and mental health court programs intentionally keep smaller caseloads because they require extensive supervision and engagement. Participants attend court frequently and receive ongoing support from probation officers and case

managers. At times, some participants may be temporarily incarcerated or unavailable due to violations or other circumstances, which affects the census numbers.

Q. How does the specialty court work with individuals to achieve positive outcomes while maintaining community safety?
A. Kristen explained that the specialty court model relies on collaboration between the court, probation officers, case managers, and treatment providers. The team works with each participant to create a structured treatment and supervision plan to stabilize the individual in the community. Hospitalization is considered only when safety concerns arise or when individuals stop taking medication or engage in risky behaviors.

Q. The presentation suggested that specialty courts partner closely with individuals to ensure a hopeful outcome, and many people may not realize how invested the court is in supporting both the individual and community safety.
A. The observation was acknowledged. It was reiterated that the program focuses on collaborative engagement and recovery planning. Court staff work closely with participants and service providers to support stability, treatment compliance, and reintegration into the community, while ensuring public safety remains a priority.

***B. Review of 2026 Legislation***

Chair Aumer led the discussion in the absence of the Committee chair, M. P. Waterhouse. Bills that already had a legislative committee hearing or were scheduled were discussed first. The Council votes on a position on a bill (testify, in support or opposition, or with caveats). Any testimony will be in accordance with the Council's vote. A negotiating Permitted Interactive Group (PIG) will be involved in finalizing the testimonies to be submitted.

*HB1854 – Establishment of a State Certifying Office for Community Behavioral Health Clinics (CCBHCs)*

The bill seeks to establish a State certifying office for CCBHCs. Certification is required to receive enhanced Medicaid payments. Hawaii's planning efforts have included a rate study.
Motion: Heidi Ilyavi moved to support; Forrest Wells seconded.
Vote: Unanimous support. No abstentions.
Notes: The Council strongly supports CCBHCs. Testimony will focus on the section on Council composition and requirements, which should be consistent with the current law.
C. Matsu stepped out during the discussion of this bill.

*HB1704 HD1, SB2080, and other PsyPACT Bills*
These bills seek to adopt the Psychology Interjurisdictional Compact, allowing more licensed professionals to practice in Hawaii and expanding access to services.
Motion: Forrest Wells moved to support the intent; Heidi Ilyavi seconded.
Vote: J. Fujii abstained; all others in support.
Concerns: Cultural sensitivity, potential impacts on local providers, fee schedule consequences, credentialing burdens on insurers, and increased system costs that may require out-of-pocket payments.
J. Fujii stepped out during the discussion of this bill.

*SB787 – Warm Line Appropriation*
Motion: K. Will moved to support; J. Fujii seconded.
Vote: Unanimous support; no abstentions.
Notes: Hawaii currently has a significant gap in warm-line services. United Self-Help previously provided this support, which helps reduce strain on the 988 crisis line and emergency hotlines.
F. Wells stepped out during the discussion of this bill.

*HB1537 Appropriate funds to contract with community-based organizations*
Motion: Forrest Wells moved to support the intent; K. Wills seconded.
Vote: Jackie Jackson abstained; all others in support.
Notes: DOE has a contract with Hazel Health. Additional resources are beneficial, but integration is needed so that services for ages 18–25 sit within a unified program alongside rest-stop services. Many bills focus on adolescents, and if all were funded, they could compete with one another. Provider capacity and careful appropriation remain key concerns.

*HB2157 – Behavioral Health Complex Patient Model*
Motion: F. Wells moved to support; J. Betlach seconded.
Vote: No votes against or abstentions.
Notes: A much-needed solution.

*HB2288 – Re-entry Support*
Motion: J. Betlach moved to support; K. Wills seconded.
Vote: F. Wells abstained; all others in support.
Notes: Supports re-entry and encourages participation; jails aim to revamp and work collaboratively.

*HB2258 – Expansion of Telehealth Services*
Motion: J. Betlach moved to support; J. Jackson seconded.
Vote: J. Fujii abstained; all others in support.
Notes: Caveats were raised regarding validation of services, licensing (including Medicare requirements), and the need to address coverage of opioids and other controlled substances.

*HB1562 – Digital Health*
Motion: F. Wells moved to support; J. Betlach seconded.
Vote: Unanimous support; no abstentions.
Notes: This topic has been previously discussed.

*SB2089 – Payment System Changes (PPS)*
Motion: F. Wells moved to support; J. Betlach seconded.
Vote: No votes against; J. Fujii abstained.
Member excused from discussion: F. Wells.
Notes: The bill does not expand services but modifies payment structures under PPS. Providers may receive significantly increased payments contingent on delivering full wraparound services. Oversight, monitoring, and clear supervision standards are essential to prevent abuse or fraud.

*SB2307 – Volunteer Clinical License for Active Retired Clinicians*
Motion: J. Fujii moved to support; J. Betlach seconded.
Vote: Unanimous support; no abstentions.
Notes: Allows retired clinicians in good standing to volunteer without maintaining a full license.

*SB2287 – Protection of Peer Support Specialists in DCR*
Motion: F. Wells moved to support; J. Betlach seconded.
Vote: Unanimous support; no abstentions.

*SB708 and HB2169; SB847 –Prescriptive Authority, Practice at FQHCs*
Notes: SB708 and HB2169 are not being pursued. SB847 would allow certain clinicians to train and work at FQHCs under defined protocols, focusing on specific opioids. Broader prescribing authority is not the focus of IGBLL at this time.
Member excused for discussion: J. Steinem.

Motion:
– J. Betlach moved to support. No one seconded. The motion died.
–Other motions not supported. There was consensus not to provide testimony.

Notes: The bills are compelling for neighbor islands facing psychiatrist shortages. Many clients have complex co-morbidities and require medical doctors. These measures may serve as a starting point, with continued program improvements needed. There is a need to review the requirements and the drugs covered. Individual members may testify independently.

*SB3160 / HB2340 – Continuation of Funding for the MauiWES Study*
Motion: F. Wells moved to support; K. Merriam seconded.
Vote: Unanimous support; no abstentions.
Notes: Support is for intent; staffing improvements recommended.

*SB3199. Emerging Therapy Task Force*
Motion: J. Betlach moved; F. Wells seconded.
Vote: Unanimous support; no abstentions.
Notes: The Council has heard presentations on emerging therapies. Some are being used and tested. It will be good to have a body that can lead to a review of evidence on whether they are effective.

*HB2570 – Gambling Disorder Resources*
Motion: F. Wells moved. J. Betlach seconded.
Vote: Unanimous; no abstentions.
Notes: The position of the Council is not whether gambling should be legalized. Its focus is on the importance of problem-gambling prevention and resources for it.

*HB1876 – Conversion Therapy*
Motion: F. Wells moved to support; K. Merriam seconded.
Vote: Unanimous support.
Notes: Conversion therapy is already not considered a standard practice. This bill aligns with existing standards.

Not all bills on the agenda were discussed due to limited time and prioritization.

**C. Identification of additional bills for future discussion**
More bills can be identified in March because of limited time.

**VI. Old Business**

Tabled

**VII. Members' Reports**

Tabled

**IX. Adjournment**

K. Aumer thanked everyone for staying on. Meeting adjourned at 12:05 p.m.

# Mental Health Unit -First Circuit Court

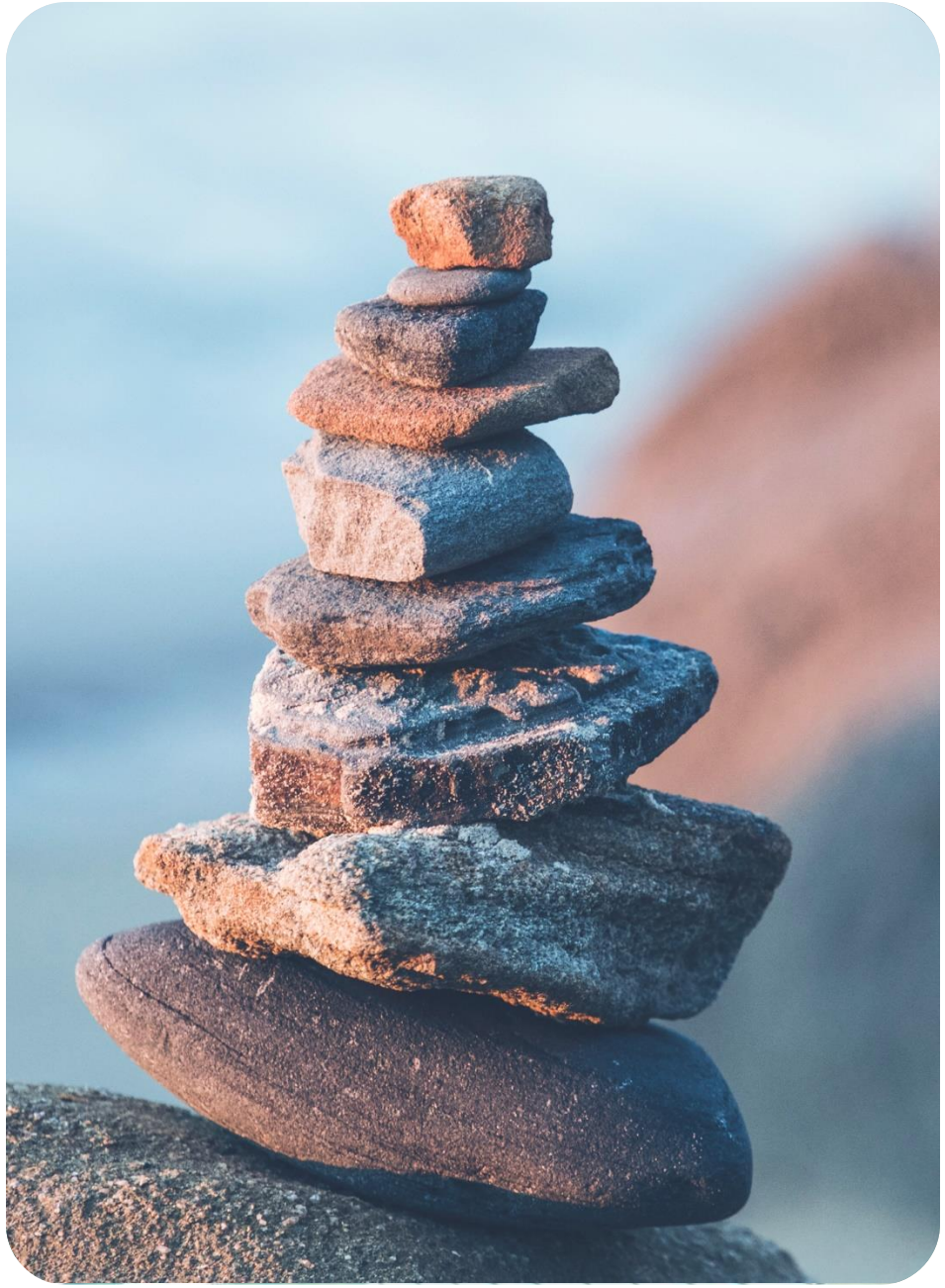
Presented by Kristin Will

# Agenda

1. Introducing yourself
2. Mental Health Unit
3. Mental Health Court
4. Conditional Release
5. Q&A

# Mental Health Court

Ending the cycle of recidivism for persons with serious mental illnesses by means of treatment accountability and intensive monitoring



# What is Mental Health Court

- Intensive Supervision of offenders with a serious and persistent mental illness

- Working collaboratively with community providers to provide supervision and effective treatment options

## How do I know if my client is appropriate for MHC

# Eligibility Criteria

Adults with a Serious and Persistent Mental Illness as the primary diagnosis that contributes to their functional impairment

Wants to participate

Minimal history of violence

Fit to proceed

# Referral Process

Referrals are initiated by the defense attorney

Forms to complete

Assessment

Team decision

# How is Mental Health Court different from regular probation ?

- Mental Illness is getting in the way of compliance
- Progress is determined by each individual’s condition and behavioral changes
- Supervision is designed to reinforce treatment
- Team support and approach

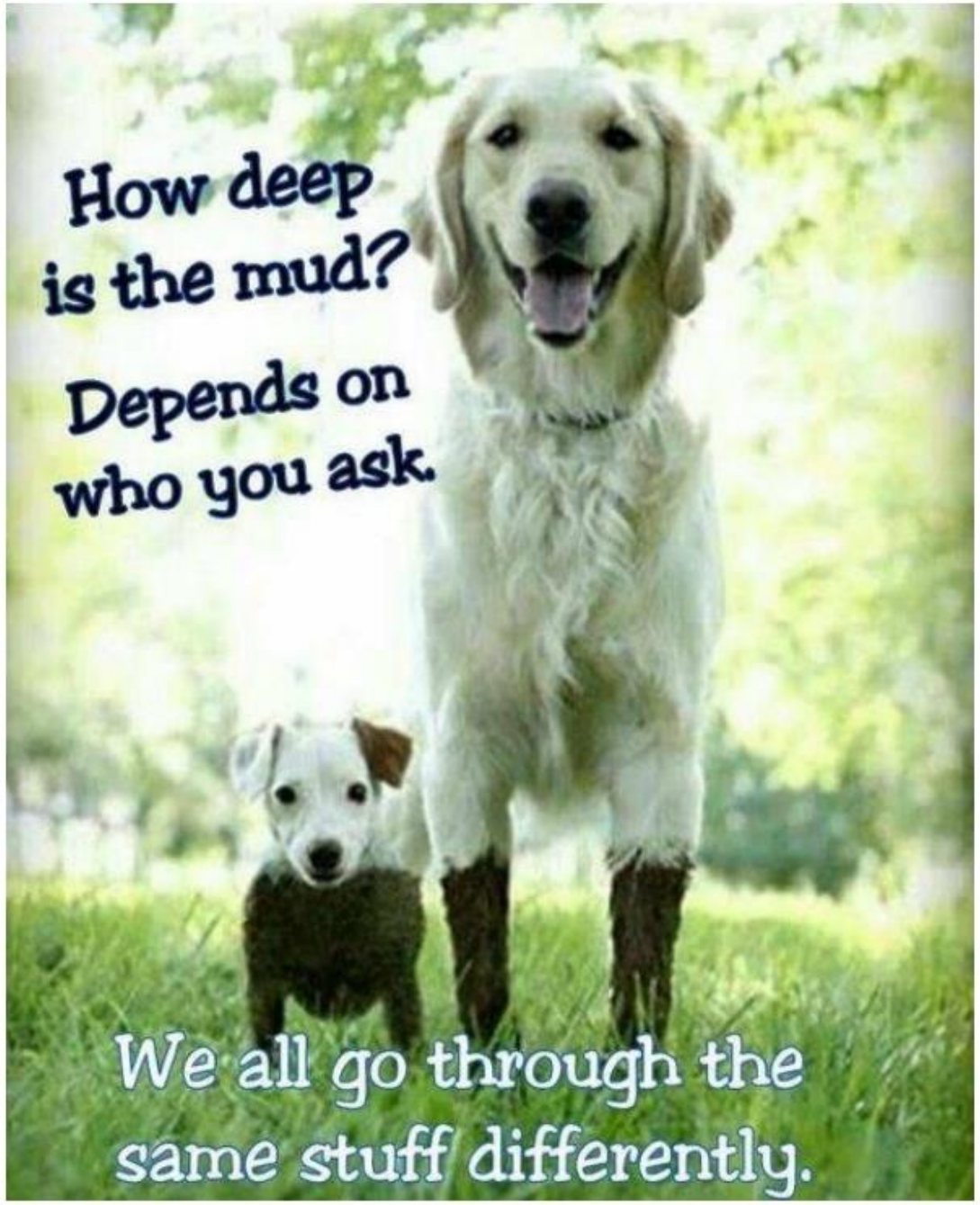
# How To Deliver Effective Responses

## A Magic Formula for Learning Opportunities:

- Identify behavior to be rewarded/ punished.
- Tell person specifically **WHAT** behavior you liked/ disliked.
- Tell the person **WHY** you liked/ disliked it.
- Discuss short and long-term costs/ benefits of the behavior? (**HOW** it effects goals?)
- Pair the approval / disapproval with the **RESPONSE** (incentive / sanction).

# Praise and Social Approval

- Never underestimate the redemptive value of the relationship.
- Praise is free, easy to administer, unlimited in supply and powerful.
- Can be used immediately


How deep is the mud?
Depends on who you ask.
We all go through the same stuff differently.


My paws are frozen!
Man, I wish that was my only problem!

P

## Mental Health Law Forms:

**MH-1** Filled out by police if they see a person who needs help and bring him/her to a hospital for emergency examination.

**MH-2** A licensed physician, psychologist, attorney, member of the clergy, health or social service professional or any state or county employee in the course of his employment may apply to the court for an ex parte' (one-sided) order directing that a police officer or other suitable individual take a person into custody and deliver him to the nearest facility designated by the director for emergency examination and treatment.

**MH-2a** Court order authorizing examination (done after the petition is completed).

**MH-4** Filled out by physician after a patient is brought to the hospital (commonly brought to the hospital on an MH-1 or MH-2); usually to the ER. 48 hour emergency commitment.

**MH-4a** Patient rights after MH-4 is completed.

**MH-5** Voluntary admission form signed by adult patients on admission. When an individual commits themselves on their own free will. A private doctor will evaluate the patient and then determine if the individual needs inpatient treatment. If the individual cannot sign the commitment forms for treatment, they will be treated as an involuntary patient for the protection of the individual and the hospital.

**MH-5a** Voluntary admission form for minors done at the hospital. Family Court sends an officer to sign the patient in once the patient is in the hospital.

**MH-5b** Patient rights after the patient is admitted voluntarily.

**MH-6c** Petition for involuntary commitment. Doctor completes this form on H.S.U. (Human Services Unit) commonly after the 48 hour time period expires on the MH-4 and the patient continues to show signs of dangerousness to self or others and is in need of treatment for mental disorder. A hearing must be held no later than 10 days from the date that the petition is filed. Lawyers for the defendants are commonly from the Public Defender's office. Hospital staff or doctors may also be represented by legal counsel. Witnesses and evidence is presented at the court hearing on the hospital grounds. Maximum confinement is 90 days, and extension can be granted following another court hearing. The patient may be involuntarily treated during this period prior to the hearing.