

**REPORT TO THE TWENTY-FOURTH LEGISLATURE  
STATE OF HAWAII  
2008**

**PURSUANT TO SECTION 334-10 (E), HAWAII REVISED STATUTES, REQUIRING  
THE STATE COUNCIL ON MENTAL HEALTH TO SUBMIT AN ANNUAL REPORT  
TO THE GOVERNOR AND THE LEGISLATURE ON IMPLEMENTATION OF THE  
STATE PLAN**

**STATE OF HAWAII  
DEPARTMENT OF HEALTH  
October 2007**

**HAWAII STATE COUNCIL ON MENTAL HEALTH  
ANNUAL REPORT TO THE GOVERNOR AND LEGISLATURE**

Legislative Session 2008

**State and Federal Mandate**

This annual report is in response to HRS 334-10 (e): “The Council shall prepare and submit an annual report to the governor and the legislature on implementation of the statewide comprehensive integrated service plan. The report presented to the Legislature shall be submitted at least twenty days prior to the convening of each regular session”.

Under federal mandate (P.L.102-321, Sec. 1914, State Mental Health Planning Council), the State Council on Mental Health (SCMH) is required to review plans and submit recommendations for modification, and monitor and review annually the allocation and adequacy of mental health services in the State. States are also required to review the implementation of the State Plan.

**SCMH Response to Federal Mandate**

In August 2007, the Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Division (CAMHD) solicited the SCMh’s review and input on their respective State mental health plans. At that time, the SCMh provided advisory comments and recommendations for the AMHD and CAMHD State Mental Health plans. The SCMh’s comments and recommendations included:

1. State Comprehensive Integrated Service Plan:  
*Adult Mental Health Division*

“The Council commends the Plan’s continued focus on effective discharge planning and case management. Continued close attention and commitment to individualized recovery plans that emphasize the strengths, needs and culture of each consumer is recommended. We acknowledge the follow through in commitments as narrated in the State Plan by broadening the core services.”

2. Children’s State Mental Health Plan:  
*Child and Adolescent Mental Health Division*

“As this Division is facing the prospect of a new Chief, the Council recommends that past progress achieved under its last leader be continued and enhanced by the State Plan.”

3. Overall Recommendations:

Although acknowledging the difficulty of recruiting adult, child and adolescent psychiatrists, the Council indicated that, “The hiring of additional psychiatrists for both Divisions is strongly recommended, especially in rural areas.”

“As a whole, the State Plan ties performance indicators to core services, showing commitment to implementing comprehensive services throughout the State as it broadens the voice of consumers on each island. However, the Behavioral Health Administration needs to continue to become more inclusive of the communities it serves and work on fully integrating consumer/family involvement at all levels of government.”

### **Federal Mental Health Planning Directions**

In October 2007, a SCMHS representative to the annual Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), National Community Mental Health Block Grant Planning Conference reported to the Council membership on the following:

- The importance of implementing the New Freedom Commission’s Goals to Transform Mental Health in State Plans.
- States will need to share information between departments to decrease fragmentation and duplication; even to the point of changing laws to transform the system.
- Without a single source of information, it will become increasingly difficult to secure federal funds. Thus, the direction of the State Plan implementation should be to:
  - seriously empower consumers, recognizing their role as navigational beacons;
  - address the 25 fewer years of life expectancy extant among persons with serious and persistent mental illness<sup>1</sup>;
  - review data to create quality information; and,
  - develop electronic transmission of information capacity throughout all systems.

### **SCMH: Major Areas of Recommendation**

Major areas of SCMHS focus over the last year included the transition population, mental health services to children in the Department of Education, services in rural areas; and dental and medical services, and empowerment of consumers and families.

#### **Transition Population**

A major concern of the SCMHS is adequate provision of services to children in transition from adolescence to adulthood during the period from 14-25/30 years of age. In concert with national directions, the SCMHS recommends that:

- Review eligibility for persons in the category, “Transition to Adulthood for Individuals with Serious Mental Health Conditions (SMHC)” for change from age to functional impairment and adaptive skills. Age criteria often leaves many young adults without the necessary supports to develop independent living skills, including finishing high school, obtaining career training, finding housing and employment, achieving financial literacy, managing and living within a budget, and developing goals. Transition to adulthood will be greatly enhanced through the collaborative actions of CAMHD, AMHD, young adults, families, DOE, DHS, DVR, Office of

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<sup>1</sup> National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. Morbidity and Mortality in People with Serious Mental Illness. October 2006, [www.nasmhpd.org](http://www.nasmhpd.org)

Youth Services, providers of services, non-profit organizations, and the business community.

- Build cultural competencies for working with the Transition Population especially with regard to respectful treatment, self-determination, and informed decision making that appropriately supports life goals and choices.
- Develop a single program with a Transition Network of services that maps funding streams and limitations and develops mechanisms for funding; e.g., braided funding.
- Develop a Transition Network of services to be supported by a Substance Abuse and Mental Health Services Administration (SAMSHA) grant for transition.
- Development of Supported Housing for the Transition to Adult Population (in AMHD's Community Housing Plan for 2008-2012).

### **Dental Services**

An area of continuing concern among the SCMHS membership has been the adequacy and access to dental services resulting in submission of a letter to the Directors of Health and Department of Human Services outlining the need to make available and promote additional preventive dental care; additional services for persons with serious and persistent mental illness (SPMI); and availability of dental prevention and treatment services on the neighbor islands. The Council indicated they considered the availability of dental prevention and treatment services as a parity issue no different than access and availability of other medical services. Co-occurring morbidity issues exist for the SPMI population based upon the nature of mental illness, the side effects of psychotropic medication, and other co-occurring issues related to substance abuse and medical illnesses that contribute to infection and poor dental health. Access to dentists must also be considered including transportation to dental services in rural areas; insurance coverage to address the years in which preventive services were not reimbursed by Medicaid; and impact of medications for serious and persistent mental illness on proliferation of dental and medical problems. The advent of "meth (methamphetamine) mouth" with related primary health issues has also exacerbated dental problems, particularly among young persons who are homeless.

### **Medical Services**

The need for a sufficient number of psychiatrists and nurses, and expansion of workforce recruitment for these staff was expressed by the Council. In addition to regular tasks performed by these positions, new findings have reinforced the importance of the medical role in mental illness. Research has shown the lifespan of persons with SPMI to be on average 25 years less than the normal population and that interactions of the new atypical second generation psychiatric medications, often exhibit consequent adverse effects (e.g., metabolic syndrome including weight gain with subsequent cardiovascular risk, and increased risk for Type 2 diabetes)<sup>2</sup>. Results of these studies reinforce the need for the AMHD to develop and expand the nursing role to address primary care issues; ensure that primary healthcare needs are addressed when changing medications; and that nurses provide linkage to and oversight of case managers

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<sup>2</sup> Lieberman, JA, Stroup TS, McEvoy, JP et al. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia, *N. Engl. J. Medicine*, 2005;353:1209-1223.

Abstract American Diabetes Association. Consensus development conference on antipsychotic drugs and obesity and diabetes.

Abstract Newcomer, JW. Second-generation (atypical) antipsychotics and metabolic effects: a comprehensive literature review. *CNS Drugs*, 2005; 19 (suppl 1):1-93.

to attend to medical issues. Attention by psychiatrists, Advance Practice Registered Nurses (APRNs), Registered Nurses (RNs) and other healthcare professionals is needed on monitoring, recognizing and intervening early on cardiovascular risk factors. Should attention be given to co-localization of primary and psychiatric care, it would contribute to reductions in adverse medical outcomes. Consequently, the SCMh supports ongoing attention to the acute, present and future mental health psychiatric and nursing shortages, including APRNs whose ability to provide prescriptive functions is especially valuable in rural areas. The SCMh advises that the AMHD/CAMHD consult, collaborate, and support the University of Hawaii's School of Nursing and Dental Hygiene programs; Hawaii Pacific University's School of Nursing and the University of Phoenix, School of Nursing towards recruitment efforts.

### **School-Based Behavioral Health Services**

Since the assignment of child and adolescent behavioral health services from the Department of Health to the Department of Education, the SCMh has been following issues of access and referral to services, as well as their amount and adequacy. A number of questions have been posed by the SCMh membership in this regard, many of which have also been discussed in the recent DOE consultant's Dikel Report, which addresses the capacity and appropriateness of the DOE's mental health role.<sup>3</sup> Among the areas the SCMh has identified as requiring further information are:

- whether the number of children and youth being served in both the DOE (behavioral health services) and DOH (clinical services) is low in consideration of the occurrence of the need in the general population;
- are those who require clinical services being appropriately referred to DOH (issues of stigma or staff overload);
- whether the DOE has the infrastructure to provide administrative services including billing for services;
- non-separation of DOE oversight from operations; and,
- how to retain confidentiality of information.

### **Consumer Empowerment**

A recent SCMh recommendation was to request the Behavioral Health Administration to continue to broaden the inclusiveness of consumers and families at all levels of the system. Through this action, consumer concerns have been more thoroughly voiced (public housing issues, equity of communication and services on Neighbor Islands, respectful staff demeanor). Actions resulting from a consumer problem in public housing included a SCMh meeting dialogue with the SCMh Hawaii Public Housing Authority (HPHA) member representative, HPHA Executive Assistant and the AMHD Statewide Service Director for Community Housing, which resulted in provision of a joint HPHA/AMHD public housing staff training.

Additionally, SCMh consumers have met with the State Director, Boards and Commissions to collaborate in the application process for Service Area Boards and State Council

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<sup>3</sup> Schick, P. Executive Summary. Walter Dikel, M.D., Independent Consulting Psychiatrist, Program Evaluation , Hawaii Department of Education, School-Based Behavioral Health Program. Overview indicates major decisions need to be made about roles and directions of SBBH services and whether they will serve the needs of students with behavioral problems, mental health disorders or a combination of the two. "Current delivery is fraught with potential financial and legal liabilities, and although services have been helpful for many students, there are significant gaps in services"

applicants. This resulted in Division level screening of applicants in order to avoid later disqualification from the nomination process. Individuals with past minor infractions of the law who demonstrate significant progress towards recovery receive more flexible treatment in the appointment process.

### **Services in Rural Areas**

A SCMH issue of continuing importance is that of service access, equity on the Neighbor Islands, especially in the rural areas. While telemedicine is currently being used in some rural areas where there is a shortage of psychiatrists, the SCMH has discovered that some consumers in these rural areas find communication via a television monitor a challenge, especially for consumers who prefer face-to-face, and for Asian and Pacific Islanders who have a cultural communication style, based on high contextual cues (e.g. the importance of non-verbal behavior, hello-goodbye protocols, and other communication nuances). The Council's recommendation for both Divisions to recruit additional psychiatrists also points to acknowledgement of national mental health workforce recruitment difficulties, particularly in rural areas<sup>4</sup>.

An acute need for housing exists on the Neighbor Islands. Both elderly and young persons on Molokai have little choice other than a care home. Mental health funding for Maui County is allocated largely to Maui Island with fewer services and less communication available on Molokai and Lanai. SCMH recommendations include: the hiring of Certified Peer Specialists on each island; consumer choice of more than one psychiatrist; and equity of service distribution on each island.

SCMH advocacy for consumers on the Neighbor Islands especially Molokai and Lanai resulted in the representation of consumers from each of these islands to the SCMH meetings. AMHD's Chief's Roundtable meetings were initiated on Molokai and Lanai and consumers participated for the first time in the AMHD's Certified Peer Specialist Training.

### **SCMH Recognized Strengths**

2007 State Plan implementation actions that were positively recognized by the SCMH included<sup>5</sup>:

- AMHD Community Housing program for increasing affordable and specialized housing (including those who have a mentally ill/substance abuse disorder) and to assist consumers to retain their housing;
- AMHD establishment of the E-ARCH (Expanded Adult Residential Care Homes) homes (older adults with co-morbidities) thereby taking the lead to divert the elderly from inappropriate long-term care facilities;
- CAMHD report of annual FY 2006 evaluation indicating 2% decrease in number of youth in the system with a court hearing; a 14% decrease in youth detained or incarcerated; and demonstration of a significant increase of providers using ten evidence-based practices.
- AMHD efforts and SCMH testimonial support to reduce stigma and discrimination through zoning law changes to allow eight unrelated persons to reside together.

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<sup>4</sup> Provision of a pay differential for AMHD psychiatrists in rural areas has recently been approved.

<sup>5</sup> SCMH Minutes, July 1, 2006-June 30, 2007

- AMHD partnering with the Honolulu Police Department to implement the new Pre-booking Jail Diversion Program on Oahu, which provides for police to call dedicated psychologists to intervene, developed a plan of action, and diverted consumers from hospital emergency rooms, jails and prisons.
- AMHD/University of Hawaii, School of Social Work Collaboration to train students as future mental health staff through assignment to AMHD projects and placements including older adults (early discharge, substance abuse), Consumer Assessment Teams, Evidence-based Practice Implementation (Illness Management and Self-Directed Recovery), Core Competency Evaluations of CMHC staff for engagement and retention, and the Case Management Manual and Resource Guide.
- Continuous participation in Hawaii's Mental Health Transformation State Incentive Grant;
- AMHD support for the Judiciary's establishment of the Mental Health Court serving persons in the criminal justice system with a serious and persistent mental illness;
- Opportunity for input into CAMHD's Strategic Plan;
- Provision of a limited amount of dental prevention services (Medicaid).
- Implementation of the Jail Diversion program on Maui; and,
- Presence of a well-operated` Crisis Mobile Outreach Team on Kauai.

### **SCMH Recognized Areas for Improvement**

Other areas of FY 2007 State Plan implementation that were noted as needing continuing attention included:

- Teen suicides, especially on the Big Island;
- Goal to achieve the seven-day standard for AMHD initiation of screening, evaluation and determination of eligibility is exceeded before consumers receive services;
- Equity in services for persons living on Molokai and Lanai; a three-island County in which the larger amount of resources are assigned to Maui proper;
- Caseload ratios for case managers over the 1/30 limit;
- Affordable housing for consumers on Kauai;
- Lack of sufficient mental health services to persons in prison;
- Education of the general public and providers to reduce stigma and discrimination;
- The need for social agencies to inform participants about available benefits such as affordable housing and adequate dental care, (e.g. major concerns of 175 Division of Vocational Rehabilitation mental health enrollees);
- Improve response to mentally ill consumers at Hilo Medical Center Emergency Services;
- Provision of DOE mental health services on Maui;
- Maui Mental health staff vacancies that may be terminated if the positions are not filled;
- Maui emergency/crisis facilities for children; and,

- Insufficient space and computers for certified peer specialist staff working at the CMHCs.

### **AMHD Action Plan Implementation: FY 2007**

Implementation of the State Plan is also reflected in AMHD's 2007 Action Plan, available on the web at [www.amh.org](http://www.amh.org). Among the service actions<sup>6</sup> completed by June 27, 2007 were:

#### AMHD Medical

- Ongoing supervision of all CMHC Medical Directors by the AMHD Medical Director;
- Establishment of regular AMHD/Department of Public Safety meetings;
- Collaboration with DOH Injury Prevention to develop a system wide suicide prevention program including training providers in the ASIST method;
- Attendance of POS Medical Directors at the AMHD's Statewide Medical Executive Council monthly meetings;

#### Clinical Operations

- Assertive Community Treatment (ACT) Services: Maui's first ACT team was established; technology transfer assistance to ACT teams was initiated to incorporate outcome and fidelity results into providers Quality Management programs; and ACT provider Quality Management programs were reviewed for full incorporation of ACT monitoring results.
- Community Housing: Developed a Tenancy Manual and Tenancy Training Manual to assist consumers to retain housing (Operation Building Bridges) and distributed to programs; modified housing contracts to require tracking information and written quarterly reports; and submitted housing and homeless grant applications for Shelter Plus Care and HUD 811 to HUD for 2008;
- Crisis Services: Submitted application for accreditation of the ACCESS Line program by the American Association of Suicidology; and, reviewed action plan to reduce the ACCESS call abandonment rate.
- Forensic Services: Provided information to clarify the role of new forensic coordinator positions; approved procedures between AMHD and Public Safety that address referral of incarcerated mentally ill individuals; clarified process and identified pathways for obtaining orders to treat at Hawaii State Hospital (HSH); provided training to community hospitals, Hawaii Health Systems Corporation (HHSC) contracted hospitals and Kahi Mohala regarding forensic admissions; designated the number of beds and future locations of specialized housing for consumers reintegrating into the community; completed program curriculum development; identified key performance indicators and initiated staff training in community-based fitness restoration programs; developed specified discharge criteria and procedures for assisting consumers in their legal discharge from conditional release; and, established the first of four forensic case management teams on Oahu.

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<sup>6</sup> Does not include fiscal, personnel and contractual actions.

- Inpatient Oversight: Implemented regular, scheduled meetings and agenda with Queen's Medical Center, Castle Medical Center, and HHSC to provide oversight of inpatient services delivered to AMHD-funded consumers.
- Interagency Agreements: Executed the DOH/Public Safety Division (PSD) Memoranda of Understanding.
- Long-term Care: Hired a long-term care consultant.
- MISA (mentally ill/substance abuse) and Other Special Populations: Established the Developmental Disabilities Division/AMHD Consultation Team; finalized the youth transition policy and procedure; completed and distributed the MISA Manual; and finalized and distributed all MISA competency material.
- Psychosocial Rehabilitation (PSR): Completed SOAR<sup>7</sup> (Supplemental Security Income (SSI) and (Social Security Disability Benefits (SSDI) Outreach, Access, and Recovery) trainings in each county; completed the AMHD Tenancy Curriculum for PSR Programs by Statewide Service Directors for PSR and Housing Services; and coordinated a Statewide Evidence-Based Practice Supported Employment and Job Fair for AMHD consumers, providers and administrators.
- Community-based Intervention (CBI) and Consumer Resource Fund (CRF): Initiated Request for Information for CBI and CRF for revised scopes of contractual services, and released a CBI Request for Proposal (RFP).
- Hawaii State Hospital: Developed plans for use of alternative spaces as post hospital discharge options; differentiated responsibilities between HSH administration and AMHD Utilization Management section regarding Kahi Mohala provider relations; revised discharge planning protocol to focus on inpatient treatment goals and recommendations for type of community-based programming.
- Case Management: Developed a case management transition plan and timeline for provider/consumer case management ratios to be at 1/30.

#### Learning Organization

- Implemented new Employee Orientation General Education; implemented Training Database for return on investment tracking; and implemented monthly clinical and quarterly administrative supervision entries related to employee competencies including psychiatrists.

#### Office of Consumer Affairs

- Facilitated a workgroup to address real or perceived retaliation to consumers and developed a recommended proposal for the Quality Improvement Committee (QIC).

#### Financial Management

- Implemented position (hiring) and expenditure control at Hawaii State hospital.
- Reduced projected deficit for FY 2007 at Hawaii State hospital.

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<sup>7</sup> [www.prainc.com/SOAR/about/facts.asp](http://www.prainc.com/SOAR/about/facts.asp)

#### Electronic Record:

- Created and implemented two Clinicians Workstations (CWS) workgroups; submitted first claims using AVATAR electronic records; and implemented the Medisoft Pharmacy solution.

#### Provider Relations

- Established and implemented a new provider orientation process;
- Convened planning group to discuss credentialing consolidation efforts; and,
- Established schedule for POS provider visits with Service Area Administrators in each county.

#### Performance Improvement

- Finalized the Quality Management Workplan;
- Developed and implemented a tracking mechanism for all performance indicators, reports, actions and recommendations by the Quality Improvement Committees.

#### Planning

- Submitted a Policy and Procedure (P&P) on Policies and Procedures and a Policy and Procedure on Standard Operating Procedures (SOP) to the AMHD Executive Team.
- Implemented a P & P tracking mechanism to ensure all P & Ps are reviewed on a regular basis and updated as necessary.
- Submitted Planning Needs Assessment to Executive Team.

#### Quality Improvement

- Initiated plan to monitor and follow up on all Quality Improvement Committee (QIC) subcommittees to ensure submission of regular reports to the QIC.

In previous years, the State Council's Report to the Governor and Legislature included the results of AMHD/CAMHD Performance Indicators for the State Plan. This year, due to an earlier timeline for submission of the Report, data will not be available for inclusion of the FY 2007 results. However, FY 2007 data is currently available on the number of consumers served, which is 14,492.<sup>8</sup> Alternatively, the results of FY 2006 Performance Indicators are being made available (Appendix 1).

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<sup>8</sup> This number includes the 532 individuals who received a screening assessment such as the Quality of Life Inventory, the CAGE-MIDAS (mentally ill/substance abuse), or MHSIP (consumer survey) for whom there were no other evidence in our database of having received any other services. However, because they received such screening or assessment events, we are confident that these individuals did receive services; unfortunately the evidence for those services was unavailable in our database. The reason for this lack of data may be that providers who are on cost-reimbursement contracts often do not report information on services they provide. If we include these individuals in our FY 2007 report, the total number of people served would be 14,492.

## APPENDIX 1

### RESULTS OF FY 2006 STATE PLAN PERFORMANCE INDICATORS

#### 1. **Adult Mental Health Division Performance Indicators:**

- **Increase Access to Services:** In FY 2006, AMHD increased services to 1,081 consumers (11,217<sup>9</sup> served), as compared to FY 2005 (10,136 served). This represents a continuing growth since FY 2003 when 4,476 consumers received services. The result for this National Outcome Measure was obtained by dividing the number of persons who received any AMHD service in FY 2006 (11,217 as recorded in the AMHD MIS system) by the numbers of adults in the State (24,684) estimated to be severely and persistently mentally ill (application of SAMHSA promulgated planning rate of 2.6% to updated 2000 census data). The increase is attributable to a variety of factors including improved screening; an increased number of diagnoses that meet eligibility requirements; provision of short-term crisis services for 30 days; and “presumptive eligibility” especially for persons with MISA (Mental Illness/Substance Abuse) and who are homeless or arrested.
- **Provide Evidence Based Practices (EBPs):** Of 11,217 persons who received services in FY 2006, 753 (6.7%) persons received high end Assertive Community Treatment (ACT). This was a slight drop from the previous year when 766 of 8,473 (9.0%) persons received ACT. The number receiving ACT services was obtained from the AMHD MIS system as a percent of the total who received any AMHD service. This National Outcome Measure fulfills Federal mandate to track the provision of EBPs. The percentage change from FY 2005 to FY 2006 is attributable to modified service authorization requests (Utilization Management) that more accurately reflected the ACT criteria. In FY 2007, it is expected the number may increase due to the addition of an ACT team on Maui. Fidelity monitoring is ongoing. Tracking of EBPs in the areas of Supported Housing (855 served) and Supported Employment (732 served) is also ongoing.

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<sup>9</sup> This number does not include the 1,028 individuals who received a screening assessment such as the Quality of Life Inventory, the CAGE-MIDAS (mentally ill/substance abuse), or MHSIP (consumer survey) for whom there were no other evidence in our database of having received any other services. However, because they received such screening or assessment events, we are confident that these individuals did receive services; unfortunately the evidence for those services was unavailable in our database. The reason for this lack of data may be that providers who are on cost-reimbursement contracts often do not report information on services they provide. If we include these individuals in our FY 2006 report, the total number of people served would be 12,245 which we believe is more accurate than the 11,217 we reported. In FY 2005, the AMHD served 10,136 (40.4%) adults from an estimated prevalence of 25,068 adults with serious and persistent mental illness (SPMI). In FY 2007, the AMHD served 11,217 (44.2%) adults from an estimated prevalence of 25,359 adults with SPMI. In FY 2006, additional persons entered the system through the recently established ACCESS Line and Warm Welcoming Policy, increased outreach, on-the-spot assessments through clinic walk-ins and flexible scheduling to the field, expanded eligibility, and presumed eligibility. This significant increase has required commensurate increases in community-based and hospital based mental health services as reflected in the AMHD Biennium Budget request for FY 2007.

- Decrease Re-admissions of Forensic and Non-Forensic Patients within 30 and 180 Days of Discharge at Hawaii State Hospital and Kahi Mohala Hospital:

In FY 2005 and FY 2006, the following results were obtained for this National Outcome Measure:

Legal Status	Returned To HSH Or Kahi Mohala Within 30 Days Of Discharge From Same Hospital		Returned To HSH Or Kahi Mohala Within 180 Days Of Discharge From Same Hospital	
	FY 2005	FY 2006	FY 2005	FY 2006
Non-Forensic	N/A	2 of 175 1.1%	N/A	None.
Forensic	4 of 200 2.0%	6 of 343 1.7%	18 of 141 12.8%	22 of 343 6.4%

Non-Forensic: In FY 2006, only 2 of 175 non-forensic discharged patients returned within 30 days of discharge, and none returned within 180 days of discharge. Non-forensic patients comprise less than 5% of the HSH population.

Forensic: The number of forensic patients returning to HSH or Kahi Mohala Hospital within 30 and 180 days of discharge decreased from FY 2005 to FY 2006. Return within 30 days decreased from 2.0% in 2005 to 1.7% in FY 2006; and return within 180 days decreased from 12.8% in FY 2005 to 6.4% in FY 2006.

The data on forensic and non-forensic discharges from Hawaii State Hospital and Kahi Mohala Hospital is collected in the AMHD MIS system and exported to the MHSRET Master Data base where it is unduplicated and the time periods calculated.

- Increase the Number of Persons Living Independently: In FY 2006, 4,165 of 5,745 persons for who housing information was available (72.5%) lived independently. In FY 2005, 2,495 of 3,446 or 72.4% of persons reported living independently. The data for this State Selected Performance Indicator was obtained by counting the number of consumers who reported “living independently” (3,537 consumers) in answer to the question, ”What is your current living arrangement?” on the AMHD Quality of Life-Very Brief (QOLI-VB) Survey. The data also included 628 consumers who moved from AMHD Supported Housing Bridge Subsidy to Section 8 and Shelter Plus Care Programs as indicated by provider reports prepared by the AMHD Community Housing Services Director. A total of 87 Independent Living housing options were added in FY 2006 including 5 for Semi-Independent Living; 47 resulting from moving consumers from the AMHD Supported Housing Bridge Subsidy to Section 8 housing; and 35 obtained Federal Shelter Plus Care rental subsidies. Increases in

independent living occur through the AMHD's Supported Housing program that maximizes funding opportunities with other city, state and federal agencies.

- Increase the Availability of New Generation (Atypical) Antipsychotic Medication: This is a new National Outcome Measure and one which the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services has under review. A baseline measure was established in Hawaii in FY 2006. Of 1,021 consumers with schizophrenia who received AMHD services, 658 consumers or 64.4% received the new generation atypical medications. This data was obtained from the number of consumers who answered "yes" on the QOLI-VB, to the question: "Are you currently taking atypical psychotropic medications, such as Abilify, Clozaril, Zyprexa, Seroquel, Risperdal, or Geodon?"
- Consumer Perception of Recovery Outcomes: In FY 2006, 706 of 1,001 (70.5%) consumers sampled reported positively about recovery outcomes, as compared to FY 2005 in which 592 of 855 consumers (69.2%) reported positively about recovery outcomes. This represents an improvement of 1.3% over the previous year. The data for this National Outcome Measure was obtained by consumers who answered "Strongly Agree" or "Agree" to each of 8 questions on the outcome scale of the AMHD Consumer Survey (including MHSIP). This measure includes well-being, relationships, life circumstances and potential recovery. The denominator was the total number of persons who responded to the question.
- Increase Active Consumer Participation in Their Recovery/Treatment Planning: In FY 2006, 822 of 1,043 (78.8%) consumers sampled on the AMHD Consumer Survey (including MHSIP) reported positively on their participation in Recovery/Treatment Planning. In FY 2005, 690 consumers of 874 (78.9%) reported positively on their participation in Recovery/Treatment planning. With increased numbers sampled, the result of 79% has been maintained. The data for this State Selected Performance Indicator was obtained by consumers who answered "Strongly Agree" or "Agree" to questions #11 ("I felt comfortable asking about my treatment and medication") and #17 ("I, not staff, decided my treatment goals") on the AMHD Consumer Survey. The denominator was the total number of persons who responded to the question.
- Provide Services That Consumers Find Appropriate and of High Quality: In FY 2006, 803 of 930 (85.5%) of consumers sampled on the AMHD Consumer Survey (including MHSIP) responded positively about the quality/appropriateness of services received. In FY 2005, 656 consumers of 792 (82.8%) responded positively about the quality/appropriateness of services received. This represents an improvement of 2.7% over the previous year. This data for this State Selected Performance indicator was obtained by a count of the number of consumers who answered "Strongly Agree" or "Agree" to each of nine questions on the AMHD

Consumer Survey Appropriateness/Quality Domain (including MHSIP). The denominator was the total number of persons who responded to the question.

- Consumer Involvement in the Criminal Justice System: In FY 2006, 468 of 4,358 AMHD consumers served (10.7%) reported they were arrested, compared to FY 2005, in which 1,002 of 10,136 consumers served (9.9%) were determined to have a forensic legal status. Although the percent increased slightly in FY 2006, it may relate to changes in measurement. In FY 2005, the numerator included any consumer who had involvement with the criminal justice system (e.g., on conditional release) and the denominator (10,136) included all served in the fiscal year. In FY 2006, the data for this State Selected Performance Indicator was determined by a count of the number of consumers who answered "yes" to the question on the QOLI-VB, "In the past six months, have you been arrested?" The denominator was the total number of persons who answered the QOLI-VB in the fiscal year (4,984). Utilization of "arrests" as the outcome measure for criminal justice involvement was determined on the Federal level. The indicator for consumer involvement with the criminal justice system has remained around the 10% level during the last few years. In FY 2006, the above figure was broken down into two measures, including those who entered AMHD service in the last 12 months and those in service for at least 12 months. The percentage was significantly less for those in service for the last 12 months with criminal justice involvement numbering 172 of 2,637 (6.6%) compared to those who entered services in the last 12 months with criminal justice involvement numbering 296 of 1,721 (17.2%).
- Number of Individuals with Co-Occurring Psychiatric and Substance Disorders: This State Selected Performance Indicator addresses the need to determine an accurate number of persons served who have a co-occurring substance abuse disorder. National prevalence estimates of MISA (mental illness/substance abuse) range around 50%. In FY 2005, 2,940 of 10,406 consumers (28.3%) were identified with MISA, as compared with 3,809 of 11,217 consumers (34.0%) identified in FY 2006. The data for this indicator was obtained by using a combination of DSM diagnosis, alcohol and drug screening tool (i.e., Cage, Drake, & Midas) and service utilization patterns projected to the entire system of care, not limited in time. Results indicated that 3,809 had evidence of substance abuse problems. However, if only those who answered on the CAGE-AID questionnaire with a score of 1 or higher were reported (1,690 consumers of 3,314), the percent of co-occurring mental health and substance abuse would be 51%. AMHD Services Research, Evaluation and Training indicate the present data would most accurately be described as a range from 28% from all sources to 51% on a screening instrument (CAGE).
- Increase Full-Time and Part-time Employment: In FY 2006, 1,154 of 4,937 (23.4%) consumers reported full-time or part-time employment. In FY 2005, 788 of 3,618 (22%) consumers reported they were employed. This is an increase of 1.4% over FY 2005. The data for this State Selected Performance Indicator was

determined through a count of the number of consumers who reported on the QOLI-VB they were employed full or part-time in answer to the question, “What is your current type of employment?” The denominator included those who answered they were employed, unemployed, and not in the labor force (e.g. retired, homemaker, student volunteer, disabled). Continued growth in Supported Employment with institution of a milestone system for contractor reimbursement that rewards consumer outcomes (e.g., becoming employed within 30, 90 and 180 days) may be a contributing factor to this increase.

- **Decrease Consumer Mortality:** Tracking mortality, a global indicator of health status, is especially important with regard to persons with serious and persistent illness who die at higher rates and younger ages<sup>10</sup>. As a result, mortality was included as one of Hawaii’s State Selected Performance Indicators. In FY 2006, a baseline of consumer mortality was established with 100 consumer deaths among 10,354 persons served. Number of consumer deaths is tracked by the AMHD’s Quality Management section and compiled from public and contracted provider sentinel event reports. This is a rate of 9.66 per 1000 population and 965.81 per 100,000 population. The rates are obtained by dividing the number of deaths (100) by 10,354 (number of persons served more than once) and multiplying by 1,000 and 100,000.

## 2. **Child and Adolescent Mental Health Division Performance Measures:**

- **Provider Agency Satisfaction:** In FY 2006, 96% of CAMHD’s POS provider agencies had no documented complaints against them. This performance measure was met and improves on FY 2005 performance of 90%. This is an important measure in a family-driven system where families should be satisfied with the services they are provided.
- **In-Home Service Provision:** In FY 2006, 70% of youth received services while living at home. This performance measure exceeded the target of 60%. A subset of youth receives treatment in out-of-home residential settings because of the high acuity of their mental health concerns and complexity of their life situations. It is noteworthy, however, that the average length of stay in these out-of-home placements was 15% less than projected. The average stay was 179 days as opposed to our projected 205 days. It should be noted that our residential programs include an array of services from hospital-based programs to therapeutic foster care.
- **Timely Coordinated Service Plans:** In FY 2006, 91% of CAMHD registered youth received an initial Coordinated Service Plan within 30 days of determination of eligibility. This performance measure exceeded the target of

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<sup>10</sup> Parks MD, Joe; Svendsen MD, Dale; Singer MD, Patricia; Foti MD, Mary Ellen. (October 2006). *Morbidity and Mortality in People with Serious Mental Illness*. National Association of State Mental Health Program Directors (NASMHPD), Medical Directors Council. [www.nasmhpd.org](http://www.nasmhpd.org)

85%. With the timely development of the plan, youth will be able to promptly access the appropriate treatments and services.

- Child Status: In FY 2006, 66% of CAMHD youth sampled showed improvement in functioning. Program performance goals were achieved for the percentage of youth showing functional improvements as measured by the Child and Adolescent Functioning Assessment Scales (CAFAS) or Achenbach Child Behavioral Checklist (ASEBA), two nationally validated functional measurement scales.
- Evidence Based Services: The CAMHD's commitment to the provision of evidence-based services continued in the fiscal year. Both CAMHD and the contracted provider staff received substantial training that increased the ability to choose and deliver evidence-based treatment services. Combined hours of training amounted to over 660 hours. It was originally projected that there would be at least 750 hours of evidence-based training provided. This lower-than-expected training value was negatively impacted by vacancies of key professionals.
- Care Coordinator Vacancies: In core infrastructure measures, primarily in the area of sufficient staffing, CAMHD performance measures have declined, negatively impacting the ability to provide comprehensive services to the intended population. In the last several months, CAMHD has dropped in percentage of care coordinator positions statewide filled. In the latest reported quarter ending September 2006, an average of 77% of care coordinator positions was filled, well below the performance goal of 95%. The drop reflects the 11th consecutive quarter that the performance goal was not met and the lowest percentage since reporting on this measure began in 2001. The length of time it takes to fill care coordinator positions through the State personnel hiring process is a significant factor in meeting this performance goal.