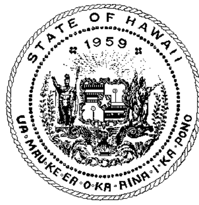
JOSH GREEN, M.D.
GOVERNOR
KE KIAʻĀINA



STATE OF HAWAIʻI | KA MOKUʻĀINA ʻO HAWAIʻI
DEPARTMENT OF PUBLIC SAFETY
Ka ʻOihana Hoʻopalekana Lehulehu
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No. ______________

TESTIMONY ON SENATE CONCURRENT RESOLUTION 89
By
Tommy Johnson, Director
Department of Public Safety

Senate Committee on Health and Human Services
Senator Joy A. San Buenaventura, Chair,
Senator Henry J.C. Aquino, Vice Chair

Senate Committee on Public Safety and Intergovernmental and Military Affairs
Senator Glenn Wakai, Chair,
Senator Brandon J.C. Elefante, Vice Chair

Friday, March 24, 2023; 2:00 p.m.
State Capitol, Conference Room 225 and via Video Conference

Chair San Buenaventura, Chair Wakai, Vice Chair Aquino, Vice Chair Elefante, and Members of the Committees:

The Department of Public Safety (PSD) offers comments on Senate Concurrent Resolution (SCR) 89, which requests the Department of Health and Department of Public Safety to work in collaboration to preserve the health and safety of special needs inmates and others in the State's jails and prisons.

PSD appreciates the sentiment of the concurrent resolution and offers additional information to provide clarification on the history and present status of mental health expertise and service delivery at our jails and prisons. In July 2017, the Department identified significant deficiencies in mental health service delivery at correctional facilities and initiated the process of organizational change to begin to transform the provision of mental health services at jails and prisons into a rehabilitative and therapeutic model of care. The ACT 144, SLH 2007, "Mental Health Services for Committed Persons" annual reports (see ACT 144, SLH 2007, annual reports from 2017 to present attached) detail the progress and improvements over the last six years. The

provision of mental health care at our jails and prisons has proven to meet or exceed national standards and independent expert evaluation. To further assess the quality and quantity of the mental health care provided at our facilities, PSD intends to seek additional national health care accreditation from the American Correctional Association (ACA) within the next three years.

Correctional mental health is a specialized field of study and clinical practice with few having the expertise and ability to operate successfully in correctional settings. All PSD mental health administrators (psychologists) are Certified Correctional Health Care Professionals of the National Commission on Correctional Health Care. Hawaiʻi is fortunate to currently have exceptional psychologists leading each of our correctional mental health sections statewide. The PSD Corrections Health Care Administrator is currently serving as Vice Chair of the ACA Behavioral Health Committee.

SCR 89 requests the Department of Health and the Department of Public Safety to work in collaboration to preserve the health and safety of incarcerated individuals. PSD is truly appreciative of the progress and accomplishments that have been demonstrated through our constructive relationship with the Department of Health over the last six years. The partnership successfully addressed both systemic and individual mental health matters through collaborative procedural modifications and consultation.

In addition to the ongoing open and productive collaborative working relationship firmly established with the Department of Health, PSD partners with several other community entities to preserve the health and safety of incarcerated individuals. Examples include the provision of psychiatric and psychological services by affiliation with the John A. Burns School of Medicine, the Queen's Health System, the Hawaiʻi State Rural Health Association, the Hawaiʻi School of Professional Psychology at Chaminade University of Honolulu, the National Health Service Corps, and the Western Interstate Commission for Higher Education. PSD has been developing our relations with the Department of Psychology at the University of Hawaiʻi through grant application

and discussions involving practicum opportunities and a potential collaborative trauma-focused project.

PSD has benefited tremendously from the resources, expertise, partnerships, and demonstration of extraordinary commitment to the prevention of suicide through involvement in the Prevent Suicide Hawai‘i Task Force. Data from our Suicide Prevention Program shows more than a 50% reduction in deaths by suicide at our jails and prisons during the 5-year period from 2018-2022 compared to the previous 5-year period from 2013-2017. Through participation in the Governor’s Challenge to Prevent Suicide Among Service Members, Veterans, and their Families, PSD has begun to explore community partnerships to improve continuity of mental health care for this special subpopulation.

The Department recognizes that the delivery of mental health services is an ongoing process of improvement. Our work and our partnerships, particularly with the Department of Health over the last six years, confirm and echo the sentiment of the proposed concurrent resolution. PSD will continue to communicate our ongoing efforts to improve correctional mental health services with the Hawai‘i Correctional System Oversight Commission.

Thank you for the opportunity to provide comments on SCR 89.

DEPARTMENT OF PUBLIC SAFETY
REPORT TO THE 2018 LEGISLATURE

IN RESPONSE TO
ACT 144, SESSION LAWS OF HAWAI'I, 2007
MENTAL HEALTH SERVICES FOR COMMITTED PERSONS

December 2017

Annual Report to the Legislature
In response to Act 144, Session Laws of Hawai'i, 2007
Mental Health Services for Committed Persons

Introduction

This report is hereby submitted to fulfill the requirements outlined in Act 144, Session Laws of Hawai'i, 2007, specifically:

(1) The Department of Public Safety shall submit a report to the Legislature no later than twenty days prior the commencement of the 2008 regular session and every session thereafter…

(2) This written report shall be submitted in a form understandable by lay readers and made available to the public.

Itemized Report

As outlined in Act 144, Session Laws of Hawai'i, 2007, the Department shall report on six (6) specific items of concern. These six items are listed below (as extracted from the statute), followed by the Department's status report on each item.

1. Assessment of the Department's existing resources and staffing, and or additional resources and staffing needed to bring mental health services up to standard and keep up with future demands.

    a. The focus on the federal investigation and subsequent Settlement Agreement between the State of Hawaii, Department of Public Safety (PSD) and the Federal Department of Justice (DOJ) was to bring the Oahu Community Correctional Center (OCCC) up to national standards for correctional mental health care. In 2015, the Department successfully disengaged from an extended Corrective Action Plan with the DOJ. However, during the maintenance period over the last fiscal year (FY 2016-17), the Mental Health Branch failed to remain compliant with the standards agreed upon with the DOJ, necessitating programmatic changes, including in the Branch's leadership. An Organizational Needs Assessment was undertaken to examine the state of OCCC's performance in relation to stakeholder expectations. It was completed in August 2017, and the following significant findings identified areas urgently requiring change.

Mental Health Administration

Leadership within the OCCC Mental Health Section was found to be ineffective. There were multiple allegations of mismanagement and “tanking” of operations by the former Mental Health Administrators. Alleged non-work activities at the desk of the temporarily-assigned Mental Health Section Administrator resulted in an ongoing and profuse culture of apathy and lack of motivation within the section. Staff demonstrated an absence of respect for leadership and indifferent job performance.

A new Chief of Mental Health Operations was appointed in August 2017 to improve the leadership and culture of the mental health section at OCCC. On November 1, 2017, the new OCCC Mental Health Section Administrator, a licensed Clinical Psychologist, replaced the previously unlicensed administrator as the Responsible Mental Health Authority, bringing important clinical expertise to the section.

Organizational Structure

The Organizational Structure of the Mental Health Section at OCCC was found to be poorly designed. The three existing supervisory chains within the structure did not allow for accountability of work performance. Existing positions were illogically placed within a chaotic structure not aligned with job class. The former Mental Health Administration essentially wasted the opportunity to implement critically needed restructuring of the Mental Health Branch following the settlement with the DOJ. By November 2017, the new Mental Health Administration had successfully completed the reorganization of the Mental Health Branch, which addressed the supervisory, structural, and accountability issues identified in the needs assessment.

Mental Health Staffing

During FY 2014 the Department requested and received staffing and other resources to address deficiencies in mental health care in the remaining correctional facilities. Positions were funded for one-half of the 2014 fiscal year, with the anticipated phase-in of positions over the course of FY 2014-2015. The Department had submitted requests to support the continued funding of these positions in the prior budget cycle. The November 2017 reorganization of the Department’s Mental Health Branch has enabled the Department to move forward in the recruitment of vacant positions critical to the provision of adequate mental health services.

In June 2017, thirteen (13) out of thirty-four (34) positions were vacant at the OCCC Mental Health Section (see Table 1 below). To date, an additional seven (7) positions have been filled, leaving six (6) vacancies.

All the Clinical Psychologist and Office Support positions have been filled. Three of the four Social Worker/Human Services Professional vacancies are in the process of being filled – two positions have applicants recommended for hire, and an employee from a neighbor island will fill another. The remaining vacant positions include one Corrections Recreation Specialist, one Para-Medical Assistant, and one Social Worker/Human Services Professional.

Table 1. Comparative Mental Health Staffing at OCCC

	July 1, 2017		**December 20, 2017**		**Comments**
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	
Psychology	2	3	0	5	
Social Services	6	6	4	8	2 applicants recommended for hire; 1 position to conduct interviews; 1 employee to be relocated into position from neighbor island
Nursing	3	6	1	8	Awaiting external applicant list
Recreation	2	1	1	2	Awaiting internal applicant list
Office Support	0	5	0	5	
TOTAL	**13**	**21**	**6**	**28**	

On June 30, 2017, there were thirty-nine (39) vacant positions and thirty-eight (38) filled positions in the Mental Health Branch statewide (See Table 2 below). Two additional vacancies were created due to a retirement and a promotional transfer to another Division within the Department. Since June 30, 2017, thirteen (13) mental health positions have been filled. Applications are currently being processed to hire seven (7) additional mental health positions: four Clinical Psychologists and three (3) Social Worker/Human Services Professionals.

Table 2. Comparative Statewide Mental Health Branch Staffing.

	July 1, 2017		December 20, 2017		Comments
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	
Psychology	10	6	7	9	4 applicant recommended for hire for KCCC, HCCC, and HCF
Social Services	16	17	11	22	3 applicants recommended for hire
Nursing	3	6	1	8	Includes paramedical staff plus (1 RN)
Occupational Therapy	2	1	1	1	1 position re-described to fund 0.5 FTE Psychologist and SW/HSP to 1.0 FTE
Recreation	2	1	1	2	
Office Support	6	7	6	7	
TOTAL	**39**	**38**	**27**	**49**	13 position filled; 1 retired and 1 promotional transfer out

Mental Health Services

The duties and responsibilities of various OCCC mental health positions, including equivalent positions, appeared to differ based on preferential treatment from former administration. Patient care employees were often unnecessarily misused for non-patient care duties. The existence of the exclusion of employees within the Oahu Mental Health Section also resulted in the abandonment of available resources and several areas of deficiency in the delivery of mental health services at OCCC.

Continuous Quality Improvement data from January 2017 through June 2017 showed Treatment Plans were not completed as required by National Correctional Mental Health Standards. (See Table 3 below.) Over the six-month period, January-June 2017, only 42% of Treatment Plans were completed. In August 2017, action by Mental Health Administration resulted in significantly improved completion rates for the provision of treatment plans. The August-November 2017 completion rate was 83%, with November 2017 showing a completion rate of 92%.

Table 3. Frequency and Percentage of Treatment Plans Completed at OCCC Mental Health Section.

	Treatment Planning		
2017	**Total (N)**	**Completed (N)**	**Completed (%)**
January	131	54	41%
February	145	48	33%
March	148	108	74%
April	154	63	41%
May	111	40	36%
June		21	19%
July	128	56	44%
August	145	109	**75%**
September	128	105	**82%**
October	114	97	**85%**
November	107	98	**92%**

Continuous Quality Improvement data from May 2016 through July 2017 showed the average weekly provision of psychosocial treatment group activities in designated mental health modules at OCCC were minimal to none. (See Table 4 below.) Since August 2017, all three designated mental health modules (i.e., Modules 1, 2, and 8), have demonstrated overwhelmingly significant improvement in average, weekly out-of-cell, structured, psychosocial treatment group activity hours.

Table 4. Average Weekly Psychosocial Treatment Group Activities in Designated Mental Health Modules at OCCC.

	Average Weekly Psychosocial Treatment Group Program Hours		
2016	**Module 1**	**Module 2**	**Module 8**
May	0.80	11.65	0.50
June	4.20	5.80	0.35
July	4.90	8.35	0.00
August	7.65	12.80	0.40
September	5.00	7.65	0.80
October	4.75	6.90	0.60
November	2.25	2.80	1.20
December	1.45	1.85	1.10
2017			
January	1.70	2.60	1.55
February	1.85	2.80	1.60
March	1.65	3.20	1.30
April	0.60	2.40	2.00
May	0.00	3.80	1.95
June	0.20	3.40	2.25
July	1.20	1.80	1.80
August	**18.35**	**16.05**	**19.55**
September	**23.00**	**23.12**	**29.18**
October	**23.37**	**20.10**	**24.43**
November	**25.15**	**19.60**	**24.95**

In addition, Continuous Quality Improvement data from January 2017 through July 2017 showed Discharge Plans were not completed as required by National Correctional Mental Health Standards. (See Table 5 below.) Over the seven-month period, January-July 2017, only 9% of Discharge Plans were completed. In September 2017, action by Mental Health and Facility Administration resulted in significantly improved completion rates for the provision of discharge plans. The September-November 2017 completion rate was 72%, with November 2017 showing a completion rate of 90%.

Table 5. Frequency and Percentage of Discharge Plans Completed at OCCC Mental Health Section.

	Discharge Planning		
2017	**Total (N)**	**Completed (N)**	**Completed (%)**
January	131	15	11%
February	145	17	12%
March	148	11	7%
April	154	15	10%
May	111	5	5%
June	115	12	10%
July	128	11	9%
August	145	20	14%
September	128	67	**52%**
October	114	89	**78%**
November	107	96	**90%**

Since July 2017, the Department has demonstrated significant improvements in several other mental health service areas. For example, in August 2017, the Department implemented Mental Health Clinical Performance Enhancement reviews, which evaluate the appropriateness of mental health services delivered by direct patient care clinicians. In September 2017, the Department initiated the Mental Health Segregation Review and the Pre-Segregation Mental Health Referral processes for all inmates placed in segregation. In October 2017, the Department rescinded the previous mental health administration directive to provide only finger foods for inmates on watch status for safety reasons. The Department now provides safety utensils with meals for such patients. In November 2017, the Department hired a Clinical Psychologist, who functions as the Prison Rape Elimination Act (PREA) specialist, to provide required trauma therapy in accordance with the federal PREA mandate. In December 2017, the Oahu Mental Health Section will initiate regularly scheduled Inter-Facility Treatment Team Meetings with Neighbor Island Mental Health Sections to improve continuity of care and better address the clinical needs of off-island patients.

In October 2017, OCCC completed the NCCHC on-site survey and obtained health services reaccreditation. OCCC remains in compliance with standards involving screening, assessment, triage, and referral to a licensed mental health professional. OCCC also remains in compliance with standards on suicide prevention, segregation, and use of clinically-ordered restraints. In 2015, NCCHC revised national standards to require 24-hour mental health coverage of acute care mental health modules. Additional staffing, either via the redescription process or a future budget request, will be required in order to meet this need.

b. Other resources to support Psychology Internships in our facilities were similarly initiated at OCCC, and within the FY2014-2015 budget, $150,000 was requested and authorized to continue this initiative. OCCC has been fully accredited by the American Psychological Association (APA) for doctoral and post-doctoral internships. The expanded resources identified in the FY 2014-2015 budget permitted the PSD to place a post-doctoral position at Women's Community Correctional Center (WCCC) in addition to the pre-doctoral position at OCCC. As the new staffing is phased into WCCC, we will prepare the facility for APA site surveys and accreditation. The following year, it is anticipated that the accreditation process will be initiated at HCF, depending on how quickly supervising Psychology staffing can be expanded at each facility which is subject to approval of the reorganization.

c. A partnership with the University of Hawai'i at Manoa John A. Burns School of Medicine, Department of Psychiatry provides Psychiatry residents with a rotation at OCCC. The residents and their Professors assist in the treatment of the acute mental health patient population.

d. The soon-to-be-released 2018 revision to the NCCHC standards will require ongoing assessment of existing resources and staffing to meet updated standards.

2. The use of alternative services, such as the use of telemedicine, to provide mental health services to incarcerated offenders.

   A telemedicine system is presently being utilized to provide tele-psychiatry services to the neighbor island correctional facilities and the Waiawa Correctional Facility. Tele-psychiatry services have served to decrease the transportation costs and the wait times for appointments with the Department psychiatrists.

3. The completion of a departmental training and policy manual.

   a. The Department continues to update the training curriculum for Mental Health Services, Suicide Prevention, and Restraint and Seclusion. Four-hour core courses are offered to all new employees in Mental Health Services and Suicide Prevention, with two-hour refresher courses in both subject areas every other year. Restraint and Seclusion is a two-hour core course with two-hour refreshers every other year. The trainings are targeted at staff having direct contact with inmates. Additionally, all staff are required to have initial First Aid/CPR training, and periodic renewals for certification. The trainings continue to be offered as part of Basic Correctional Training (BCT) and Civilian Familiarization Training (CFT) for

all new uniformed and non-uniformed facility employees, respectively. During FY2015, Mental Health Services and Suicide Prevention Training was expanded to include the PSD Law Enforcement Division (Sheriffs/Narcotics Enforcement Divisions).

b. The Health Care Division has updated many of its policies and procedures contained in the Departmental Policy Manual. All new employees are required to be oriented to this manual.

c. Mental Health Policies and Procedures are reviewed annually for general operational updating, as well as to integrate any changes in best practices to continue to remain current or ahead of national standards.

4. The appropriate type of updated record-keeping system.

The Health Care Division utilizes an Electronic Medical Record (EMR) for all inmate patients in all correctional facilities.

5. An update on the feasibility study initiated by the Departments of Health and Public Safety regarding the expansion of Hawaii State Hospital (HSH), to possibly include a wing so as to be able to adequately treat mental health patients who require incarceration.

a. The DOH has submitted a 21-year plan to address the census issues related to HSH. It is PSD's understanding that this plan is comprised of three 7-year phases focusing on demolition, replacement and construction. Presently HSH is "over census" and has been for several years since the inception of the requirement outlined in Act 144. At this point in time, no capacity exists to entertain the designation of a wing or expansion to treat incarcerated mental health patients.

b. There is an assumption in this requirement that individuals with mental health disorders are not being treated "adequately" in PSD correctional facilities. However, PSD has been able to demonstrate more than adequate treatment at OCCC for these inmates and in spite of some of the physical challenges of our antiquated facilities, the care is "adequate" and will continue to improve, particularly with the additional staff being phased-in during this fiscal year.

6. Any other suggestions or ideas to improve mental health services to incarcerated individuals to comply with local, state and federal laws and mandates.

   a. Periodically, inmates with extreme mental health disorders require long-term involuntary treatment with medication. Recognizing that PSD did not have the capacity to administer long-term involuntary medication for such individuals, PSD proposed and eventually saw the enactment of a new statute that enabled such treatment in the correctional facilities. Since the approval of this statute, PSD has routinely secured court-authorized medications for mentally ill inmates in need of such intervention. In the past 2017 legislative session, the Department sought to operationally refine this statute to streamline the process, while continuing to protect the due process rights of patients.

   b. The Department continues to support and participate in the Stepping-Up Initiative, in conjunction with the Department of Health and the City and County of Honolulu. This initiative will attempt to reduce the number of individuals with mental health disorders, who were incarcerated for minor violations such as trespassing, violating park rules, etc. Additionally, once mentally ill individuals are incarcerated, they remain longer than non-mentally ill individuals with similar charges.

   c. Future Department plans to improve the delivery of Mental Health Care:

      A Centralized Mental Health Treatment center is currently being designed for the Halawa Correctional Facility to house and centralize treatment services for the facility's Severely Mentally Ill patients. It will include individual and group treatment areas and adjacent offices for the mental health staff.

      The plans for the new OCCC facility will include a centralized mental health treatment area which would provide a higher level of care for patients from OCCC and support for the neighbor island correctional facilities.

DAVID Y. IGE
GOVERNOR

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DEPARTMENT OF PUBLIC SAFETY
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No. ____________________

December 4, 2018

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Twenty-Ninth State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Scott K. Saiki, Speaker
and Members of the House of
Representatives
Twenty-Ninth State Legislature
State Capitol, Room 431
Honolulu, HI 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the **Report on Mental Health Services for Committed Persons**, as required by Act 144, Session Laws of Hawaii 2007. Attached to the report is the **Expert Report on Mental Health Care at the Oahu Community Correctional Facility**, presented to the Hawaii Office of the Attorney General and the Hawaii Department of Public Safety, by Joel A. Dvoskin, Ph.D.

In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the combined reports may be viewed electronically at:
https://dps.hawaii.gov/wp-content/uploads/2018/12/Mental-Health-Services-for-Committed-Persons.pdf

Sincerely,

Nolan P. Espinda
Director

Enclosures

DEPARTMENT OF PUBLIC SAFETY
REPORT TO THE 2018 LEGISLATURE

IN RESPONSE TO
ACT 144, SESSION LAWS OF HAWAI'I, 2007
MENTAL HEALTH SERVICES FOR COMMITTED PERSONS

December 2018

Annual Report to the Legislature
In response to Act 144, Session Laws of Hawai'i, 2007
Mental Health Services for Committed Persons

Introduction

This report is hereby submitted to fulfill the requirements outlined in Act 144, Session Laws of Hawai'i, 2007, specifically:

(1) The Department of Public Safety shall submit a report to the Legislature no later than twenty days prior to the commencement of the 2008 regular session and every session thereafter…

(2) This written report shall be submitted in a form understandable by lay readers and made available to the public.

Itemized Report

As outlined in Act 144, Session Laws of Hawai'i, 2007, the Department shall report on six (6) specific items of concern. These six items are listed below (as extracted from the statute), followed by the Department's status report on each item.

1. Assessment of the Department's existing resources and staffing, and or additional resources and staffing needed to bring mental health services up to standard and keep up with future demands.

    a. The focus on the federal investigation and subsequent Settlement Agreement between the State of Hawaii, Department of Public Safety (PSD) and the Federal Department of Justice (DOJ) was to bring the Oahu Community Correctional Center (OCCC) up to national standards for correctional mental health care. In 2015, the Department successfully disengaged from an extended Corrective Action Plan with the DOJ. However, during the maintenance period over the 2016 fiscal year, the Mental Health Branch failed to remain compliant with the standards agreed upon with the DOJ, necessitating programmatic and structural changes, which included the Branch's leadership. In the last fiscal year (FY 2017-18), mental health services at OCCC significantly improved and demonstrated sustained compliance (see attached Expert Report on Mental Health Care at the Oahu Community Correctional Facility, dated 11/30/2018). As a result, the Department has been expanding compliance efforts at other Hawaii facilities.

Mental Health Staffing

In June 2017, thirteen (13) out of thirty-four (34) positions were vacant at the OCCC Mental Health Section (see Table 1 below). To date, six (6) vacancies remain. Most of the six (6) vacancies were created by recent personnel movements, including three (3) promotions within the Mental Health Branch, one (1) transfer within the Health Care Division, and one (1) retirement. OCCC experienced one (1) recent resignation in which a licensed Clinical Psychologist was lost to the Department of Education. The Clinical Psychologist position and one Social Worker/Human Services Professional vacancy is in the process of being filled – both positions have applicants recommended for hire. The remaining vacant positions are in active recruitment with two (2) promotions within the OCCC Mental Health Section pending.

Table 1. Comparative Mental Health Staffing at OCCC

	July 1, 2017		**November 23, 2018**		**Comments**
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	
Psychology	2	3	1	4	One applicant recommended for hire
Social Services	6	6	2	10	One applicant recommended for hire; one vacancy created by recent retirement and one by promotion
Nursing	3	6	1	8	One vacancy created by recent transfer within Health Care Division
Recreation	2	1	0	2	One position to be re-described to PSW/HSP for MCCC
Office Support	0	5	2	3	Two vacancies created by recent promotions within the Mental Health Branch
TOTAL	**13**	**21**	**6**	**27**	

On June 30, 2017, there were thirty-nine (39) vacant positions and thirty-eight (38) filled positions in the Mental Health Branch statewide (see Table 2 below). Since June 30, 2017, twenty (20) mental health positions have been filled. Applications are currently being processed to hire five (5) additional mental health positions: three (3) Clinical Psychologists and two

(2) Social Worker/Human Services Professionals. All remaining vacancies are in active recruitment.

Table 2. Comparative Statewide Mental Health Branch Staffing.

	July 1, 2017		November 23, 2018		Comments
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	
Psychology	10	6	3	13	3 applicants recommended for hire for OCCC and HCF
Social Services	16	17	8	27	2 applicants recommended for hire
Nursing	3	6	1	8	Includes paramedical staff plus (1 RN)
Occupational Therapy	2	1	1	0	1 position to be re-described to Clinical Psychologist
Recreation	2	1	0	2	One position to be re-described to PSW/HSP
Office Support	6	7	4	6	
MH Statistician (RCUH)			0	2	Two positions funded through RCUH
TOTAL	**39**	**38**	**17**	**58**	**20 positions filled**

Over the past year, the Department has identified three (3) key areas affecting mental health resource and staffing needs:

(1) **Statistics Clerk (2.0 FTE)**: Two (2) Statistics Clerk positions were legislatively abolished during the last fiscal year. The two positions are critical for compliance with the DOJ requirement of maintaining a Quality Assurance program. Without the two positions, the Department is unable to sustain compliance with the DOJ requirement. In order to temporarily maintain compliance, the Department has been obliged to contract with RCUH for a maximum of one year to temporarily receive the services of two Mental Health Statisticians. The Department respectfully requests the re-establishment of the two (2) Statistics Clerk positions.

(2) **Retention of Licensed Clinical Psychologist**: The Department participates in the Statewide DHRD Pilot Project for Licensed Health Care Providers. The program, however, requires the Department to fund the program through non-existent resources. Within the last year, the Department experienced resignations from two licensed Clinical

Psychologists: one to the Hawaii State Hospital and one to the Department of Education. In addition, prospective licensed applicants from federal and private agencies have declined Clinical Psychologist positions due to the Department's budgetary constraints and non-competitive salary. The Department respectfully requests an increase in budgetary resources for licensed Clinical Psychologists in order to become salary competitive with other State, Federal and local agencies.

(3) **Weekend and Relief Coverage**: As identified by Dr. Joel Dvoskin, in his Expert Report, the Department is not currently staffed to provide mental health services on weekends. The Department is also not staffed to provide relief mental health coverage for vacation, sick, and other time-off. In order to comply with national standards for the provision of mental health services on weekends and weekday relief, the Department requires the addition of minimal mental health staffing for weekend and relief services at OCCC, WCCC, and the Neighbor Island facilities. The Department respectfully requests the following positions to meet national standards for such coverage:

Clinical Psychologist Supervisor (1.0 FTE)
Clinical Psychologist (4.0 FTE)
Social Worker/Human Services Professional (4.0 FTE)

Mental Health Services

As identified and discussed in Dr. Dvoskin's Expert Report, mental health services at OCCC show significantly improved compliance. Table 3 illustrates Quality Assurance data for Treatment Plan completion rates at OCCC. In December 2017, OCCC mental health achieved a 100% completion rate. This level of performance was sustained, with the exception of the period April-June 2018. Root cause analysis examining the period of sub-performance identified the primary issue as an absence of relief mental health coverage. In addition, the previous practice of completing two treatment plans was replaced by the completion of one comprehensive treatment plan. Finally, the Department's approach to the treatment planning process has been modified from the previous practice of completing the task by the fourteenth day to completion of the treatment plan upon identification of an individual with a serious mental health need.

Table 3. Percentage of Treatment Plans Completed at OCCC.

Treatment Plans Completed (%)		
Month	**2017**	**2018**
January	41%	100%
February	33%	100%
March	74%	100%
April	41%	71%
May	36%	62%
June	19%	59%
July	44%	100%
August	75%	100%
September	82%	100%
October	85%	99%
November	92%	
December	100%	

As mentioned above, the Department has been expanding DOJ compliance efforts at other Hawaii facilities. Table 4 shows Quality Assurance data for Treatment Plan completion rates at WCCC and HCF beginning July 2018. WCCC attained the 100% completion rate in October 2018. HCF has been in sustained 100% compliance.

Table 4. Percentage of Treatment Plans Completed at WCCC and HCF.

Treatment Plans Completed (%)		
2018	**WCCC**	**HCF**
July	83%	100%
August	80%	100%
September	88%	100%
October	100%	100%

Quality Assurance data from May 2016 through July 2017 showed the average monthly provision of psychosocial treatment group activities in designated mental health modules at OCCC were minimal to non-existent (see Table 5 below). Since August 2017, all three designated mental health modules (i.e., Modules 1, 2, and 8), have demonstrated overwhelmingly significant improvement and sustained compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours.

Table 5. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at OCCC.

OCCC			
2016	**Module 1**	**Module 2**	**Module 8**
May	0.80	11.65	0.50
June	4.20	5.80	0.35
July	4.90	8.35	0.00
August	7.65	12.80	0.40
September	5.00	7.65	0.80
October	4.75	6.90	0.60
November	2.25	2.80	1.20
December	1.45	1.85	1.10
2017	**Module 1**	**Module 2**	**Module 8**
January	1.70	2.60	1.55
February	1.85	2.80	1.60
March	1.65	3.20	1.30
April	0.60	2.40	2.00
May	0.00	3.80	1.95
June	0.20	3.40	2.25
July	1.20	1.80	1.80
August	18.35	16.05	19.55
September	23.00	23.12	29.18
October	23.37	20.10	24.43
November	25.15	19.60	24.95
December	23.06	21.25	20.75
2018	**Module 1**	**Module 2**	**Module 8**
January	27.90	26.30	29.00
February	21.06	28.79	31.38
March	24.12	31.00	25.00
April	23.83	29.10	24.60
May	22.40	30.30	26.50
June	27.25	30.88	28.63
July	27.5	29.2	30.7
August	37.9	29.1	38.1
September	36.4	26.4	43.6
October	30.1	31.0	34.1

Table 6 shows Quality Assurance data for the average monthly provision of psychosocial treatment group activities in designated mental health modules at WCCC and HCF. The Women's Mental Health Section includes one residential mental health module and the Halawa Mental Health Section operates four residential mental health housing areas. In May 2018, WCCC achieved compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours. In October 2018, HCF

achieved compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours in all four designated mental health modules (i.e., Modules 1A1, 7I, 7II, and 7III).

Table 6. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at WCCC and HCF.

2018	WCCC	HCF M1A1	HCF M7I	HCF M7II	HCF M7III
January	14.3	15.8	10.0	10.5	10.5
February	15.5	10.5	12.7	11.8	13.1
March	16.3	13.7	11.8	13.5	13.8
April	15.1	19.1	15.8	17.0	17.3
May	21.4	16.2	13.7	14.6	13.5
June	22.4	23.8	15.4	16.2	18.0
July	17.7	22.0	15.8	15.3	13.3
August	21.7	15.5	13.2	13.6	11.4
September	23.8	21.5	17.5	16.8	16.7
October	27.4	20.3	23.2	23.9	21.1

Quality Assurance data from January 2017 through July 2017 showed Discharge Plans were not completed at OCCC as required by National Correctional Mental Health Standards (see Table 7 below). Over the seven-month period, January-July 2017, only 9% of OCCC Discharge Plans were completed. In September 2017, action by Mental Health and Facility Administration resulted in significantly improved completion rates for the provision of discharge plans. Since January 2018, OCCC demonstrated sustained compliance at a 100% completion rate.

Table 7. Percentage of Discharge Plans Completed at OCCC.

Discharge Plans Completed (%)		
Month	**2017**	**2018**
January	11%	100%
February	12%	100%
March	7%	100%
April	10%	100%
May	5%	100%
June	10%	100%
July	9%	100%
August	14%	100%
September	52%	100%
October	78%	100%
November	90%	
December	98%	

Table 8 shows Quality Assurance data for Discharge Plan completion rates at WCCC and HCF beginning July 2018. WCCC and HCF have been in sustained 100% compliance.

Table 8. Percentage of Discharge Plans Completed at WCCC and HCF.

Discharge Plans Completed (%)		
2018	**WCCC**	**HCF**
July	100%	100%
August	100%	100%
September	100%	100%
October	100%	100%

Suicide Prevention

As reported at the most recent NCCHC Correctional Health Care Conference in October 2018, suicide rates in correctional facilities have been increasing steadily nationwide. The Department is dedicated to the continued commitment of suicide prevention in our correctional facilities. As the Nation and the Department continue to uncover additional considerations of risk for suicide, our efforts in implementing suicide prevention strategies to address new learnings persist. Our ongoing goal of developing an infallible suicide prevention program remains unchanged.

In addition to Receiving Screening conducted by the Intake Services Center and Healthcare Intake Screening conducted by nursing staff, inmates entering the correctional system receive specialized Post-Admission Mental Health Screening, which is conducted by qualified mental health professionals. Table 9 shows the percentage of Post-Admission Mental Health Screens completed at OCCC, WCCC, and HCF. Since August 2018, all three facilities have maintained a 100% completion rate.

Table 9. Percentage of Post-Admission Mental Health Screens Completed.

PAMHA Completed (%)			
2017	**OCCC**	**WCCC**	**HCF**
November	99%		
December	100%		
2018	**OCCC**	**WCCC**	**HCF**
January	100%		
February	100%		100%
March	100%	79%	94%

April	100%	100%	100%
May	100%	100%	100%
June	100%	93%	100%
July	100%	91%	100%
August	100%	100%	100%
September	100%	100%	100%
October	100%	100%	100%

In July 2018 and September 2018, the Department's Clinical Psychologists received Suicide Risk Evaluation training. Table 10 shows the completion rates of Suicide Risk Evaluations for infirmary admissions and discharges. Since August 2017, OCCC has demonstrated a sustained 100% completion rate. Available quality assurance data since July 2018 at WCCC and HCF shows a sustained 100% completion rate.

Table 10. Percentage of Suicide Risk Evaluations Completed.

Suicide Risk Evaluations Completed (%)						
	OCCC		WCCC		HCF	
	Admit	D/C	Admit	D/C	Admit	D/C
2017						
August	100%	100%				
September	100%	100%				
October	100%	100%				
November	100%	100%				
December	100%	100%				
2018						
January	100%	100%				
February	100%	100%				
March	100%	100%				
April	100%	100%				
May	100%	100%				
June	100%	100%				
July	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%

Upon discharge from infirmary level care, inmates are provided Caring Contact in-person follow-up services at two periods: 1-3 days and 7-10 days post-discharge. Table 11 shows the percentage of Caring Contacts completed during both periods. Since April 2018, OCCC has

demonstrated a sustained 100% completion rate. The table also shows available quality assurance data at WCCC and HCF since July 2018.

Table 11. Percentage of Caring Contact Follow-Up Completed.

Caring Contact Follow-Up Completed (%)						
	OCCC		WCCC		HCF	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
2017						
July	93%	100%				
August	100%	91%				
September	100%	100%				
October	98%	100%				
November	100%	100%				
December	100%	100%				
2018						
January	94%	100%				
February	100%	100%				
March	100%	91%				
April	100%	100%				
May	100%	100%				
June	100%	100%				
July	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	90%	100%	100%
September	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%

Since December 2017, the Department has demonstrated significant improvements in several other mental health service areas. The following highlights the Department's accomplishments:

- In December 2017, the Oahu Mental Health Section initiated regularly scheduled Inter-Facility Treatment Team Meetings with Neighbor Island Mental Health Sections to improve continuity of care and better address the clinical needs of off-island patients.

- In January 2018, Safety Planning, which was implemented at HCF in 2012, was incorporated into the Suicide Prevention Program at all other facilities. Safety Planning is an empirically-informed suicide intervention for inmates who present with a risk for self-harm.

- In January 2018, Qualified Mental Health Professionals were trained to conduct Mental Health Segregation Reviews to assist in identifying

inmates in need of diversion from segregation placement for the purpose of treatment.

- In January 2018, OCCC implemented no-overtime seven (7) days/week mental health coverage.

- In February 2018, WCCC implemented the Mental Health Status Report (originated at HCF in 2016), which was designed to provide factual mental health treatment information about inmates to assist individuals involved in the parole process with decision-making.

- As a component of the Department's expanded suicide prevention paradigm, in February 2018, HCF and WCCC implemented Mental Health Post-Hearing Assessments of all inmates after parole board hearings. The assessments focus resources on a particularly high risk event during incarceration and assists in the identification of inmates in need of additional evaluation and or treatment.

- In June 2018, the Department, in collaboration with Mike Tamashiro, implemented the AMHD eligibility determination project, which strengthens continuity of care by providing discharge planning services to newly identified inmates in preparation for transition to community-based services.

- In July 2018, the Department contracted with UH REPS to initiate the NCCHC Mental Health Specialty Accreditation Project. The focus of the project is to revise mental health policies and forms in accordance with the 2018 NCCHC standards for prisons and jails, as well as the 2015 NCCHC mental health standards for correctional facilities. The project also intends to develop a Statewide Quality Assurance Program, incorporating NCCHC compliance indicators.

- In July 2018, the Department implemented supplemental weekly segregation rounds conducted by Clinical Psychologists. In addition to the weekly segregation rounds by the Licensed Mental Health Professional, a Qualified Mental Health Professional conducts daily segregation rounds, and a Qualified Health Care Professional conducts at least daily segregation rounds.

- In August 2018, the Department completed Mental Health First Aid Training for all mental health staff Statewide.

- In November 2018, Oahu mental health staff participated in Suicide Prevention training conducted by the Prevent Suicide Hawai'i Statewide Task Force. Oahu mental health staff also participated in the

two-day Applied Suicide Intervention Skills Training (ASIST) throughout the year.

b. Resources to continue to support American Psychological Association (APA) accredited Clinical Psychology Internships and Post-Doctoral Fellowships in our facilities have been submitted in the current budget request. OCCC has been fully accredited by the APA for doctoral internships through WICHE. The Department also participates in WICHE Post-Doctoral fellowships. The expanded resources identified in the FY 2016-2017 budget permitted the Department to place a post-doctoral position at WCCC and a Clinical Psychology Pre-Doctoral Internship position at OCCC. As the Department builds upon an investment on early career psychologists, the near-term plan is the expansion of APA accredited Clinical Psychology opportunities for residents of Hawaii.

c. A partnership with the University of Hawai'i at Manoa, John A. Burns School of Medicine, Department of Psychiatry, provides Psychiatry residents with a rotation at OCCC. The residents and their Professors assist in the treatment of the acute mental health patient population.

2. The use of alternative services, such as telemedicine, to provide mental health services to incarcerated offenders.

A telemedicine system is presently being utilized to provide tele-psychiatry services to the neighbor island correctional facilities and the Waiawa Correctional Facility. Tele-psychiatry services have served to decrease the transportation costs and the wait times for appointments with the Department psychiatrists.

3. The completion of a departmental training and policy manual.

a. The Department continues to update the training curriculum for Mental Health Services, Suicide Prevention, and Restraint and Seclusion. Four-hour core courses are offered to all new employees in Mental Health Services and Suicide Prevention, with two-hour refresher courses in both subject areas every other year. Restraint and Seclusion is a two-hour core course with two-hour refreshers every other year. The trainings are targeted at staff having direct contact with inmates. Additionally, all staff are required to have initial First Aid/CPR training with periodic renewals for certification. The trainings continue to be offered as part of Basic Correctional Training (BCT) and Corrections Familiarization Training (CFT) for all new uniformed and non-uniformed facility employees, respectively. During FY2015, Mental Health Services and Suicide Prevention Training was expanded to include the Law Enforcement Division.

b. The Health Care Division has updated many of its policies and procedures contained in the Departmental Policy Manual. All new employees are required to be oriented to this manual.

c. Mental Health Policies and Procedures are reviewed annually for general operational updating. The Department, in collaboration with UH REPS (headed by Dr. Julie Takishima-Lacasa), initiated the NCCHC Mental Health Specialty Accreditation Project. The focus of the project is to revise mental health policies and forms in accordance with the 2018 NCCHC standards for prisons and jails, as well as the 2015 NCCHC mental health standards for correctional facilities.

4. The appropriate type of updated record-keeping system.

The Health Care Division utilizes an Electronic Medical Record (EMR) for inmate patients in all correctional facilities.

5. An update on the feasibility study initiated by the Departments of Health and Public Safety regarding the expansion of Hawaii State Hospital (HSH), to possibly include a wing so as to be able to adequately treat mental health patients who require incarceration.

a. The DOH has submitted a 21-year plan to address the census issues related to HSH. It is PSD's understanding that this plan is comprised of three 7-year phases focusing on demolition, replacement and construction. Presently HSH is "over census" and has been for several years since the inception of the requirement outlined in Act 144. At this point in time, no capacity exists to entertain the designation of a wing or expansion to treat incarcerated mental health patients.

b. There is an assumption in this requirement that individuals with mental health disorders are not being treated "adequately" in PSD correctional facilities. However, the Department has been able to demonstrate more than adequate treatment at OCCC for these inmates and in spite of some of the physical challenges of our antiquated facilities, the care is "adequate" and will continue to improve.

6. Any other suggestions or ideas to improve mental health services to incarcerated individuals to comply with local, state and federal laws and mandates.

a. As identified by Dr. Dvoskin in his Expert Report, the Department's mental health staff is in need of additional resources for training in order to improve the quality of psychosocial treatment groups.

b. The Department continues to support and participate in the Stepping-Up Initiative, in conjunction with the Department of Health and the City and County of Honolulu. This initiative will attempt to reduce the number of individuals with mental health disorders incarcerated for minor violations such as trespassing, violating park rules, etc. Additionally, once mentally ill individuals are incarcerated, they remain longer than non-mentally ill individuals with similar charges.

c. Future Department plans to improve the delivery of Mental Health Care:

The Halawa Correctional Facility is presently in the design phase of a Centralized Mental Health Treatment center which will house and centralize the treatment services for the facility's Severely Mentally Ill patients. This will include individual and group treatment areas and provide the mental health staff with adjacent office areas.

The plans for the new OCCC facility will include a centralized mental health treatment area, which would provide a higher level of care for patients from OCCC and support for the Neighbor Island correctional facilities.

Expert Report on Mental Health Care at the Oahu Community Correctional Facility
Presented to the Hawaii Office of the Attorney General
and the Hawaii Department of Public Safety

Joel A. Dvoskin, Ph. D.
November 30, 2018

At the request of Deputy Attorney General Diane Taira and Director of Public Safety Nolan Espinda, I toured the Oahu Community Correctional Center (OCCC) on August 14 and 15, 2018.

My charge was to assess the adequacy of mental health care at OCCC, with specific attention to maintenance of the improvements that were accomplished during the period of investigation and Settlement Agreement with the United States Department of Justice (DOJ).

OCCC is predominantly used as a pretrial detention facility for detainees awaiting trial on the Island of Oahu. However, because many of the psychiatric and mental health services are centralized at OCCC, some detainees from the other islands with mental health needs are housed there as well. The facility holds both male and female detainees and inmates, and includes specialized mental health housing for both men and women.

Overcrowding and Staffing

The most significant finding regarding OCCC is that the facility remains overcrowded, which creates stress on inmates and staff alike. A significant number of inmates were unfortunately required to sleep on mattresses on the floor. While crowding itself will remain a huge problem, no inmate or detainee should be sleeping on a mattress that is laying directly on the floor.

> **I recommend to the Department the purchase of plastic "boats," or plastic canoe-shaped trays that can be laid on the ground, and which keep the mattresses off the floor.**

I was informed by Director Espinda that the State of Hawaii is considering legislation that will create bail reform as well as incentives for criminal justice agencies to engage in diversion from the criminal justice system for certain non-dangerous offenders, especially those with drug or mental health problems.

> **I strongly support such legislation. Jails should be reserved for the people who pose a serious risk to the public safety.**

I have also been told that Hawaii is considering creation of a new, modern, and somewhat larger jail on Oahu.

> **I strongly support creation of a new jail. Even if additional diversion and bail reform efforts come to fruition, it is likely that OCCC will be too small to accommodate the people who actually need pre-trial detention. More importantly, OCCC is currently housed in buildings that are not particularly well suited for modern correctional programs, especially those programs specifically aimed at inmates and detainees with serious mental illnesses.**

Due to high use of sick leave and occupational injury leave (OIL), staffing is a constant challenge to the Department and OCCC leadership. On average, OCCC has an astonishing number of absentee staff, as many as 100 per day. The absences in turn create extreme stress for the staff that show up for work, as well as mandatory overtime, which negatively affects morale, and in turn increases absenteeism.

> **Considering the chronically high rate of sick leave and OIL, it appears to me that OCCC's staffing complement is inadequate. Relief factors should include known use of vacation, sick leave, OIL, weekends, vacancies, and suspensions.**

The most serious consequence of the frequent staffing shortages occurs when Sergeants are sometime unable to immediately respond to an emergency because they have to wait for backup. So far, I am unaware of any tragic consequence related to this problem, but it must be remedied.

> **Again, the so-called "essential" posts must be filled at all times. In my opinion, this will require a staffing pattern that accounts for the predictable use of sick leave, OIL, vacancies, and other forms of absenteeism.**

Segregated Housing (Control Unit) and Mitigation Reviews

Despite the crowding and staffing challenges, I was pleased to see that OCCC has decreased its use of segregated housing (when compared to its use during the period of the Settlement Agreement with DOJ).

The staff at OCCC has done an excellent job of conducting mental health rounds in segregation, consistently scoring 100% compliance. Rounds are conducted 7 days per week by social work staff, and one day per week by psychologists, which is above and beyond the standard of care for such settings. Similarly, the mitigation reviews of disciplinary charges were conducted with 100% compliance.

> **The staff at OCCC is completely compliant with the mental health rounds in segregation as well as mitigation reviews when inmates with mental illness are charged with disciplinary violations.**

Unfortunately, I observed several inmates in the Control Unit whose beds did not appear to have sheets or other bedding. When I brought this to the attention of the staff, they immediately remedied the situation. I was not able to ascertain the reason for the missing bedding. However, regular rounds by supervisory staff should prevent this from happening at all.

> **Supervisory staff should visit each cell on the control unit at least several times per shift.**

Treatment Planning

At the time of my visit, OCCC was in the process of combining the initial and the comprehensive treatment plans. This promises to be more efficient, and to improve the quality of those plans. The preliminary treatment plans were completed 100% of the time, although approximately 2% of them were late. On the other hand, the comprehensive treatment plans were only completed on time about 57% of the time. While this is unacceptable, in my opinion, the decision to combine the preliminary and comprehensive treatment plans is very likely to remedy this problem.

> **OCCC is substantially compliant with the standard of care regarding timely preliminary treatment plans for newly admitted inmates with serious mental health needs. However, the comprehensive treatment plans are late approximately half the time. I support the plan to combine these treatment plans, which should improve timeliness and productivity.**

Suicide Prevention

The staff at OCCC was compliant with the suicide risk assessments (SRE) upon admission, as well as the SRE's upon discharge from suicide watch. Similarly, there was 100% compliance with the important 1-3 day follow-up assessments for people who were recently discharged from suicide watch status, as well as the 7-10 day follow-ups. During the past year, there were no deaths by suicide at OCCC, although there were 2 serious attempts.

> **OCCC is compliant with the standard of care for suicide risk assessments and follow-up assessments for people who have been released from suicide watch status.**

Due to some long-standing abuse of the doors by patients, I observed some difficulty in seeing into the rooms that are used for suicide watch. However, the Warden informed me that plans are underway to renovate these cells to ameliorate this problem.

While it is still possible for staff to see into the suicide watch rooms, I support the plan to renovate the cells to allow unimpeded vision.

As was the case in prior years, the wands used to verify suicide watch by officers do not always work, this despite repeated efforts by the facility to work with the vendor. Nevertheless, the Department has ensured compliance with suicide watch requirements by contracting with independent observers who randomly sample video footage. These reviews have confirmed consistent compliance with the required frequency of observations.

OCCC is compliant with suicide watch procedures.

Improvements in Eligibility Process for the Adult Mental Health Division (AMHD)

The Department has improved the process of AMHD eligibility for inmates and detainees with serious mental illnesses. This process is especially important in regard to continuity of care for inmates and detainees with serious and disabling mental illnesses who return directly to the community from OCCC.

I applaud the improved relationship between DPS and AMHD, especially in regard to the eligibility process for inmates and detainees with serious and disabling mental illnesses.

Quality Improvement (QI) and Structured Therapeutic Programs

I reviewed the minutes of the quarterly QI meetings. The agenda was appropriate, and the quality of data seemed much improved from my last visit to OCCC. Indeed, I would describe the format and content of the QI data as excellent.

The Department of Public Safety is compliant with the QI requirements of the DOJ Settlement Agreement. Indeed, the process is even better than it was when it was approved by DOJ.

The audits of group treatment for inmates and detainees in mental health housing showed that the number of hours appeared adequate and compliant with the former DOJ Settlement Agreements. It is especially important to note that the number of structured therapeutic hours increased significantly when Dr. Gavin Takenaka took over supervision of the mental health program within DPS.

That being said, my observations suggest a need for continued improvement in the quality of group therapy, which suggests a need for additional training specifically aimed at the provision of group therapy with persons with serious mental illness, as well as those in psychiatric, emotional, or suicidal crisis.

The Department is substantially compliant with the number of therapeutic hours in the acute mental health units, although there is room for improvement in regard to the quality of the groups. I recommend additional training for the staff that provide and supervise the groups.

One concern was the fact that custody staff would talk unnecessarily loudly during group therapy, which interrupted the groups. Custody staff must be reminded that they have an important role in creating and maintaining a therapeutic environment in the acute units. This includes avoiding any unnecessary interruptions during group therapy.

Except where necessary, I recommend that custody staff be required to remain silent while groups are being conducted in the acute mental health units.

I noted that the Department does not count recreation therapy as structured therapeutic hours. If the recreation therapy is merely free time on the yard, I agree that these hours should not be counted. However, when the activities are structured and consistent with the treatment needs of the patients (e.g., organized team sports), I would recommend that these hours be documented in each patient's record and counted as structured therapeutic hours.

I recommend that formal recreation therapy (e.g., team sports) be counted as structured therapeutic activity.

Staff Training

Quality improvement data revealed 100% compliance with mandated staff training. In addition OCCC has begun implementation of Mental Health First Aid Training for some officers.

OCCC has exceeded compliance with staff training requirements.

Seclusion and Restraint

The Custody and Mental Health staff and leadership at OCCC used seclusion in accordance with the DOJ Settlement Agreements. When patients were confined to their rooms, either to prevent violence or to prevent suicide, the incidents were managed and documented appropriately. As noted above, when cell confinement was due to custody concerns (e.g., danger to others, protective custody, or disciplinary infraction) the Department followed the DOJ Settlement Agreement to the letter. This compliance included both mental health rounds in the holding unit as well as the mitigation evaluations.

One low-tech but helpful change has been flagging certain inmates and detainees as ineligible for segregation due to their clinical status.

> **OCCC is compliant in regard to the use of seclusion and restraint.**

Discharge Planning

I was impressed with the improvements in discharge planning. As noted above, this is especially important for those patients who are expected to return to the community, but also applies to those who will eventually serve a prison sentence. The discharge planning process for jails must always begin with the initial and comprehensive treatment plans, since it is often difficult to know if and when any individual will be released from jail.

> **OCCC is substantially compliant with discharge planning.**

Staffing

As noted above, OCCC has been beset by a combination of crowding and inadequate staffing (mainly due to sick and occupational injury leave). As a result, posts that are supposed to be filled at all times are not. On the other hand, mental health staffing is richer than what was agreed to with the Department of Justice.

> **In my opinion, it is imperative that essential security posts in the acute mental health units be maintained at all times.**

Medication Adherence

When inmates or detainees refuse medication, the prescriber is notified almost immediately by email. The standard of care is to notify the prescriber if a patient refuses medication for 3 consecutive doses, more than fifty percent of doses in a week, or any other clinically significant pattern of non-adherence. At OCCC, the nurses email prescribers each time a dose is refused, which exceeds the standard of care.

> **OCCC is exceeding the standard of care for notifying prescribers of non-adherence to medication.**

Institutional Culture and Morale

Despite the significant problems posed by overcrowding and understaffing, the morale among the mental health staff appeared to me to be excellent. Mental health staff members appeared to communicate well and frequently with each other. Morale among custody staff has been a challenge, largely due to the combination of overcrowding and understaffing mentioned above. In my experience, it is virtually

impossible to maintain good morale when custody staff are frequently required to work mandatory overtime shifts.

> **Again, the staffing allocation at OCCC must take into consideration the known history of of various forms of leave and absenteeism.**

Miscellaneous Recommendations

1. I recommend consideration of the creation of a "program unit." This unit would include some inmates and detainees with serious mental illness who are reasonably stable but whose psychological vulnerability requires a less stressful correctional environment. In order to ensure that all beds are filled, however, the unit should also include other inmates who are physically and/or psychologically vulnerable. The unit would need to be restricted to those individuals who pose no threat of violence or predatory behavior toward these vulnerable inmates and detainees. Any evidence of such predatory, violent, or intimidating behavior should result in immediate transfer out of the unit.

2. When people are assigned to the acute mental health units due to a crisis, it is common for them to require a day or two of rest or convalescence before they should be expected to participate in structured therapeutic activities. Some of these patients will have received a first dose of psychotropic medication, while others will be on suicide prevention status. For this reason, the Department might consider eliminating the first day or two of housing in the acute mental health units from the accounting of therapeutic hours. Of course, if the patient is willing and able to tolerate such structured activities, they should be encouraged to do so.

3. Whenever any policy, procedure, or practice is changed, I recommend that it be temporarily added to the QI audits to ensure that it is being implemented as intended.

4. For several reasons, I strongly recommend the addition of a half-time psychologist, to provide coverage and treatment on weekends.

5. Individuals on the highest level of suicide watch are almost always confined to their cells. I recommend that inmates on this status be allowed out of their cells, under supervision, whenever possible for at least several hours per day.

6. Inmates on suicide watch should be allowed reading materials, such as magazines or books without staples. There is simply no reason to enforce extreme idleness and boredom when an individual is deemed to be acutely suicidal.

7. Whenever a patient refuses their prescribed medication, the nurses should try again in a little while.

8. It is my understanding that the Department is striving to create wireless access to medical records, which will dramatically improve the productivity of the treatment staff and the quality of the medical records.

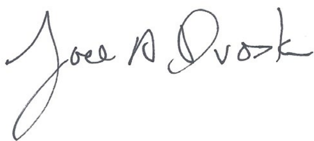
9. The process for involuntary medication administration is cumbersome and time-consuming., and appears to be much more restrictive than required by constitutional law (see, e.g., *Harper v. Washington*) and processes used in other states. While I agree that involuntary medication should never be a first choice, there are times when it is necessary to avoid unnecessary suffering on the part of a patient, and unnecessary danger to staff and other inmates. It is not clear to me if changing this process would require legislation, but I recommend consideration of a more streamlined and efficient process for making decisions about forced medication.

Summary and Conclusions

Overall, I was impressed with the enthusiasm of the OCCC mental health and custody staff and leadership to comply with the Department's prior agreements with the Department of Justice. In my opinion, virtually all of the areas of needed improvement listed in this report are due to two sources – overcrowding and understaffing. The OCCC physical plant, in addition to being too small to accommodate its population, is poorly designed for modern correctional and detention methods. It is my understanding that the Department is interested in building a new jail to replace OCCC, a plan with which I enthusiastically agree. In addition, I also support passage of legislation that will accomplish bail reform and diversion of non-dangerous offenders (especially those with serious mental illness) from the criminal justice system.

As always, I am deeply appreciative of the trust that has been shown to me by the Office of the Attorney General and the Department of Public Safety.

Respectfully submitted,



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December 12, 2019

The Honorable Ronald D. Kouchi,
President and Members of the Senate
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State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Scott K. Saiki, Speaker
and Members of the House of
Representatives
Thirtieth State Legislature
State Capitol, Room 431
Honolulu, HI 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the Report on Mental Health Services for Committed Persons, as required by Act 144, Session Laws of Hawaii, 2007. In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at: https://dps.hawaii.gov/wp-content/uploads/2019/12/Report on Mental Health Services for Committed Persons.pdf.

Sincerely,

Nolan P. Espinda
Director

Enclosures

DEPARTMENT OF PUBLIC SAFETY
REPORT TO THE 2020 LEGISLATURE

IN RESPONSE TO
ACT 144, SESSION LAWS OF HAWAII, 2007
MENTAL HEALTH SERVICES FOR COMMITTED PERSONS

December 2019

Annual Report to the Legislature
In response to Act 144, Session Laws of Hawaii, 2007
Mental Health Services for Committed Persons

Introduction

This report is hereby submitted to fulfill the requirements outlined in Act 144, Session Laws of Hawai'i, 2007, specifically:

(1) The Department of Public Safety shall submit a report to the Legislature no later than twenty days prior to the commencement of the 2008 regular session and every session thereafter…

(2) This written report shall be submitted in a form understandable by lay readers and made available to the public.

Itemized Report

As outlined in Act 144, Session Laws of Hawai'i, 2007, the Department shall report on six (6) specific items of concern. These six items are listed below (as extracted from the statute), followed by the Department's status report on each item.

1. Assessment of the Department's existing resources and staffing, and or additional resources and staffing needed to bring mental health services up to standard and to keep up with future demands.

    a. The focus on the federal investigation and subsequent Settlement Agreement between the State of Hawaii, Department of Public Safety (PSD) and the Federal Department of Justice (DOJ) was to bring the Oahu Community Correctional Center (OCCC) up to national standards for correctional mental health care. In 2015, the Department successfully disengaged from an extended Corrective Action Plan with the DOJ. However, during the maintenance period over the next two years, the Mental Health Branch failed to remain compliant with the standards agreed upon with the DOJ, necessitating programmatic and structural changes, which included the Branch's leadership. Since the 2018 fiscal year, mental health services at OCCC significantly improved and demonstrated sustained compliance with the DOJ requirements for the provision of mental health services. As a result, the Department has been expanding compliance efforts at other Hawaii facilities.

Mental Health Staffing

In June 2017, thirteen (13) out of thirty-four (34) positions were vacant at the OCCC Mental Health Section (see Table 1 below). Nine vacancies have been filled, leaving four (4) vacant positions at present. Two of the four remaining vacant positions are in active recruitment, with one position nearing completion in the hiring process. Two of the four vacant positions are being re-described to Research Statistician positions and relocated within the Health Care Division to support the comprehensive Health Care Quality Assurance Program.

Table 1. Comparative Mental Health Staffing at OCCC

	July 1, 2017		**November 25, 2019**		**Comments**
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	
Psychology	2	3	1	4	Through the WICHE agreement, PSD employs an additional Post-Doctoral Clinical Psychologist.
Social Services	6	6	1	11	One vacancy created by a recent resignation to move out-of-state in May 2019.
Nursing	3	6	0	9	
Recreation	2	1	0	2	
Office Support	0	5	2	3	Two vacancies to be re-described to Research Statistician positions and relocated within the Health Care Division to support the Health Care Quality Assurance Program.
TOTAL	**13**	**21**	**4**	**29**	

On June 30, 2017, there were thirty-nine (39) vacant positions and thirty-eight (38) filled positions in the Mental Health Branch statewide (see Table 2 below), as compared with the current fifteen (15) vacant positions and fifty-eight (58) filled positions in the Mental Health Branch statewide. In addition to the re-description of two office support positions, the Mental Health Branch intends to re-describe the Occupational Therapist position to a Clinical Psychologist position to support the overwhelming demand for

trauma therapy at the Women's Community Correctional Center (WCCC). Applications are currently being processed to hire five (5) additional mental health positions: two (2) Clinical Psychologists, two (2) Social Worker/Human Services Professionals, and one (1) office support staff. The seven (7) remaining vacancies are in active recruitment.

Table 2. Comparative Statewide Mental Health Branch Staffing.

	July 1, 2017		**November 25, 2019**		**Comments**
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	
Psychology	10	6	3	13	One recent promotion within the Health Care Division and one recent resignation on 10/18/19.
Social Services	16	17	7	28	Two recommended hires pending completion of the background check.
Nursing	3	6	0	9	
Occupational Therapy	2	1	1	0	Position to be re-described to Clinical Psychologist
Recreation	2	1	0	2	
Office Support	6	7	4	6	One recommended hire, pending completion of the background check. Two vacancies to be re-described to Research Statistician positions and relocated within the Health Care Division to support the Health Care Quality Assurance Program.
TOTAL	**39**	**38**	**15**	**58**	

Over the past two years, the Department has identified three (3) key areas affecting mental health resource and staffing needs:

(1) **Statistics Clerk (2.0 FTE)**: Previously, two (2) Statistics Clerk positions were abolished by Act 53, SLH 2018. The two positions were critical for compliance with the DOJ requirement of maintaining a Quality Assurance program. Without the two positions, the Department would have been unable to sustain compliance with the DOJ requirement. In order to temporarily maintain compliance, the Department was obliged to contract with RCUH (Research Corporation of the University of Hawaii) for a maximum of one year, to temporarily receive the services of two Mental Health Statisticians. The Department will be requesting the re-establishment of the Statistics Clerk position in the upcoming Legislative session.

(2) **Retention of Licensed Clinical Psychologist**: The Department participates in the Statewide DHRD (Department of Human Resources Development) Pilot Project for Licensed Health Care Providers. The program, however, requires the Department to fund the program through non-existent resources. Within the past two years, the Department lost three licensed Clinical Psychologists to other State agencies that had the resources to competitively recruit licensed providers. In addition, prospective licensed applicants from federal and private agencies have declined Clinical Psychologist positions due to the Department's budgetary constraints and non-competitive salaries. The Department respectfully requests an increase in budgetary resources for Clinical Psychologists, in order to become salary competitive with other State, federal, and local agencies.

(3) **Weekend and Relief Coverage**: As identified by Dr. Joel Dvoskin, in his 2018 Expert Report (Attached; also attached to Act 144 Report to the 2019 Legislature), the Department is not currently staffed to provide mental health services on weekends. The Department is also not staffed to provide relief mental health coverage for vacation, sick, and other time-off. The current number of allotted Clinical Psychologist positions at our correctional facilities statewide was designated by the mental health staffing plan to provide clinical psychology services during normal business hours (i.e., Monday through Friday, 0745 to 1630). An assessment of the mental health needs of individuals in custody, however, indicates that the current staffing plan does not fully meet the needs of the comprehensive Suicide Prevention Program. The identified problem is an absence of evening and weekend Clinical Psychology services at our Mental Health Sections statewide.

Individuals in custody do not only become suicidal and do not only require therapeutic intervention for the reduction of suicide risk during normal business hours. Presently, an individual being monitored for

suicide risk over the weekend must wait until the next business day for evaluation and treatment of suicide risk. An individual who enters a correctional facility during the evening and exhibits suicide warning signs must wait until the next business day for a Suicide Risk Evaluation. These scenarios requiring urgent psychological evaluation and intervention are common problems identified in the Suicide Prevention Program as caused by the limitations of the current allotment of Clinical Psychology positions. The addition of one Clinical Psychologist at six correctional facilities (i.e., Halawa Correctional Facility, Oahu Community Correctional Center, Women's Community Correctional Center, Hawaii Community Correctional Center, Maui Community Correctional Center, and Kauai Community Correctional Center), would allow the Department to begin addressing the urgent need for evening and weekend mental health services.

Mental Health Services

Over the past year, mental health services at OCCC showed overall sustained compliance with DOJ requirements for the provision of mental health services. Table 3 illustrates Quality Assurance data for Treatment Plan completion rates at OCCC over the last three years. The data clearly show ongoing and sustained improvement in treatment plan completion rates, with the highest completion rates occurring during the past year. The Department's approach to the treatment planning process, which was modified from the previous practice of completing the task by the fourteenth day to completion of the treatment plan upon identification of an individual with a serious mental health need, has contributed to the improved outcomes.

Table 3. Percentage of Treatment Plans Completed at OCCC.

Treatment Plans Completed (%)			
Month	**2017**	**2018**	**2019**
January	41%	100%	100%
February	33%	100%	100%
March	74%	100%	100%
April	41%	71%	100%
May	36%	62%	100%
June	19%	59%	100%
July	44%	100%	100%
August	75%	100%	100%
September	82%	100%	100%
October	85%	99%	100%
November	92%	100%	
December	100%	100%	

As mentioned above, the Department has been expanding DOJ compliance efforts at other Hawaii facilities. Table 4 shows Quality Assurance data for Treatment Plan completion rates at WCCC and HCF beginning July 2018. Over the past year, WCCC maintained the 100% completion rate in all months except December 2018. Root Cause Analysis examining the month of sub-performance identified the source of the problem as the initial transition period when women from OCCC were being temporarily housed at WCCC due to construction at the OCCC female mental health module. In the months following the transition, the data show that corrective action by WCCC was immediate and effective. In addition, HCF has been in sustained 100% compliance.

Table 4. Percentage of Treatment Plans Completed at WCCC and HCF.

Treatment Plans Completed (%)		
2018	**WCCC**	**HCF**
July	83%	100%
August	80%	100%
September	88%	100%
October	100%	100%
November	100%	100%
December	94%	100%
2019	**WCCC**	**HCF**
January	100%	100%
February	100%	100%
March	100%	100%
April	100%	100%
May	100%	100%
June	100%	100%
July	100%	100%
August	100%	100%
September	100%	100%
October	100%	100%

Quality Assurance data from May 2016 through July 2017 showed the average monthly provision of psychosocial treatment group activities in designated mental health modules at OCCC were minimal to non-existent (see Table 5 below).

Table 5. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at OCCC (05/2016 – 07/2017).

OCCC			
2016	**Module 1**	**Module 2**	**Module 8**
May	0.80	11.65	0.50
June	4.20	5.80	0.35
July	4.90	8.35	0.00
August	7.65	12.80	0.40
September	5.00	7.65	0.80
October	4.75	6.90	0.60
November	2.25	2.80	1.20
December	1.45	1.85	1.10
2017	**Module 1**	**Module 2**	**Module 8**
January	1.70	2.60	1.55
February	1.85	2.80	1.60
March	1.65	3.20	1.30
April	0.60	2.40	2.00
May	0.00	3.80	1.95
June	0.20	3.40	2.25
July	1.20	1.80	1.80

Since August 2017, all three designated mental health modules (i.e., Modules 1, 2, and 8), have demonstrated overwhelmingly significant improvement and overall sustained compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours (see Table 6 below). Despite resource limitations, attention to the importance of ensuring compliance with this DOJ requirement by OCCC facility administration and security staff has been the primary cause for sustained compliance and success. Note: Over the past year, the construction project at OCCC mental health Modules 1 and 8 resulted in module closures, which is reflected in the data table.

Table 6. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at OCCC (08/2017 – 09/2019).

OCCC			
2017	**Module 1**	**Module 2**	**Module 8**
August	18.35	16.05	19.55
September	23.00	23.12	29.18
October	23.37	20.10	24.43
November	25.15	19.60	24.95
December	23.06	21.25	20.75
2018	**Module 1**	**Module 2**	**Module 8**
January	27.90	26.30	29.00
February	21.06	28.79	31.38
March	24.12	31.00	25.00
April	23.83	29.10	24.60
May	22.40	30.30	26.50
June	27.25	30.88	28.63
July	27.5	29.2	30.7
August	37.9	29.1	38.1
September	36.4	26.4	43.6
October	30.1	31.0	34.1
November	32.0	20.9	18.2
*December	N/A	30.8	N/A
2019	**Module 1**	**Module 2**	**Module 8**
*January	N/A	28.0	N/A
*February	N/A	23.1	N/A
*March	26.8	18.7	N/A
*April	34.7	32.3	N/A
*May	18.4	32.4	N/A
June	20.5	20.0	26.8
July	40.1	31.4	21.9
August	21.8	27.2	22.4
September	46.8	46.6	27.6
October	45.1	41.3	37.9

*Period of construction at mental health modules requiring module closure.

Table 7 shows Quality Assurance data for the average monthly provision of psychosocial treatment group activities in designated mental health modules at WCCC and HCF. The Women's Mental Health Section includes one residential mental health module, and the Halawa Mental Health Section operates four residential mental health housing areas. Since August 2018, WCCC has demonstrated sustained compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours.

Due to the construction project at the OCCC female mental health module, WCCC operated an additional mental health module from part of December 2018 to May 2019.

In October 2018, HCF achieved compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours in all four designated mental health modules (i.e., Modules 1A1, 7I, 7II, and 7III). This level of performance was sustained, with the exception of the period April-May 2019. During this period, a new, temporary mental health administrator at the facility altered operations in a manner that contradicted the objectives of the Department, resulting in poor performance outcomes on this measure. The temporary administrator was removed at the end of May 2019, and operational issues were immediately corrected. HCF has since demonstrated significant improvement and sustained compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours.

Table 7. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at WCCC and HCF.

2018	**WCCC OB**	**WCCC OB-J**	**HCF M1A1**	**HCF M7I**	**HCF M7II**	**HCF M7III**
January	14.3	N/A	15.8	10.0	10.5	10.5
February	15.5	N/A	10.5	12.7	11.8	13.1
March	16.3	N/A	13.7	11.8	13.5	13.8
April	15.1	N/A	19.1	15.8	17.0	17.3
May	21.4	N/A	16.2	13.7	14.6	13.5
June	22.4	N/A	23.8	15.4	16.2	18.0
July	17.7	N/A	22.0	15.8	15.3	13.3
August	21.7	N/A	15.5	13.2	13.6	11.4
September	23.8	N/A	21.5	17.5	16.8	16.7
October	27.4	N/A	20.3	23.2	23.9	21.1
November	22.9	N/A	21.2	21.1	22.0	20.4
December	22.3	11.06	20.5	22.1	22.6	20.9
2019	**WCCC OB**	**WCCC OB-J**	**HCF M1A1**	**HCF M7I**	**HCF M7II**	**HCF M7III**
January	25.9	25.8	16.4	22.0	22.4	21.4
February	27.8	34.2	16.1	20.1	21.6	18.7
March	27.6	38.7	20.1	20.7	21.4	18.9
April	24.8	44.4	24.5	15.4	16.9	15.4
May	27.3	23.6	21.7	11.9	10.8	11.5
June	32.2	N/A	25.8	20.2	20.9	19.9
July	37.3	N/A	20.8	24.2	23.7	23.0
August	27.9	N/A	27.6	45.3	45.4	45.4
September	25.8	N/A	25.4	48.3	48.8	48.7
October	34.2	N/A	28.1	46.4	45.0	47.2

Quality Assurance data from January 2017 through July 2017 showed Discharge Plans were not completed at OCCC as required by National Correctional Mental Health Standards (see Table 8 below). Over the seven-month period, January-July 2017, only 9% of OCCC Discharge Plans were completed. In September 2017, action by Mental Health and Facility Administration resulted in significantly improved completion rates for the provision of discharge plans. Since January 2018, OCCC has demonstrated overall sustained compliance and significant improvement with the requirement of providing discharge planning for individuals in custody with serious mental health needs.

Table 8. Percentage of Discharge Plans Completed at OCCC.

Discharge Plans Completed (%)			
Month	**2017**	**2018**	**2019**
January	11%	100%	100%
February	12%	100%	100%
March	7%	100%	100%
April	10%	100%	100%
May	5%	100%	100%
June	10%	100%	100%
July	9%	100%	100%
August	14%	100%	100%
September	52%	100%	100%
October	78%	100%	100%
November	90%	100%	
December	98%	100%	

Table 9 shows Quality Assurance data for Discharge Plan completion rates at WCCC and HCF beginning July 2018. WCCC and HCF have been in sustained 100% compliance.

Table 9. Percentage of Discharge Plans Completed at WCCC and HCF.

Discharge Plans Completed (%)		
2018	**WCCC**	**HCF**
July	100%	100%
August	100%	100%
September	100%	100%
October	100%	100%
November	100%	100%
December	100%	100%

2019	WCCC	HCF
January	100%	100%
February	100%	100%
March	100%	100%
April	100%	100%
May	100%	100%
June	100%	100%
July	100%	100%
August	100%	100%
September	100%	100%
October	100%	100%

Suicide Prevention

State Mental Health Directors and Health Authorities at the National Commission on Correctional Health Care, the American Correctional Association, and the National Institute of Corrections continue to report increasing rates of suicide in correctional facilities nationwide. The Department is dedicated to the continued commitment of suicide prevention in our correctional facilities. As the nation and the Department continue to uncover additional considerations of risk for suicide, our efforts in implementing suicide prevention strategies to address new knowledge persist. Our ongoing goal of developing an infallible suicide prevention program remains unchanged.

The Department administers a comprehensive and multifaceted team approach to the Suicide Prevention Program, which includes the following components: training, identification, referral, evaluation, treatment, housing, monitoring, communication, intervention, notification, reporting, review, and postvention. Individuals in custody receive three levels of screening for the identification of suicide risk. Upon admission to the correctional system, all individuals in custody receive Intake Screening for the identification and immediate referral of urgent health care needs, including suicide risk. Individuals in custody also receive the Nursing Intake Assessment and the Post-Admission Mental Health Screen within fourteen (14) days of admission to the correctional system. Individuals in custody identified as having a serious mental health need are referred to a Qualified Mental Health Professional or Licensed Mental Health Professional for further evaluation and/or intervention.

Table 10 shows the percentage of Post-Admission Mental Health Screens completed at OCCC, WCCC, HCF, HCCC, and KCCC. Since August 2018, HCF has maintained a 100% completion rate. OCCC and WCCC experienced slight decreases in completion rates during the OCCC mental health module construction period. After the period of adjustment, OCCC and WCCC maintained the 100% completion rate. In an effort to expand

and measure compliance at neighbor island facilities, the Department initiated data tracking at HCCC and KCCC in April 2019. The data show HCCC and KCCC have maintained a 100% completion rate.

Table 10. Percentage of Post-Admission Mental Health Screens Completed.

PAMHA Completed (%)					
2017	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
November	99%				
December	100%				
2018	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%				
February	100%		100%		
March	100%	79%	94%		
April	100%	100%	100%		
May	100%	100%	100%		
June	100%	93%	100%		
July	100%	91%	100%		
August	100%	100%	100%		
September	100%	100%	100%		
October	100%	100%	100%		
November	100%	100%	100%		
December	99%	100%	100%		
2019	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	99%	97%	100%		
February	99%	100%	100%		
March	99%	100%	100%		
April	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%

In 2018, the Department's Clinical Psychologists received Suicide Risk Evaluation training. Table 11 shows the completion rates of Suicide Risk Evaluations for infirmary admissions and discharges. Since August 2017, OCCC has demonstrated a sustained 100% completion rate. WCCC and HCF have maintained the 100% completion rate for Suicide Risk Evaluations on admission and discharge since July 2018. In an effort to expand and measure compliance at neighbor island facilities, the

Department initiated data tracking at HCCC in April 2019. The data show HCCC has maintained a 100% completion rate.

Table 11. Percentage of Suicide Risk Evaluations Completed.

Suicide Risk Evaluations Completed (%)								
2017	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
August	100%	100%						
September	100%	100%						
October	100%	100%						
November	100%	100%						
December	100%	100%						
2018	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
January	100%	100%						
February	100%	100%						
March	100%	100%						
April	100%	100%						
May	100%	100%						
June	100%	100%						
July	100%	100%	100%	100%	100%	100%		
August	100%	100%	100%	100%	100%	100%		
September	100%	100%	100%	100%	100%	100%		
October	100%	100%	100%	100%	100%	100%		
November	100%	100%	100%	100%	100%	100%		
December	100%	100%	100%	100%	100%	100%		
2019	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
January	100%	100%	100%	100%	100%	100%		
February	100%	100%	100%	100%	100%	100%		
March	100%	100%	100%	100%	100%	100%		
April	100%	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%

Upon discharge from infirmary level care, individuals in custody are provided Caring Contact in-person follow-up services at two periods: 1-3 days and 7-10 days post-discharge. Table 12 shows the percentage of Caring Contacts completed during both periods. Since April 2018, OCCC has demonstrated a sustained 100% completion rate. WCCC showed a sustained 100% completion rate since September 2018, while HCF has maintained a 100% completion rate since January 2019. The table also

shows available quality assurance data from HCCC, which indicate a sustained 100% completion rate since July 2019.

Table 12. Percentage of Caring Contact Follow-Up Completed.

Caring Contact Follow-Up Completed (%)								
2017	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
July	93%	100%						
August	100%	91%						
September	100%	100%						
October	98%	100%						
November	100%	100%						
December	100%	100%						
2018	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
January	94%	100%						
February	100%	100%						
March	100%	91%						
April	100%	100%						
May	100%	100%						
June	100%	100%						
July	100%	100%	100%	100%	100%	100%		
August	100%	100%	100%	90%	100%	100%		
September	100%	100%	100%	100%	100%	100%		
October	100%	100%	100%	100%	100%	100%		
November	100%	100%	100%	100%	100%	100%		
December	100%	100%	100%	100%	90%	90%		
2019	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
January	100%	100%	100%	100%	100%	100%		
February	100%	100%	100%	100%	100%	100%		
March	100%	100%	100%	100%	100%	100%		
April	100%	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%	92%
June	100%	100%	100%	100%	100%	100%	100%	90%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%

Since December 2017, the Department has demonstrated significant improvements in several other mental health service areas. The following highlights the Department's accomplishments since the previous report:

- In March 2019, the Mental Health Crisis Response Team, which was composed of Clinical Psychologists from all Mental Health Sections statewide, traveled to Maui to provide Crisis Intervention Services to affected employees and individuals in custody in an unprecedented response to the MCCC disturbance.

- In March 2019, HSH (Hawaii State Hospital) and the PSD Mental Health Branch improved communication on individuals with dual HSH-PSD commitment status. Dr. Janet Phillips has been the HSH lead on the project.

- In April 2019, four Mental Health Administrators completed Psychological Autopsy Certification training by the American Association of Suicidology. The Psychological Autopsy is a required component of the National Commission on Correctional Health Care review process for deaths by suicide.

- In April 2019, a Department Clinical Psychologist completed the Suicide Bereavement Clinician training by the American Foundation for Suicide Prevention at the Prevent Suicide Hawaii Statewide Conference. Postvention is a key component of the Department's Suicide Prevention Program.

- In May 2019, a system to communicate and share Dual HSH-PSD Treatment Over Objection Orders was established. Deputy Attorney General Debbie Tanakaya has been the HSH lead on obtaining Court Orders to Treat.

- In May 2019, all mental health staff statewide completed Adverse Side-Effects of Psychotropic Medication training. Identification of adverse reactions to psychotropic medications allows for an improved process for the recognition and referral of affected individuals to a Licensed Mental Health Professional for further evaluation and treatment.

- In June 2019, mental health staff statewide completed a 20-week Dialectical Behavior Therapy (DBT) didactic training. The goal was to improve the quality of mental health services, particularly focusing on the content of psychosocial treatment groups and individual sessions. The education provided to mental health staff included four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Certification of Clinical Psychologists in DBT is not being pursued at this time due to difficulties in adapting DBT to the correctional environment. However, individual and group mental health interventions are now DBT-informed.

- In July 2019, all facility Mental Health Administrators statewide obtained Certified Correctional Health Professional (CCHP) status with the National Commission on Correctional Health Care (NCCHC). The NCCHC CCHP project is designed to improve health care staff knowledge about the NCCHC standards. The goal is to provide education to health care staff on all relevant NCCHC standards through ongoing education at the facilities during monthly staff meetings on a routine and ongoing basis. This will be accomplished by the requirement of Mental Health and Nursing Administrators to become NCCHC CCHPs (and subsequently obtaining CCHP-MH or CCHP-RN status).

- In August 2019, the Correctional Health Care Administrator became a member of the American Correctional Association's Behavioral Health Committee.

- In September 2019, two Mental Health Branch employees received certification as Mental Health First Aid Instructors. Mental Health First Aid is an 8-hour course that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps individuals identify, understand, and respond to signs of addiction and mental illness. The accomplishment will allow the Department to continue to provide certification for new mental health staff and expand certification to include all health care staff.

- In October 2019, the Mental Health Branch completed the development of the Cognitive-Behavioral Therapy – Insomnia (CBT-I) Program, which is a non-pharmacological intervention for the treatment of complaints of sleep difficulty. The objective of the CBT-I program is to improve access to psychiatric services for individuals with serious mental health needs by diverting individuals with non-serious mental health needs from psychiatry clinic and providing first-line non-pharmacological interventions.

b. Psychiatric Services

Psychiatry positions are aligned within the Medical Services Branch of the Health Care Division. A significant challenge for the Department is the recruitment and retention of experienced and qualified licensed health care professionals, particularly psychiatrists. The national shortage of physicians and psychiatrists has been well documented. The American Medical Association (AMA), the Health Resources and Services Administration (HRSA), and the Association of American Medical Colleges (AAMC) have projected an ongoing deficit in physicians and psychiatrists.

While many causes have been identified as contributors to the problem, the baby-boomer generation has reached retirement age, and the large size of this group has had unavoidable impact. Statistical data on physician shortage numbers presented at the 2019 Hawaii Health Workforce Summit showed a dismal projection in which 50% of Hawaii physicians are age 55 and over. Over the last several months, the Department lost 1.0 FTE Physician to retirement, 1.0 FTE Psychiatrist to retirement, and 1.0 FTE Psychiatrist to another higher paying department. In order to compete in the national market for the recruitment and retention of psychiatrists, an increase in the salary budget is needed to match local and national demand.

c. Student Education Partnerships

In partnership with the University of Hawaii John A. Burns School of Medicine (JABSOM) and the University Clinical, Education & Research Associates (UCERA), the Department provides an opportunity for JABSOM residents to complete clinical rotations in psychiatry at the Oahu Community Correctional Center. Additional funding to match JABSOM and UCERA cost increases will be required to continue these contractual agreements.

Through an ongoing agreement with the Western Interstate Commission for Higher Education (WICHE), the Department offers an American Psychological Association (APA) Accredited Clinical Psychology Internship position, with preference to Hawaii residents or individuals who intend to practice in Hawaii. The Department also offers a Post-Doctoral Clinical Psychology fellowship through the WICHE program. Along with the Department of Education and the Child and Adolescent Mental Health Division of the Department of Health, the Department of Public Safety is subject to increased costs associated with participation in the Hawaii Psychology Internship Consortium (HIPIC). Additional resource requirements are also needed to expand the APA accredited Clinical Psychology internship opportunities for residents of Hawaii.

The Department serves as a Practicum Training Site for the Hawaii School of Professional Psychology at Chaminade University of Honolulu (formerly Argosy University, Hawaii). Licensed Clinical Psychologists provide on-site training for diagnostic, intervention, and advanced practicum graduate students.

2. The use of alternative services, such as telemedicine, to provide mental health services to incarcerated offenders.

The Department has been monitoring the use of telepsychiatry services through consultation with State Health Authorities. The primary problem with the national implementation of telepsychiatry services in correctional facilities appears to be an initial draw by the cost-savings pitch, followed by increased costs due to an overall 25-40% increase in the number of referrals for psychiatry services. Prior to the implementation of national telepsychiatry services in our correctional settings, the Department intends to develop prudent protocols for the judicious use of this alternative service.

3. The completion of a departmental training and policy manual.

   a. The Department continues to update the training curriculum for Mental Health, Suicide Prevention, and Restraint and Seclusion. Four-hour core courses are offered to all new employees in Mental Health and Suicide Prevention, with two-hour refresher courses in both subject areas every other year. Restraint and Seclusion is a two-hour core course with two-hour refreshers every other year. The trainings are targeted at staff having direct contact with inmates. Additionally, all staff are required to have initial First Aid/CPR training with periodic renewals for certification. The trainings continue to be offered as part of Basic Correctional Training (BCT) and Corrections Familiarization Training (CFT) for all new uniformed and non-uniformed facility employees, respectively. During FY 2015, Mental Health Services and Suicide Prevention Training was expanded to include the Law Enforcement Division.

   b. The Health Care Division has updated many of its policies and procedures contained in the Departmental Policy Manual. All new employees are required to be oriented to this manual.

   c. Mental Health Policies and Procedures are reviewed annually. In addition to adherence with State and federal law, Mental Health Policies and Procedures are revised in accordance with the current version of the NCCHC Standards for Prisons, NCCHC Standards for Jails, and NCCHC Mental Health Standards for Correctional Facilities.

4. The appropriate type of updated record-keeping system.

   The existing electronic medical record system is a leading challenge for the Department. The current system is limited in the ability to gain access to the system from an external site, which places firm boundaries on the growing need for flexibility in obtaining out-of-state telepsychiatry services. The current system also lacks the capability to integrate with pharmacy software, which necessitates a dual order system that inefficiently expends valuable psychiatry and nursing staff resources. The Department intends to explore alternative electronic medical record systems that will meet our anticipated, future needs.

The Hawaii Health Information Exchange (HHIE) is the State's designated entity for health data exchange. HHIE was established to enhance care coordination, improve the health outcomes of Hawaii's patients, and reduce the cost of care for both patients and healthcare providers. In September 2019, the Department completed required system-use trainings and became a receiving participant with HHIE.

5. An update on the feasibility study initiated by the Departments of Health and Public Safety regarding the expansion of Hawaii State Hospital (HSH), to possibly include a wing so as to be able to adequately treat mental health patients who require incarceration.

    a. The DOH has submitted a 21-year plan to address the census issues related to HSH. It is PSD's understanding that this plan is comprised of three 7-year phases focusing on demolition, replacement and construction. Presently HSH is "over census" and has been for several years, since the inception of the requirement outlined in Act 144. At this time, no capacity exists to entertain the designation of a wing or expansion to treat incarcerated mental health patients.

    b. There is an assumption in this requirement that individuals with mental health disorders are not being treated "adequately" in PSD correctional facilities. However, the Department has been able to demonstrate more than adequate treatment at OCCC for these inmates and in spite of some of the physical challenges of our antiquated facilities, the care is "adequate" and will continue to improve.

6. Any other suggestions or ideas to improve mental health services to incarcerated individuals to comply with local, state and federal laws and mandates.

    a. The current number of allotted nursing positions at our neighbor island jail facilities provides nursing services approximately twelve hours a day at HCCC, MCCC, and KCCC. An assessment of the health care needs of individuals in custody, however, indicates that the current staffing plan does not fully meet the needs of the comprehensive Suicide Prevention Program. The identified problem is an absence of 24-hour, in-facility health care coverage at our neighbor island jails.

        When an individual in custody is at moderate to high acute risk for suicide, the provision of 24-hour infirmary-level of care monitoring by nursing staff at designated intervals is an essential component of the Suicide Prevention Program. Additionally, nursing staff must be available 24-hours a day to provide in-person Mental Health and Medical Crisis Assessment and Intervention, particularly when mental health staff are not on duty. The

current system of relying on Security staff to make health care decisions when health care staff are not available at the facility is unwise.

In order to provide 24-hour nursing services at our neighbor island jails, an additional 3.5 FTE Registered Nurse III positions are needed at each of the three neighbor-island jails.

b. Over the last several years, Lindsey Hayes, the Prevent Suicide Hawaii Task Force, and Correctional Health Authorities across the country have reported that the national suicide rate has been on the rise. Despite the overwhelming concern, there are still only three empirically-supported therapy approaches for suicide prevention: Dialectical Behavior Therapy (DBT), Beck's Cognitive-Behavioral Therapy (CBT), and Collaborative Assessment and Management of Suicidality (CAMS). Due to difficulties in adapting DBT and CAMS to the correctional environment, Beck's CBT has proven to have the greatest utility in correctional settings. In September 2019, certification in Beck's Cognitive-Behavioral Therapy became available. As part of the Zero Suicide Initiative, resources are needed to support Clinical Psychologists in becoming certified in Beck's CBT. Certification is the preferred method for demonstrating and ensuring competence in the therapy.

c. As identified by Dr. Dvoskin in his 2018 Expert Report, the Department's mental health staff is in need of additional resources for ongoing training in order to improve the quality of psychosocial treatment groups.

d. Also in his 2018 Expert Report, Dr. Dvoskin recommended the assignment of a dedicated module for mental health residential treatment at the Oahu Community Correctional Center.

Expert Report on Mental Health Care at the Oahu Community Correctional Facility
Presented to the Hawaii Office of the Attorney General
and the Hawaii Department of Public Safety

Joel A. Dvoskin, Ph. D.
November 30, 2018

At the request of Deputy Attorney General Diane Taira and Director of Public Safety Nolan Espinda, I toured the Oahu Community Correctional Center (OCCC) on August 14 and 15, 2018.

My charge was to assess the adequacy of mental health care at OCCC, with specific attention to maintenance of the improvements that were accomplished during the period of investigation and Settlement Agreement with the United States Department of Justice (DOJ).

OCCC is predominantly used as a pretrial detention facility for detainees awaiting trial on the Island of Oahu. However, because many of the psychiatric and mental health services are centralized at OCCC, some detainees from the other islands with mental health needs are housed there as well. The facility holds both male and female detainees and inmates, and includes specialized mental health housing for both men and women.

Overcrowding and Staffing

The most significant finding regarding OCCC is that the facility remains overcrowded, which creates stress on inmates and staff alike. A significant number of inmates were unfortunately required to sleep on mattresses on the floor. While crowding itself will remain a huge problem, no inmate or detainee should be sleeping on a mattress that is laying directly on the floor.

> **I recommend to the Department the purchase of plastic "boats," or plastic canoe-shaped trays that can be laid on the ground, and which keep the mattresses off the floor.**

I was informed by Director Espinda that the State of Hawaii is considering legislation that will create bail reform as well as incentives for criminal justice agencies to engage in diversion from the criminal justice system for certain non-dangerous offenders, especially those with drug or mental health problems.

> **I strongly support such legislation. Jails should be reserved for the people who pose a serious risk to the public safety.**

I have also been told that Hawaii is considering creation of a new, modern, and somewhat larger jail on Oahu.

I strongly support creation of a new jail. Even if additional diversion and bail reform efforts come to fruition, it is likely that OCCC will be too small to accommodate the people who actually need pre-trial detention. More importantly, OCCC is currently housed in buildings that are not particularly well suited for modern correctional programs, especially those programs specifically aimed at inmates and detainees with serious mental illnesses.

Due to high use of sick leave and occupational injury leave (OIL), staffing is a constant challenge to the Department and OCCC leadership. On average, OCCC has an astonishing number of absentee staff, as many as 100 per day. The absences in turn create extreme stress for the staff that show up for work, as well as mandatory overtime, which negatively affects morale, and in turn increases absenteeism.

Considering the chronically high rate of sick leave and OIL, it appears to me that OCCC's staffing complement is inadequate. Relief factors should include known use of vacation, sick leave, OIL, weekends, vacancies, and suspensions.

The most serious consequence of the frequent staffing shortages occurs when Sergeants are sometime unable to immediately respond to an emergency because they have to wait for backup. So far, I am unaware of any tragic consequence related to this problem, but it must be remedied.

Again, the so-called "essential" posts must be filled at all times. In my opinion, this will require a staffing pattern that accounts for the predictable use of sick leave, OIL, vacancies, and other forms of absenteeism.

Segregated Housing (Control Unit) and Mitigation Reviews

Despite the crowding and staffing challenges, I was pleased to see that OCCC has decreased its use of segregated housing (when compared to its use during the period of the Settlement Agreement with DOJ).

The staff at OCCC has done an excellent job of conducting mental health rounds in segregation, consistently scoring 100% compliance. Rounds are conducted 7 days per week by social work staff, and one day per week by psychologists, which is above and beyond the standard of care for such settings. Similarly, the mitigation reviews of disciplinary charges were conducted with 100% compliance.

The staff at OCCC is completely compliant with the mental health rounds in segregation as well as mitigation reviews when inmates with mental illness are charged with disciplinary violations.

Unfortunately, I observed several inmates in the Control Unit whose beds did not appear to have sheets or other bedding. When I brought this to the attention of the staff, they immediately remedied the situation. I was not able to ascertain the reason for the missing bedding. However, regular rounds by supervisory staff should prevent this from happening at all.

> **Supervisory staff should visit each cell on the control unit at least several times per shift.**

Treatment Planning

At the time of my visit, OCCC was in the process of combining the initial and the comprehensive treatment plans. This promises to be more efficient, and to improve the quality of those plans. The preliminary treatment plans were completed 100% of the time, although approximately 2% of them were late. On the other hand, the comprehensive treatment plans were only completed on time about 57% of the time. While this is unacceptable, in my opinion, the decision to combine the preliminary and comprehensive treatment plans is very likely to remedy this problem.

> **OCCC is substantially compliant with the standard of care regarding timely preliminary treatment plans for newly admitted inmates with serious mental health needs. However, the comprehensive treatment plans are late approximately half the time. I support the plan to combine these treatment plans, which should improve timeliness and productivity.**

Suicide Prevention

The staff at OCCC was compliant with the suicide risk assessments (SRE) upon admission, as well as the SRE's upon discharge from suicide watch. Similarly, there was 100% compliance with the important 1-3 day follow-up assessments for people who were recently discharged from suicide watch status, as well as the 7-10 day follow-ups. During the past year, there were no deaths by suicide at OCCC, although there were 2 serious attempts.

> **OCCC is compliant with the standard of care for suicide risk assessments and follow-up assessments for people who have been released from suicide watch status.**

Due to some long-standing abuse of the doors by patients, I observed some difficulty in seeing into the rooms that are used for suicide watch. However, the Warden informed me that plans are underway to renovate these cells to ameliorate this problem.

While it is still possible for staff to see into the suicide watch rooms, I support the plan to renovate the cells to allow unimpeded vision.

As was the case in prior years, the wands used to verify suicide watch by officers do not always work, this despite repeated efforts by the facility to work with the vendor. Nevertheless, the Department has ensured compliance with suicide watch requirements by contracting with independent observers who randomly sample video footage. These reviews have confirmed consistent compliance with the required frequency of observations.

OCCC is compliant with suicide watch procedures.

Improvements in Eligibility Process for the Adult Mental Health Division (AMHD)

The Department has improved the process of AMHD eligibility for inmates and detainees with serious mental illnesses. This process is especially important in regard to continuity of care for inmates and detainees with serious and disabling mental illnesses who return directly to the community from OCCC.

I applaud the improved relationship between DPS and AMHD, especially in regard to the eligibility process for inmates and detainees with serious and disabling mental illnesses.

Quality Improvement (QI) and Structured Therapeutic Programs

I reviewed the minutes of the quarterly QI meetings. The agenda was appropriate, and the quality of data seemed much improved from my last visit to OCCC. Indeed, I would describe the format and content of the QI data as excellent.

The Department of Public Safety is compliant with the QI requirements of the DOJ Settlement Agreement. Indeed, the process is even better than it was when it was approved by DOJ.

The audits of group treatment for inmates and detainees in mental health housing showed that the number of hours appeared adequate and compliant with the former DOJ Settlement Agreements. It is especially important to note that the number of structured therapeutic hours increased significantly when Dr. Gavin Takenaka took over supervision of the mental health program within DPS.

That being said, my observations suggest a need for continued improvement in the quality of group therapy, which suggests a need for additional training specifically aimed at the provision of group therapy with persons with serious mental illness, as well as those in psychiatric, emotional, or suicidal crisis.

The Department is substantially compliant with the number of therapeutic hours in the acute mental health units, although there is room for improvement in regard to the quality of the groups. I recommend additional training for the staff that provide and supervise the groups.

One concern was the fact that custody staff would talk unnecessarily loudly during group therapy, which interrupted the groups. Custody staff must be reminded that they have an important role in creating and maintaining a therapeutic environment in the acute units. This includes avoiding any unnecessary interruptions during group therapy.

Except where necessary, I recommend that custody staff be required to remain silent while groups are being conducted in the acute mental health units.

I noted that the Department does not count recreation therapy as structured therapeutic hours. If the recreation therapy is merely free time on the yard, I agree that these hours should not be counted. However, when the activities are structured and consistent with the treatment needs of the patients (e.g., organized team sports), I would recommend that these hours be documented in each patient's record and counted as structured therapeutic hours.

I recommend that formal recreation therapy (e.g., team sports) be counted as structured therapeutic activity.

Staff Training

Quality improvement data revealed 100% compliance with mandated staff training. In addition OCCC has begun implementation of Mental Health First Aid Training for some officers.

OCCC has exceeded compliance with staff training requirements.

Seclusion and Restraint

The Custody and Mental Health staff and leadership at OCCC used seclusion in accordance with the DOJ Settlement Agreements. When patients were confined to their rooms, either to prevent violence or to prevent suicide, the incidents were managed and documented appropriately. As noted above, when cell confinement was due to custody concerns (e.g., danger to others, protective custody, or disciplinary infraction) the Department followed the DOJ Settlement Agreement to the letter. This compliance included both mental health rounds in the holding unit as well as the mitigation evaluations.

One low-tech but helpful change has been flagging certain inmates and detainees as ineligible for segregation due to their clinical status.

OCCC is compliant in regard to the use of seclusion and restraint.

Discharge Planning

I was impressed with the improvements in discharge planning. As noted above, this is especially important for those patients who are expected to return to the community, but also applies to those who will eventually serve a prison sentence. The discharge planning process for jails must always begin with the initial and comprehensive treatment plans, since it is often difficult to know if and when any individual will be released from jail.

OCCC is substantially compliant with discharge planning.

Staffing

As noted above, OCCC has been beset by a combination of crowding and inadequate staffing (mainly due to sick and occupational injury leave). As a result, posts that are supposed to be filled at all times are not. On the other hand, mental health staffing is richer than what was agreed to with the Department of Justice.

In my opinion, it is imperative that essential security posts in the acute mental health units be maintained at all times.

Medication Adherence

When inmates or detainees refuse medication, the prescriber is notified almost immediately by email. The standard of care is to notify the prescriber if a patient refuses medication for 3 consecutive doses, more than fifty percent of doses in a week, or any other clinically significant pattern of non-adherence. At OCCC, the nurses email prescribers each time a dose is refused, which exceeds the standard of care.

OCCC is exceeding the standard of care for notifying prescribers of non-adherence to medication.

Institutional Culture and Morale

Despite the significant problems posed by overcrowding and understaffing, the morale among the mental health staff appeared to me to be excellent. Mental health staff members appeared to communicate well and frequently with each other. Morale among custody staff has been a challenge, largely due to the combination of overcrowding and understaffing mentioned above. In my experience, it is virtually

impossible to maintain good morale when custody staff are frequently required to work mandatory overtime shifts.

> **Again, the staffing allocation at OCCC must take into consideration the known history of of various forms of leave and absenteeism.**

Miscellaneous Recommendations

1. I recommend consideration of the creation of a "program unit." This unit would include some inmates and detainees with serious mental illness who are reasonably stable but whose psychological vulnerability requires a less stressful correctional environment. In order to ensure that all beds are filled, however, the unit should also include other inmates who are physically and/or psychologically vulnerable. The unit would need to be restricted to those individuals who pose no threat of violence or predatory behavior toward these vulnerable inmates and detainees. Any evidence of such predatory, violent, or intimidating behavior should result in immediate transfer out of the unit.

2. When people are assigned to the acute mental health units due to a crisis, it is common for them to require a day or two of rest or convalescence before they should be expected to participate in structured therapeutic activities. Some of these patients will have received a first dose of psychotropic medication, while others will be on suicide prevention status. For this reason, the Department might consider eliminating the first day or two of housing in the acute mental health units from the accounting of therapeutic hours. Of course, if the patient is willing and able to tolerate such structured activities, they should be encouraged to do so.

3. Whenever any policy, procedure, or practice is changed, I recommend that it be temporarily added to the QI audits to ensure that it is being implemented as intended.

4. For several reasons, I strongly recommend the addition of a half-time psychologist, to provide coverage and treatment on weekends.

5. Individuals on the highest level of suicide watch are almost always confined to their cells. I recommend that inmates on this status be allowed out of their cells, under supervision, whenever possible for at least several hours per day.

6. Inmates on suicide watch should be allowed reading materials, such as magazines or books without staples. There is simply no reason to enforce extreme idleness and boredom when an individual is deemed to be acutely suicidal.

7. Whenever a patient refuses their prescribed medication, the nurses should try again in a little while.

8. It is my understanding that the Department is striving to create wireless access to medical records, which will dramatically improve the productivity of the treatment staff and the quality of the medical records.

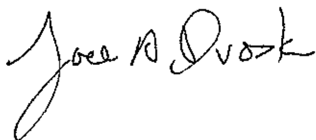
9. The process for involuntary medication administration is cumbersome and time-consuming., and appears to be much more restrictive than required by constitutional law (see, e.g., *Harper v. Washington*) and processes used in other states. While I agree that involuntary medication should never be a first choice, there are times when it is necessary to avoid unnecessary suffering on the part of a patient, and unnecessary danger to staff and other inmates. It is not clear to me if changing this process would require legislation, but I recommend consideration of a more streamlined and efficient process for making decisions about forced medication.

Summary and Conclusions

Overall, I was impressed with the enthusiasm of the OCCC mental health and custody staff and leadership to comply with the Department's prior agreements with the Department of Justice. In my opinion, virtually all of the areas of needed improvement listed in this report are due to two sources – overcrowding and understaffing. The OCCC physical plant, in addition to being too small to accommodate its population, is poorly designed for modern correctional and detention methods. It is my understanding that the Department is interested in building a new jail to replace OCCC, a plan with which I enthusiastically agree. In addition, I also support passage of legislation that will accomplish bail reform and diversion of non-dangerous offenders (especially those with serious mental illness) from the criminal justice system.

As always, I am deeply appreciative of the trust that has been shown to me by the Office of the Attorney General and the Department of Public Safety.

Respectfully submitted,



Joel A. Dvoskin, Ph.D

DEPARTMENT OF PUBLIC SAFETY
REPORT TO THE 2021 LEGISLATURE

IN RESPONSE TO
ACT 144, SESSION LAWS OF HAWAII, 2007
MENTAL HEALTH SERVICES FOR COMMITTED PERSONS

December 2020

Annual Report to the Legislature
In response to Act 144, Session Laws of Hawaii, 2007
Mental Health Services for Committed Persons

Introduction

This report is hereby submitted to fulfill the requirements outlined in Act 144, Session Laws of Hawai'i, 2007, specifically:

(1) The Department of Public Safety shall submit a report to the Legislature no later than twenty days prior to the commencement of the 2008 regular session and every session thereafter…

(2) This written report shall be submitted in a form understandable by lay readers and made available to the public.

Itemized Report

As outlined in Act 144, Session Laws of Hawai'i, 2007, the Department shall report on six (6) specific items of concern. These six items are listed below (as extracted from the statute), followed by the Department's status report on each item.

1. Assessment of the Department's existing resources and staffing, and or additional resources and staffing needed to bring mental health services up to standard and to keep up with future demands.

   a. The focus on the federal investigation and subsequent Settlement Agreement between the State of Hawaii, Department of Public Safety (PSD) and the Federal Department of Justice (DOJ) was to bring the Oahu Community Correctional Center (OCCC) up to national standards for correctional mental health care. In 2015, the Department successfully disengaged from an extended Corrective Action Plan with the DOJ. However, during the maintenance period over the next two years, the Mental Health Branch failed to remain compliant with the standards agreed upon with the DOJ, necessitating programmatic and structural changes, which included change in the Branch's leadership. Since the 2018 fiscal year, mental health services at OCCC significantly improved and demonstrated sustained compliance with the DOJ requirements for the provision of mental health services. As a result, the Department has been expanding compliance efforts at other Hawaii facilities.

Mental Health Staffing

In June 2017, thirteen (13) out of thirty-four (34) positions were vacant at the Oahu Mental Health Section (see Table 1 below). As a result of the 2019 Health Care Division needs assessment and through the 2020 Reorganization of the Health Care Division, two Office Support positions were moved to the Research and Statistics Unit within the Health Care Division to support the Health Care Quality Assurance Program, which expands the Mental Health Quality Assurance Program to additional areas of health care service delivery. At present, there are four (4) vacant positions within the Oahu Mental Health Section. Three Clinical Psychologist positions have recommended hires awaiting completion of the recruitment process. The one (1) remaining vacant position is in active recruitment.

Table 1. Comparative Mental Health Staffing at OCCC

	July 1, 2017		**November 15, 2020**		**Comments**
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	
Psychology	2	3	3	2	Three recommended hires pending completion of the background check.
Social Services	6	6	1	11	One vacancy created by resignation on 7/22/20.
Nursing	3	6	0	9	
Recreation	2	1	0	2	
Office Support	0	5	0	3	Two positions moved to the Research and Statistics Unit within the Health Care Division to support the Health Care Quality Assurance Program.
TOTAL	**13**	**21**	**4**	**27**	

On June 30, 2017, there were thirty-nine (39) vacant positions and thirty-eight (38) filled positions in the Mental Health Branch statewide (see Table 2 below), as compared with the current sixteen (16) vacant positions and fifty-four (54) filled positions in the Mental Health Branch statewide. Due to the coronavirus pandemic and as a result of SB126, SD1, HD1, CD1, nine (9) vacant mental health positions were temporarily defunded in July 2020 through the end of the current fiscal year. The seven (7) remaining funded

vacant positions are in active recruitment with five (5) recommended hires pending completion of the recruitment process. The Mental Health Branch also intends to re-describe the vacant Occupational Therapist position to a Clinical Psychologist position to support the overwhelming demand for trauma therapy at the Women's Community Correctional Center (WCCC).

Table 2. Comparative Statewide Mental Health Branch Staffing.

	July 1, 2017		November 15, 2020		Comments
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	
Psychology	10	6	6	10	Four recommended hires pending completion of the background check (3 OCCC and 1 WCCC).
Social Services	16	17	7	28	
Nursing	3	6	0	9	
Occupational Therapy	2	1	1	0	Position pending GOV approval for re-description to Clinical Psychologist
Recreation	2	1	0	2	
Office Support	6	7	2	5	One recommended hire pending completion of the background check.
TOTAL	**39**	**38**	**16**	**54**	

During the coronavirus pandemic, correctional mental health has often been overlooked as frontline health care workers. In our jails and prisons, mental health staff gear up several times daily in full personal protective equipment (PPE) to provide much needed in-person mental health services in medical isolation and quarantine areas for incarcerated individuals. In July 2020, SB126, SD1, HD1, CD1, temporarily defunded more than half of the Department's vacant mental health positions through the end of the current fiscal year. The Department wishes to reiterate the importance of our essential frontline mental health positions in not only performing day-to-day clinical functions in the facilities, but the urgency of helping incarcerated individuals in navigating the mental health aspects of the extended coronavirus crisis. The Legislature's consideration of reinstituting these critical funds would be greatly appreciated.

Over the past three years, the Department has also identified three (3) key areas affecting mental health resource and staffing needs:

(1) **Statistics Clerk (2.0 FTE)**: Previously, two (2) Statistics Clerk positions were abolished by Act 53, SLH 2018. The two positions were critical for compliance with the DOJ requirement of maintaining a Quality Assurance program. Without the two positions, the Department would have been unable to sustain compliance with the DOJ requirement. In order to temporarily maintain compliance, the Department was obliged to contract with RCUH (Research Corporation of the University of Hawaii) for a maximum of one year, to temporarily receive the services of two Mental Health Statisticians. Due to the coronavirus pandemic, the Department was unsuccessful in the request to re-establish the Statistics Clerk positions during the past Legislative session. The Department will again request the re-establishment of the Statistics Clerk positions in the upcoming Legislative session.

(2) **Retention of Licensed Clinical Psychologist**: The Department participates in the Statewide DHRD (Department of Human Resources Development) Pilot Project for Licensed Health Care Providers. The program, however, requires the Department to fund the program through non-existent resources. Within the past three years, the Department lost four licensed Clinical Psychologists to other agencies that had the resources to competitively recruit licensed providers. In addition, prospective licensed applicants from federal and private agencies have declined Clinical Psychologist positions due to the Department's budgetary constraints and non-competitive salaries. The Department continues to respectfully request an increase in budgetary resources for Clinical Psychologists, in order to become salary competitive with other State, Federal, and local agencies.

(3) **Weekend and Relief Coverage**: As identified by Dr. Joel Dvoskin, in his 2018 Expert Report, the Department is not currently staffed to provide mental health services on weekends. The Department is also not staffed to provide relief mental health coverage for vacation, sick, and other time-off. The current number of allotted Clinical Psychologist positions at our correctional facilities statewide was designed by the mental health staffing plan to provide clinical psychology services during normal business hours (i.e., Monday through Friday, 0745 to 1630). An assessment of the mental health needs of individuals in custody, however, indicates that the current staffing plan does not fully meet the needs of the comprehensive Suicide Prevention Program. The identified problem is an absence of evening and weekend Clinical Psychology services at our Mental Health Sections statewide.

Individuals in custody do not only become suicidal and do not only require therapeutic intervention for the reduction of suicide risk during normal business hours. Presently, an individual being monitored for

suicide risk over the weekend must wait until the next business day for evaluation and treatment of suicide risk. An individual who enters a correctional facility during the evening and exhibits suicide warning signs must wait until the next business day for a Suicide Risk Evaluation. These scenarios requiring urgent psychological evaluation and intervention are common problems identified in the Suicide Prevention Program as caused by the limitations of the current allotment of Clinical Psychology positions. The addition of one Clinical Psychologist at six correctional facilities (i.e., Halawa Correctional Facility, Oahu Community Correctional Center, Women's Community Correctional Center, Hawaii Community Correctional Center, Maui Community Correctional Center, and Kauai Community Correctional Center), would allow the Department to begin addressing the urgent need for evening and weekend mental health services.

Mental Health Services

Over the past year, mental health services at OCCC showed overall sustained compliance with DOJ requirements for the provision of mental health services. Table 3 illustrates Quality Assurance data for Treatment Plan completion rates at OCCC over the last three years. The data clearly shows sustained improvement in treatment plan completion rates, with the highest completion rates occurring during the past two years. The Department's approach to the treatment planning process, which was modified from the previous practice of completing the task by the fourteenth day to completion of the treatment plan upon identification of an individual with a serious mental health need, has contributed to the improved outcome.

Table 3. Percentage of Treatment Plans Completed at OCCC.

Treatment Plans Completed (%)				
Month	**2017**	**2018**	**2019**	**2020**
January	41%	100%	100%	100%
February	33%	100%	100%	100%
March	74%	100%	100%	100%
April	41%	71%	100%	100%
May	36%	62%	100%	100%
June	19%	59%	100%	100%
July	44%	100%	100%	100%
August	75%	100%	100%	100%
September	82%	100%	100%	100%
October	85%	99%	100%	100%
November	92%	100%	100%	
December	100%	100%	100%	

As mentioned above, the Department has been expanding DOJ compliance efforts at other Hawaii facilities. Table 4 shows Quality Assurance data for Treatment Plan completion rates at WCCC and HCF beginning July 2018. Over the past year, WCCC and HCF have been in sustained compliance with a 100% completion rate. In November 2019, HCCC also started tracking Treatment Plan completion rates. Over the past year, HCCC has demonstrated a sustained 100% completion rate. In January 2000, QA data collection expanded to include KCCC Treatment Plan completion rates. KCCC has sustained a 100% completion rate.

Table 4. Percentage of Treatment Plans Completed at WCCC, HCF, HCCC, and KCCC.

Treatment Plans Completed (%)				
2018	**WCCC**	**HCF**	**HCCC**	**KCCC**
July	83%	100%		
August	80%	100%		
September	88%	100%		
October	100%	100%		
November	100%	100%		
December	94%	100%		
2019	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%	100%		
February	100%	100%		
March	100%	100%		
April	100%	100%		
May	100%	100%		
June	100%	100%		
July	100%	100%		
August	100%	100%		
September	100%	100%		
October	100%	100%		
November	100%	100%	100%	
December	100%	100%	100%	
2020	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%	100%	100%	100%
February	100%	100%	100%	100%
March	100%	100%	100%	100%
April	100%	100%	100%	100%
May	100%	100%	100%	100%
June	100%	100%	100%	100%
July	100%	100%	100%	100%
August	100%	100%	100%	100%
September	100%	100%	100%	100%
October	100%	100%	100%	100%

Quality Assurance data from May 2016 through July 2017 showed the average monthly provision of psychosocial treatment group activities in designated mental health modules at OCCC were minimal to non-existent (see Table 5 below).

Table 5. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at OCCC (05/2016 – 07/2017).

OCCC			
2016	**Module 1**	**Module 2**	**Module 8**
May	0.80	11.65	0.50
June	4.20	5.80	0.35
July	4.90	8.35	0.00
August	7.65	12.80	0.40
September	5.00	7.65	0.80
October	4.75	6.90	0.60
November	2.25	2.80	1.20
December	1.45	1.85	1.10
2017	**Module 1**	**Module 2**	**Module 8**
January	1.70	2.60	1.55
February	1.85	2.80	1.60
March	1.65	3.20	1.30
April	0.60	2.40	2.00
May	0.00	3.80	1.95
June	0.20	3.40	2.25
July	1.20	1.80	1.80

Since August 2017, all three designated OCCC mental health modules had demonstrated overwhelmingly significant improvement and overall sustained compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours through July 2020 (see Table 6 below). In August 2020, OCCC experienced an outbreak of the coronavirus, which impacted operations throughout the facility. Psychosocial treatment group hours showed a corresponding decline reflecting the effects of quarantine requirements for designated mental health modules. Although group activities were suspended at times for public health and safety reasons, mental health services continued through individual psychosocial interventions and activities, which are not reflected in the monthly psychosocial treatment group hours from August 2020 to October 2020. Despite resource limitations and the negative impact of the coronavirus pandemic, the Oahu Mental Health Section demonstrated sustained compliance with this DOJ requirement.

Table 6. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at OCCC (08/2017 – 10/2020).

OCCC			
2017	**Module 1**	**Module 2**	**Module 8**
August	18.35	16.05	19.55
September	23.00	23.12	29.18
October	23.37	20.10	24.43
November	25.15	19.60	24.95
December	23.06	21.25	20.75
2018	**Module 1**	**Module 2**	**Module 8**
January	27.90	26.30	29.00
February	21.06	28.79	31.38
March	24.12	31.00	25.00
April	23.83	29.10	24.60
May	22.40	30.30	26.50
June	27.25	30.88	28.63
July	27.5	29.2	30.7
August	37.9	29.1	38.1
September	36.4	26.4	43.6
October	30.1	31.0	34.1
November	32.0	20.9	18.2
December	Construction	30.8	Construction
2019	**Module 1**	**Module 2**	**Module 8**
January	Construction	28.0	Construction
February	Construction	23.1	Construction
March	26.8	18.7	Construction
April	34.7	32.3	Construction
May	18.4	32.4	Construction
June	20.5	20.0	26.8
July	40.1	31.4	21.9
August	21.8	27.2	22.4
September	46.8	46.6	27.6
October	45.1	41.3	37.9
November	38.0	42.9	47.0
December	31.2	33.5	30.5
2020	**Module 1**	**Module 11**	**Module 8**
January	31	28	32
February	33	23	30
March	33	20	35
April	42	22	31
May	50	55	31
June	41	62	31
July	40	39	35
August	21	15	16
September	17	18	17
October	16	16	15

Table 7 shows Quality Assurance data for the average monthly provision of psychosocial treatment group activities in designated mental health modules at WCCC and HCF. The Women's Mental Health Section includes one residential mental health module and the Halawa Mental Health Section operates four residential mental health housing areas. In April 2020, one HCF residential mental health housing area was temporarily repurposed to accommodate facility housing needs. In March 2020, the Mental Health Branch began implementing modifications to the structure of psychosocial group activities to ensure compliance with social distancing requirements and infection prevention measures. Over the last year, despite the coronavirus pandemic, WCCC and HCF have demonstrated sustained compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours.

Table 7. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at WCCC and HCF.

2018	**WCCC OB**	**WCCC OB-J**	**HCF M1A1**	**HCF M7I**	**HCF M7II**	**HCF M7III**
January	14.3		15.8	10.0	10.5	10.5
February	15.5		10.5	12.7	11.8	13.1
March	16.3		13.7	11.8	13.5	13.8
April	15.1		19.1	15.8	17.0	17.3
May	21.4		16.2	13.7	14.6	13.5
June	22.4		23.8	15.4	16.2	18.0
July	17.7		22.0	15.8	15.3	13.3
August	21.7		15.5	13.2	13.6	11.4
September	23.8		21.5	17.5	16.8	16.7
October	27.4		20.3	23.2	23.9	21.1
November	22.9		21.2	21.1	22.0	20.4
December	22.3	11.06	20.5	22.1	22.6	20.9
2019	**WCCC OB**	**WCCC OB-J**	**HCF M1A1**	**HCF M7I**	**HCF M7II**	**HCF M7III**
January	25.9	25.8	16.4	22.0	22.4	21.4
February	27.8	34.2	16.1	20.1	21.6	18.7
March	27.6	38.7	20.1	20.7	21.4	18.9
April	24.8	44.4	24.5	15.4	16.9	15.4
May	27.3	23.6	21.7	11.9	10.8	11.5
June	32.2		25.8	20.2	20.9	19.9
July	37.3		20.8	24.2	23.7	23.0
August	27.9		27.6	45.3	45.4	45.4
September	25.8		25.4	48.3	48.8	48.7
October	34.2		28.1	46.4	45.0	47.2
November	32.8		27.8	42.5	42.2	41.4
December	28.4		25.3	44.1	43.8	41.5

2020	WCCC OB	WCCC OB-J	HCF M1A1	HCF M7I	HCF M7II	HCF M7III
January	38		35	45	44	42
February	29		22	44	38	38
March	21		20	38	39	37
April	21		31	40	40	
May	20		27	38	36	
June	21		33	32	33	
July	25		21	35	34	
August	33		24	32	32	
September	29		24	32	31	
October	25		23	32	31	

Quality Assurance data from January 2017 through July 2017 showed Discharge Plans were not completed at OCCC as required by National Correctional Mental Health Standards (see Table 8 below). Over the seven-month period, January-July 2017, only 9% of OCCC Discharge Plans were completed. In September 2017, action by Mental Health Administration resulted in significantly improved completion rates for the provision of discharge plans. Since January 2018, OCCC has demonstrated overall sustained compliance and significant improvement with the requirement of providing discharge planning for individuals in custody with serious mental health needs.

Table 8. Percentage of Discharge Plans Completed at OCCC.

Discharge Plans Completed (%)				
Month	**2017**	**2018**	**2019**	**2020**
January	11%	100%	100%	100%
February	12%	100%	100%	100%
March	7%	100%	100%	100%
April	10%	100%	100%	100%
May	5%	100%	100%	100%
June	10%	100%	100%	100%
July	9%	100%	100%	100%
August	14%	100%	100%	100%
September	52%	100%	100%	100%
October	78%	100%	100%	100%
November	90%	100%	100%	
December	98%	100%	100%	

Table 9 shows Quality Assurance data for Discharge Plan completion rates at WCCC and HCF beginning July 2018. WCCC and HCF have been in sustained 100% compliance. In April 2020, KCCC began tracking Discharge Plan completion rates. KCCC has since demonstrated a 100% completion rate.

Table 9. Percentage of Discharge Plans Completed at WCCC, HCF, and KCCC.

Discharge Plans Completed (%)			
2018	**WCCC**	**HCF**	**KCCC**
July	100%	100%	
August	100%	100%	
September	100%	100%	
October	100%	100%	
November	100%	100%	
December	100%	100%	
2019	**WCCC**	**HCF**	**KCCC**
January	100%	100%	
February	100%	100%	
March	100%	100%	
April	100%	100%	
May	100%	100%	
June	100%	100%	
July	100%	100%	
August	100%	100%	
September	100%	100%	
October	100%	100%	
November	100%	100%	
December	100%	100%	
2020	**WCCC**	**HCF**	**KCCC**
January	100%	100%	
February	100%	100%	
March	100%	100%	
April	100%	100%	100%
May	100%	100%	100%
June	100%	100%	100%
July	100%	100%	100%
August	100%	100%	100%
September	100%	100%	100%
October	100%	100%	100%

Suicide Prevention

State Mental Health Directors and Health Authorities at the National Commission on Correctional Health Care, the American Correctional Association, and the National Institute of Corrections continue to report increasing rates of suicide in correctional facilities nationwide. The Department is dedicated to the continued commitment of suicide prevention in our correctional facilities. As the nation and the Department continue to uncover additional considerations of risk for suicide, our efforts in implementing suicide prevention strategies to address new knowledge persist. Our ongoing goal of developing an infallible suicide prevention program remains unchanged.

The Department administers a comprehensive and multifaceted team approach to the Suicide Prevention Program, which includes the following components: training, identification, referral, evaluation, treatment, housing, monitoring, communication, intervention, notification, reporting, review, and postvention. Individuals in custody receive three levels of screening for the identification of suicide risk. Upon admission to the correctional system, all individuals in custody receive Intake Screening for the identification and immediate referral of urgent health care needs, including suicide risk. Individuals in custody also receive the Nursing Intake Assessment and the Post-Admission Mental Health Screen within fourteen (14) days of admission to the correctional system. Individuals in custody identified as having a serious mental health need are referred to a Qualified Mental Health Professional or Licensed Mental Health Professional for further evaluation and/or intervention.

Table 10 shows the percentage of Post-Admission Mental Health Screens completed at OCCC, WCCC, HCF, HCCC, and KCCC. Over the last year, OCCC, WCCC, and HCF have demonstrated a sustained 100% completion rate. In an effort to expand and measure compliance at Neighbor Island facilities, the Department initiated data tracking at HCCC and KCCC in April 2019. The data shows HCCC and KCCC have also maintained a 100% completion rate.

Table 10. Percentage of Post-Admission Mental Health Screens Completed.

PAMHA Completed (%)					
2017	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
November	99%				
December	100%				
2018	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%				
February	100%		100%		
March	100%	79%	94%		
April	100%	100%	100%		
May	100%	100%	100%		
June	100%	93%	100%		
July	100%	91%	100%		
August	100%	100%	100%		
September	100%	100%	100%		
October	100%	100%	100%		
November	100%	100%	100%		
December	99%	100%	100%		
2019	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	99%	97%	100%		
February	99%	100%	100%		
March	99%	100%	100%		
April	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%
November	100%	100%	100%	100%	100%
December	100%	100%	100%	100%	100%
2020	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%	100%	100%	100%	100%
February	100%	100%	100%	100%	100%
March	100%	100%	100%	100%	100%
April	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%

Table 11. Percentage of Suicide Risk Evaluations Completed.

Suicide Risk Evaluations Completed (%)								
2017	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
August-December	100%	100%						
2018	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
January	100%	100%						
February	100%	100%						
March	100%	100%						
April	100%	100%						
May	100%	100%						
June	100%	100%						
July	100%	100%	100%	100%	100%	100%		
August	100%	100%	100%	100%	100%	100%		
September	100%	100%	100%	100%	100%	100%		
October	100%	100%	100%	100%	100%	100%		
November	100%	100%	100%	100%	100%	100%		
December	100%	100%	100%	100%	100%	100%		
2019	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
January	100%	100%	100%	100%	100%	100%		
February	100%	100%	100%	100%	100%	100%		
March	100%	100%	100%	100%	100%	100%		
April	100%	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%
November	100%	100%	100%	100%	100%	100%	100%	100%
December	100%	100%	100%	100%	100%	100%	100%	100%
2020	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
January	100%	100%	100%	100%	100%	100%	100%	100%
February	100%	100%	100%	100%	100%	100%	100%	100%
March	100%	100%	100%	100%	100%	100%	100%	100%
April	100%	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%

In 2018, the Department's Clinical Psychologists received Suicide Risk Evaluation training. Table 11 shows the completion rates of Suicide Risk Evaluations for infirmary admissions and discharges. Since August 2017, OCCC has demonstrated a sustained 100% completion rate. WCCC and HCF have maintained the 100% completion rate for Suicide Risk Evaluations on admission and discharge since July 2018. In an effort to expand and measure compliance at Neighbor Island facilities, the Department initiated data tracking at HCCC in April 2019. The data shows HCCC has maintained a 100% completion rate.

Upon discharge from infirmary level care, individuals in custody are provided Caring Contact in-person follow-up services at two periods: 1-3 days and 7-10 days post-discharge. Table 12 shows the percentage of Caring Contacts completed during both periods. Over the last year, OCCC and WCCC have demonstrated sustained 100% completion rates. At the July 2020 Mental Health Quality Assurance Quarterly Meeting, data identified completion rate issues at HCF and HCCC. Mental Health Section Administrators conducted root cause analyses and implemented corrective action. HCF and HCCC have since maintained 100% completion rates.

Table 12. Percentage of Caring Contact Follow-Up Completed.

Caring Contact Follow-Up Completed (%)								
2017	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
July	93%	100%						
August	100%	91%						
September	100%	100%						
October	98%	100%						
November	100%	100%						
December	100%	100%						
2018	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
January	94%	100%						
February	100%	100%						
March	100%	91%						
April	100%	100%						
May	100%	100%						
June	100%	100%						
July	100%	100%	100%	100%	100%	100%		
August	100%	100%	100%	90%	100%	100%		
September	100%	100%	100%	100%	100%	100%		
October	100%	100%	100%	100%	100%	100%		
November	100%	100%	100%	100%	100%	100%		
December	100%	100%	100%	100%	90%	90%		
2019	**OCCC**		**WCCC**		**HCF**		**HCCC**	

	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
January	100%	100%	100%	100%	100%	100%		
February	100%	100%	100%	100%	100%	100%		
March	100%	100%	100%	100%	100%	100%		
April	100%	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%	92%
June	100%	100%	100%	100%	100%	100%	100%	90%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%
November	100%	100%	100%	100%	100%	100%	100%	100%
December	100%	100%	100%	100%	100%	100%	100%	100%
2020	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
January	100%	100%	100%	100%	100%	100%	100%	100%
February	100%	100%	100%	100%	100%	100%	100%	100%
March	100%	100%	100%	100%	100%	100%	75%	100%
April	100%	100%	100%	100%	100%	83%	100%	88%
May	100%	100%	100%	100%	100%	88%	86%	100%
June	100%	100%	100%	100%	100%	95%	100%	100%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%

Since December 2017, the Department has demonstrated significant improvements in several other mental health service areas. The following highlights the Department's accomplishments since the previous report:

- All facility Mental Health Administrators statewide obtained Certified Correctional Health Professional (CCHP) status with the National Commission on Correctional Health Care (NCCHC). The NCCHC CCHP project is designed to improve health care staff knowledge about the NCCHC standards. The goal is to provide education to health care staff on all relevant NCCHC standards through ongoing education at the facilities during monthly staff meetings on a routine and ongoing basis. This will be accomplished by the requirement of Mental Health and Nursing Administrators to become NCCHC CCHPs (and subsequently obtaining CCHP-MH or CCHP-RN status). In November 2019, 67% of Nursing Administrators obtained CCHP status.

- In November 2019, the Oahu Community Correctional Center achieved Accredited status by the National Commission on Correctional Health Care (NCCHC).

- In December 2019, Mental Health First Aid Instructors completed the Department's first official Mental Health First Aid certification course for new mental health employees and clinical services staff. The 8-hour training helps individuals identify, understand, and respond to signs and symptoms of substance use and mental illness.

- In January 2020, the Oahu Community Correctional Center established a Residential Mental Health Module dedicated for individuals in custody with severe and persistent mental illnesses. The project corrected the limitations on housing availability for eligible inmates with serious mental health needs by expanding the residential mental health bed capacity from only 8 cells in Module 2 to the entire Module 11 with 32 cells. The corrective action also allowed for the implementation of a level system based on mental health acuity and treatment needs.

- In January 2020, the Oahu Community Correctional Center and the Halawa Correctional Facility implemented the Segregation Diversion and Treatment Program through the establishment of Structured Living Units, which attempts to divert inmates with severe and persistent mental illnesses (SPMI) from segregation. The pilot project emphasizes mental health treatment, as opposed to punishment, for inmates diagnosed with SPMI who experience certain misconduct violations.

- In January 2020, the Health Care Division partnered with Dr. Kelley Withy of JABSOM to implement telepsychiatry services at the Hawaii Community Correctional Center, and later at the Oahu Community Correctional Center.

- In February 2020, mental health staff completed the 2-day Motivational Interviewing training conducted by the Interagency Council on Intermediate Sanctions (ICIS).

- In March 2020, Mental Health First Aid Instructors completed the second Mental Health First Aid certification course for new mental health employees and clinical services staff.

- In March 2020, the Mental Health Branch started training on the Pandemic Response Plan for COVID-19 for purposes of implementation of the plan and modification to existing practices. As the Centers for Disease Control and Prevention (CDC) updated guidance to COVID-19 over time, training and procedural modifications to mental health service delivery have been revised accordingly and continue to the present day.

b. Psychiatric Services

Psychiatry positions are aligned within the Medical Services Branch of the Health Care Division. A significant challenge for the Department is the recruitment and retention of experienced and qualified licensed health care professionals, particularly psychiatrists. The national shortage of physicians and psychiatrists has been well documented. The American Medical Association (AMA), the Health Resources and Services Administration (HRSA), and the Association of American Medical Colleges (AAMC) have projected an ongoing deficit in physicians and psychiatrists.

While many causes have been identified as contributors to the problem, the baby-boomer generation has reached retirement age, and the large size of this group has had unavoidable impact. Statistical data on physician shortage numbers presented at the 2019 Hawaii Health Workforce Summit showed a dismal projection in which 50% of Hawaii physicians are age 55 and over. Over the last two years, the Department lost 1.75 FTE Physician to retirement, 1.0 FTE Psychiatrist to retirement, and 1.0 FTE Psychiatrist to another higher paying department. In order to compete in the national market for the recruitment and retention of psychiatrists, an increase in budgeted salary is needed to match local and national demand.

c. Student Education Partnerships

In partnership with the University of Hawaii John A. Burns School of Medicine (JABSOM) and the University Clinical, Education & Research Associates (UCERA), the Department provides an opportunity for JABSOM residents to complete clinical rotations in psychiatry at the Oahu Community Correctional Center. Additional funding to match JABSOM and UCERA cost increases will be required to continue these contractual agreements.

Through an ongoing agreement with the Western Interstate Commission for Higher Education (WICHE), the Department offers an American Psychological Association (APA) Accredited Clinical Psychology Internship position with preference to Hawaii residents or individuals who intend to practice in Hawaii. The Department also offers a Post-Doctoral Clinical Psychology fellowship through the WICHE program. Along with the Department of Education and the Child and Adolescent Mental Health Division of the Department of Health, the Department of Public Safety is subject to increased costs associated with participation in the Hawaii Psychology Internship Consortium (HIPIC). Additional resource requirements are also needed to expand the APA accredited Clinical Psychology internship opportunities for residents of Hawaii.

The Department serves as a Practicum Training Site for the Hawaii School of Professional Psychology at Chaminade University of Honolulu (formerly Argosy University, Hawaii). Licensed Clinical Psychologists provide on-site training for diagnostic, intervention, and advanced practicum graduate students.

2. The use of alternative services, such as telemedicine, to provide mental health services to incarcerated offenders.

   In January 2020, the Health Care Division partnered with Dr. Kelley Withy of JABSOM to implement telepsychiatry services at the Hawaii Community Correctional Center, and later at the Oahu Community Correctional Center. The timeliness of the collaborative partnership, predating the onset of the coronavirus pandemic, resulted in the successful implementation of telepsychiatry services. The Health Care Division intends to continue to explore additional uses of telepsychiatry at our other correctional facilities.

3. The completion of a departmental training and policy manual.

   a. The Department continues to update the training curriculum for Mental Health, Suicide Prevention, and Restraint and Seclusion. Four-hour core courses are offered to all new employees in Mental Health and Suicide Prevention, with two-hour refresher courses in both subject areas every other year. Restraint and Seclusion is a two-hour core course with two-hour refreshers every other year. The trainings are targeted at staff having direct contact with inmates. Additionally, all staff are required to have initial First Aid/CPR training with periodic renewals for certification. The trainings continue to be offered as part of Basic Correctional Training (BCT) and Corrections Familiarization Training (CFT) for all new uniformed and non-uniformed facility employees, respectively. During FY 2015, Mental Health Services and Suicide Prevention Training was expanded to include the Law Enforcement Division.

   b. The Health Care Division has updated many of its policies and procedures contained in the Departmental Policy Manual. All new employees are required to be oriented to this manual.

   c. Mental Health Policies and Procedures are reviewed annually. In addition to adherence with State and Federal law, Mental Health Policies and Procedures are revised in accordance with the current version of the NCCHC Standards for Prisons, NCCHC Standards for Jails, and NCCHC Mental Health Standards for Correctional Facilities.

4. The appropriate type of updated record-keeping system.

The existing electronic medical record system is a leading challenge for the Department. The current system lacks the capability to integrate with pharmacy software, which necessitates a dual order system that inefficiently expends valuable psychiatry and nursing staff resources. Prior to the coronavirus pandemic, the Department began working collaboratively with the Department of Health and the Department of Human Services on the procurement of an electronic medical record system that would allow for access to records across departments. This project has been suspended due to the coronavirus pandemic. The Department intends to resume the collaborative exploration of an alternative electronic medical record system that will meet our anticipated, future needs.

The Hawaii Health Information Exchange (HHIE) is the State's designated entity for health data exchange. HHIE was established to enhance care coordination, improve the health outcomes of Hawaii's patients, and reduce the cost of care for both patients and healthcare providers. In September 2019, the Department completed required system-use trainings and became a receiving participant with HHIE.

5. An update on the feasibility study initiated by the Departments of Health and Public Safety regarding the expansion of Hawaii State Hospital (HSH), to possibly include a wing so as to be able to adequately treat mental health patients who require incarceration.

   a. The DOH has submitted a 21-year plan to address the census issues related to HSH. It is PSD's understanding that this plan is comprised of three 7-year phases focusing on demolition, replacement and construction. Presently HSH is "over census" and has been for several years since the inception of the requirement outlined in Act 144. At this time, no capacity exists to entertain the designation of a wing or expansion to treat incarcerated mental health patients.

   b. There is an assumption in this requirement that individuals with mental health disorders are not being treated "adequately" in PSD correctional facilities. However, the Department has been able to demonstrate more than adequate mental health treatment at OCCC for these inmates and in spite of some of the physical challenges of our antiquated facilities, the care is "adequate" and will continue to improve.

6. Any other suggestions or ideas to improve mental health services to incarcerated individuals to comply with local, state and federal laws and mandates.

   a. The current number of allotted nursing positions at our neighbor island jail facilities provides nursing services approximately twelve hours a day at HCCC, MCCC, and KCCC. An assessment of the health care needs of

individuals in custody, however, indicates that the current staffing plan does not fully meet the needs of the comprehensive Suicide Prevention Program. The identified problem is an absence of 24-hour, in-facility health care coverage at our neighbor island jails.

When an individual in custody is at moderate to high acute risk for suicide, the provision of 24-hour infirmary-level of care monitoring by nursing staff at designated intervals is an essential component of the Suicide Prevention Program. Additionally, nursing staff must be available 24-hours a day to provide in-person Mental Health and Medical Crisis Assessment and Intervention, particularly when mental health staff are not on duty. The current system of relying on Security staff to make health care decisions when health care staff are not available at the facility is ill-advised.

In order to provide 24-hour nursing services at our neighbor island jails, an additional 3.5 FTE Registered Nurse III positions are needed at each of the three neighbor-island jails.

b. Over the last several years, Lindsey Hayes, the Prevent Suicide Hawaii Task Force, and Correctional Health Authorities across the country have reported that the national suicide rate has been on the rise. Despite the overwhelming concern, there are still only three empirically-supported therapy approaches for suicide prevention: Dialectical Behavior Therapy (DBT), Beck's Cognitive-Behavioral Therapy (CBT), and Collaborative Assessment and Management of Suicidality (CAMS). Due to difficulties in adapting DBT and CAMS to the correctional environment, Beck's CBT has proven to have the greatest utility in our correctional settings. In September 2019, certification in Beck's Cognitive-Behavioral Therapy became available. As part of the Zero Suicide Initiative, resources are needed to support Clinical Psychologists in becoming certified in Beck's CBT. Certification is the preferred method for demonstrating and ensuring competence in the therapy.

c. As identified by Dr. Dvoskin in his 2018 Expert Report, the Department's mental health staff is in need of additional resources for ongoing training in order to improve the quality of psychosocial treatment groups.

DAVID Y. IGE
GOVERNOR

MAX N. OTANI
DIRECTOR

Maria C. Cook
Deputy Director
Administration

Tommy Johnson
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Jordan Lowe
Deputy Director
Law Enforcement

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
919 Ala Moana Boulevard, 4th Floor
Honolulu, Hawaii 96814

No. ____________________

December 30, 2021

The Honorable Ronald D. Kouchi, President
and Members of the Senate
Thirty-First State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Scott K. Saiki, Speaker
and Members of the House of Representatives
Thirty-First State Legislature
State Capitol, Room 431
Honolulu, HI 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the **Report on Mental Health Services for Committed Persons**, as required by Act 144, Session Laws of Hawaii 2007. In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at: https://dps.hawaii.gov/wp-content/uploads/2022/01/Report-on-Mental-Health-Services-for-Committed-Persons.pdf.

Sincerely,

Max N. Otani
Director

Enclosure

DEPARTMENT OF PUBLIC SAFETY
REPORT TO THE 2022 LEGISLATURE

IN RESPONSE TO
ACT 144, SESSION LAWS OF HAWAII, 2007
MENTAL HEALTH SERVICES FOR COMMITTED PERSONS

December 2021

Annual Report to the Legislature
In response to Act 144, Session Laws of Hawaii, 2007
Mental Health Services for Committed Persons

Introduction

This report is hereby submitted to fulfill the requirements outlined in Act 144, Session Laws of Hawai'i, 2007, specifically:

(1) The Department of Public Safety shall submit a report to the Legislature no later than twenty days prior to the commencement of the 2008 regular session and every session thereafter…

(2) This written report shall be submitted in a form understandable by lay readers and made available to the public.

Itemized Report

As outlined in Act 144, Session Laws of Hawai'i, 2007, the Department shall report on six (6) specific items of concern. These six items are listed below (as extracted from the statute), followed by the Department's status report on each item.

1. Assessment of the Department's existing resources and staffing, and or additional resources and staffing needed to bring mental health services up to standard and to keep up with future demands.

   a. The focus on the federal investigation and subsequent Settlement Agreement between the State of Hawaii, Department of Public Safety (PSD) and the Federal Department of Justice (DOJ) was to bring the Oahu Community Correctional Center (OCCC) up to national standards for correctional mental health care. In 2015, the Department successfully disengaged from an extended Corrective Action Plan with the DOJ. However, during the maintenance period over the next two years, the Mental Health Branch failed to remain compliant with the standards agreed upon with the DOJ, necessitating programmatic and structural changes, which included changes in the Branch's leadership. The changes in leadership seem to have brought about the desired improvements, with mental health services at OCCC significantly improved and the demonstration of sustained compliance with the DOJ requirements for the provision of mental health services. As a result of this success, the Department has been expanding compliance efforts at other Hawaii facilities.

Mental Health Staffing

In June 2017, thirteen (13) out of thirty-four (34) positions were vacant at the Oahu Mental Health Section (see Table 1 below). At present, there are five (5) vacant positions out of thirty-one (31) within the Oahu Mental Health Section. Two of the four vacant Human Services Professional/ Social Worker positions have recommended hires awaiting completion of the recruitment process. The Mental Health Registered Nurse position was recently vacated, with the promotion of the employee to fill the OCCC Clinical Services Section Administrator position. The Health Care Office has made substantial progress in reducing the vacancies among the staff of the OCCC Mental Health Section, going from a high of 38% in 2017 to the present 19%, which will be further reduced with hire of the two pending HSP positions and a vacancy rate of 10%.

Table 1. Comparative Mental Health Staffing at OCCC

	July 1, 2017		November 30, 2021		Comments
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	
Psychology	2	3	0	5	One position is filled by EH.
Social Services	6	6	4	8	Two HSP positions with recommended hires pending completion of recruitment process.
Nursing	3	6	1	8	Mental Health Registered Nurse recently promoted to OCCC Clinical Services Section Administrator.
Recreation	2	1	0	2	
Office Support	0	5	0	3	
TOTAL	**13**	**21**	**5**	**26**	

On June 30, 2017, there were thirty-nine (39) vacant positions and thirty-eight (38) filled positions in the Mental Health Branch statewide (see Table 2 below), as compared with the current twenty-two (22) vacant positions and fifty (50) filled positions in the Mental Health Branch statewide. Of the eighteen (18) vacant Social Services positions, seven (7) positions have recommended hires pending completion of the recruitment process. The remaining fifteen (15) vacant mental health positions are in active recruitment.

Table 2. Comparative Statewide Mental Health Branch Staffing.

	July 1, 2017		November 30, 2021		Comments
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	
Psychology	10	6	1	15	
Social Services	16	17	18	18	Seven (7) recommended hires pending completion of recruitment process.
Nursing	3	6	1	8	
Occupational Therapy	2	1	0	0	
Recreation	2	1	0	2	
Office Support	6	7	2	7	
TOTAL	**39**	**38**	**22**	**50**	

Especially during the coronavirus pandemic, correctional mental health care staff were often overlooked as frontline health care workers. In our jails and prisons, mental health staff were required to gear up several times daily in full personal protective equipment (PPE) to provide much needed in-person mental health services for incarcerated individuals in medical isolation and quarantine areas. In July 2020, SB126, SD1, HD1, CD1, temporarily defunded more than half of the Department's vacant mental health positions, on which, the Health Care Division had concentrated its efforts. The Department wishes to reiterate the importance of our essential frontline mental health positions in not only performing day-to-day clinical functions in the facilities, but the urgency of helping incarcerated individuals in navigating the mental health aspects of the extended coronavirus crisis. PSD greatly appreciates the Legislature's consideration and ongoing efforts in reinstituting funding for these critical positions.

Over the past few years, the Department has also identified two (2) key areas affecting mental health resource and staffing needs:

(1) **Retention of Licensed Clinical Psychologist**: The Department participates in the Statewide DHRD (Department of Human Resources Development) Pilot Project for Licensed Health Care Providers. The program, however, requires the Department to fund the program through non-existent resources. Within the past four years, the Department lost ten Clinical Psychologists to other agencies that had the resources to competitively recruit licensed providers. In addition, prospective licensed applicants from federal and private agencies have declined Clinical Psychologist positions due to the Department's budgetary constraints and non-competitive salaries. PSD continues to respectfully request an increase in budgetary resources for Clinical Psychologists, in order to become salary competitive with other State, Federal, and local agencies.

(2) **Weekend and Relief Coverage**: As identified by Dr. Joel Dvoskin, in his 2018 Expert Report, the Department is not currently staffed to provide mental health services on weekends. The Department is also not staffed to provide relief mental health coverage for vacation, sick, and other employee leave. The current number of allotted Clinical Psychologist positions at our correctional facilities statewide was designed by the mental health staffing plan to provide clinical psychology services during normal business hours (i.e., Monday through Friday, 0745 to 1630). The current staffing plan does not fully meet the needs outlined in the comprehensive Suicide Prevention Program, and the main reason is the absence of evening and weekend Clinical Psychology services at our Mental Health Sections statewide.

It is unreasonable to think that individuals in custody become suicidal or require therapeutic intervention for the reduction of suicide risk only during normal business hours. Presently, an individual being monitored for suicide risk over the weekend must wait until the next business day for evaluation and treatment of suicide risk; an individual entering a correctional facility during the evening and exhibiting suicide warning signs must wait until the next business day for a Suicide Risk Evaluation. These unacceptable scenarios are common problems identified in the Suicide Prevention Program as caused by the limitations of the current allotment of Clinical Psychology positions. PSD needs to begin addressing the urgent need for evening and weekend mental health services with the addition of one Clinical Psychologist at six correctional facilities: Halawa Correctional Facility, Oahu Community Correctional Center, Women's Community Correctional Center, Hawaii Community Correctional Center, Maui Community Correctional Center, and Kauai Community Correctional Center.

Mental Health Services

Over the past year, mental health services at OCCC showed overall sustained compliance with DOJ requirements for the provision of mental health services. Table 3 illustrates Quality Assurance data for Treatment Plan completion rates at OCCC over the last five years. The data clearly shows sustained improvement in treatment plan completion rates, with the highest completion rates occurring during the past three years. The Department's approach to the treatment planning process, which was modified from the previous practice of completing the task by the fourteenth day to completion of the treatment plan upon identification of an individual with a serious mental health need, has contributed to the improved outcome.

Table 3. Percentage of Treatment Plans Completed at OCCC.

Treatment Plans Completed (%)					
Month	**2017**	**2018**	**2019**	**2020**	**2021**
January	41%	100%	100%	100%	100%
February	33%	100%	100%	100%	100%
March	74%	100%	100%	100%	100%
April	41%	71%	100%	100%	100%
May	36%	62%	100%	100%	100%
June	19%	59%	100%	100%	100%
July	44%	100%	100%	100%	100%
August	75%	100%	100%	100%	100%
September	82%	100%	100%	100%	100%
October	85%	99%	100%	100%	100%
November	92%	100%	100%	100%	
December	100%	100%	100%	100%	

As mentioned above, the Department has been expanding DOJ compliance efforts at other Hawaii facilities. Table 4 shows Quality Assurance data for Treatment Plan completion rates at WCCC and HCF beginning July 2018. Over the past year, WCCC and HCF have been in sustained compliance with a 100% completion rate. In November 2019, HCCC also started tracking Treatment Plan completion rates. Over the past year, HCCC has demonstrated a sustained 100% completion rate. In January 2000, QA data collection expanded to include KCCC Treatment Plan completion rates. KCCC has sustained a 100% completion rate.

Table 4. Percentage of Treatment Plans Completed at WCCC, HCF, HCCC, and KCCC.

Treatment Plans Completed (%)				
2018	**WCCC**	**HCF**	**HCCC**	**KCCC**
July	83%	100%		
August	80%	100%		
September	88%	100%		
October	100%	100%		
November	100%	100%		
December	94%	100%		
2019	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%	100%		
February	100%	100%		
March	100%	100%		
April	100%	100%		
May	100%	100%		
June	100%	100%		
July	100%	100%		
August	100%	100%		
September	100%	100%		
October	100%	100%		
November	100%	100%	100%	
December	100%	100%	100%	
2020	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%	100%	100%	100%
February	100%	100%	100%	100%
March	100%	100%	100%	100%
April	100%	100%	100%	100%
May	100%	100%	100%	100%
June	100%	100%	100%	100%
July	100%	100%	100%	100%
August	100%	100%	100%	100%
September	100%	100%	100%	100%
October	100%	100%	100%	100%
November	100%	100%	100%	100%
December	100%	100%	100%	100%
2021	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%	100%	100%	100%
February	100%	100%	100%	100%
March	100%	100%	100%	100%
April	100%	100%	100%	100%
May	100%	100%	100%	100%
June	100%	100%	100%	100%
July	100%	100%	100%	100%
August	100%	100%	100%	100%
September	100%	100%	100%	100%
October	100%	100%	100%	100%

Quality Assurance data from May 2016 through July 2017 showed the average monthly provision of psychosocial treatment group activities in designated mental health modules at OCCC were minimal to non-existent (see Table 5 below).

Table 5. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at OCCC (05/2016 – 07/2017).

OCCC			
2016	**Module 1**	**Module 2**	**Module 8**
May	0.80	11.65	0.50
June	4.20	5.80	0.35
July	4.90	8.35	0.00
August	7.65	12.80	0.40
September	5.00	7.65	0.80
October	4.75	6.90	0.60
November	2.25	2.80	1.20
December	1.45	1.85	1.10
2017	**Module 1**	**Module 2**	**Module 8**
January	1.70	2.60	1.55
February	1.85	2.80	1.60
March	1.65	3.20	1.30
April	0.60	2.40	2.00
May	0.00	3.80	1.95
June	0.20	3.40	2.25
July	1.20	1.80	1.80

Since August 2017, all three designated OCCC mental health modules had demonstrated overwhelmingly significant improvement and overall sustained compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours through July 2020 (see Table 6 below). In August 2020 and August 2021, OCCC experienced an outbreak of the coronavirus, which impacted operations throughout the facility. Psychosocial treatment group hours showed a corresponding decline reflecting the effects of quarantine requirements for designated mental health modules. Although group activities were suspended at times for public health and safety reasons, mental health services continued through individual psychosocial interventions and activities, which are not reflected in the monthly psychosocial treatment group hours from August 2020 to December 2020 and August 2021 to September 2021 [note: Module 8 was repurposed as housing for medical isolation between August 2021 and October 2021]. Despite resource limitations and the negative impact of the coronavirus pandemic, the Oahu Mental Health Section demonstrated sustained compliance with this DOJ requirement.

Table 6. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at OCCC (08/2017 – 10/2021).

OCCC			
2017	**Module 1**	**Module 2**	**Module 8**
August	18.35	16.05	19.55
September	23.00	23.12	29.18
October	23.37	20.10	24.43
November	25.15	19.60	24.95
December	23.06	21.25	20.75
2018	**Module 1**	**Module 2**	**Module 8**
January	27.90	26.30	29.00
February	21.06	28.79	31.38
March	24.12	31.00	25.00
April	23.83	29.10	24.60
May	22.40	30.30	26.50
June	27.25	30.88	28.63
July	27.5	29.2	30.7
August	37.9	29.1	38.1
September	36.4	26.4	43.6
October	30.1	31.0	34.1
November	32.0	20.9	18.2
December	Construction	30.8	Construction
2019	**Module 1**	**Module 2**	**Module 8**
January	Construction	28.0	Construction
February	Construction	23.1	Construction
March	26.8	18.7	Construction
April	34.7	32.3	Construction
May	18.4	32.4	Construction
June	20.5	20.0	26.8
July	40.1	31.4	21.9
August	21.8	27.2	22.4
September	46.8	46.6	27.6
October	45.1	41.3	37.9
November	38.0	42.9	47.0
December	31.2	33.5	30.5
2020	**Module 1**	**Module 11**	**Module 8**
January	31	28	32
February	33	23	30
March	33	20	35
April	42	22	31
May	50	55	31
June	41	62	31
July	40	39	35
August	21	15	16
September	17	18	17
October	16	16	15
November	8	7	8
December	10	11	7

2021	Module 1	Module 11	Module 8
January	21	22	21
February	21	23	20
March	21	23	20
April	21	23	20
May	21	25	23
June	20	24	25
July	21	23	22
August	Quarantine	Quarantine	Medical Isolation
September	Quarantine	Quarantine	Medical Isolation
October	24	20	Medical Isolation

Table 7 shows Quality Assurance data for the average monthly provision of psychosocial treatment group activities in designated mental health modules at WCCC and HCF. The Women's Mental Health Section includes one residential mental health module, and the Halawa Mental Health Section operates four residential mental health housing areas. In March 2020, the Mental Health Branch began implementing modifications to the structure of psychosocial group activities to ensure compliance with social distancing requirements and infection prevention measures. In April 2020, one HCF residential mental health housing area was temporarily repurposed to accommodate facility housing needs.

Between November 2020 and December 2020, HCF experienced an outbreak of the coronavirus, which impacted operations throughout the facility. Psychosocial treatment group hours showed a corresponding decline reflecting the effects of quarantine requirements for designated mental health modules. Although group activities were suspended at times for public health and safety reasons, mental health services continued through individual psychosocial interventions and activities, which are not reflected in the monthly psychosocial treatment group hours. Over the last year, despite the coronavirus pandemic, WCCC and HCF have demonstrated sustained compliance in the average, monthly out-of-cell, psychosocial treatment group activity hours.

Table 7. Average Monthly Psychosocial Treatment Group Activities in Designated Mental Health Modules at WCCC and HCF.

2018	WCCC OB	WCCC OB-J	HCF M1A1	HCF M7I	HCF M7II	HCF M7III
January	14.3		15.8	10.0	10.5	10.5
February	15.5		10.5	12.7	11.8	13.1
March	16.3		13.7	11.8	13.5	13.8
April	15.1		19.1	15.8	17.0	17.3
May	21.4		16.2	13.7	14.6	13.5
June	22.4		23.8	15.4	16.2	18.0
July	17.7		22.0	15.8	15.3	13.3
August	21.7		15.5	13.2	13.6	11.4
September	23.8		21.5	17.5	16.8	16.7
October	27.4		20.3	23.2	23.9	21.1
November	22.9		21.2	21.1	22.0	20.4
December	22.3	11.06	20.5	22.1	22.6	20.9
2019	**WCCC OB**	**WCCC OB-J**	**HCF M1A1**	**HCF M7I**	**HCF M7II**	**HCF M7III**
January	25.9	25.8	16.4	22.0	22.4	21.4
February	27.8	34.2	16.1	20.1	21.6	18.7
March	27.6	38.7	20.1	20.7	21.4	18.9
April	24.8	44.4	24.5	15.4	16.9	15.4
May	27.3	23.6	21.7	11.9	10.8	11.5
June	32.2		25.8	20.2	20.9	19.9
July	37.3		20.8	24.2	23.7	23.0
August	27.9		27.6	45.3	45.4	45.4
September	25.8		25.4	48.3	48.8	48.7
October	34.2		28.1	46.4	45.0	47.2
November	32.8		27.8	42.5	42.2	41.4
December	28.4		25.3	44.1	43.8	41.5
2020	**WCCC OB**	**WCCC OB-J**	**HCF M1A1**	**HCF M7I**	**HCF M7II**	**HCF M7III**
January	38		35	45	44	42
February	29		22	44	38	38
March	21		20	38	39	37
April	21		31	40	40	
May	20		27	38	36	
June	21		33	32	33	
July	25		21	35	34	
August	33		24	32	32	
September	29		24	32	31	
October	25		23	32	31	
November	26		Quarantine			
December	25		Quarantine			

2021	WCCC OB	WCCC OB-J	HCF M1A1	HCF M7I	HCF M7II	HCF M7III
January	27		20	28	28	28
February	27		21	26	28	29
March	28		21	26	28	29
April	25		21	26	28	29
May	26		20	25	29	29
June	25		21	25	28	27
July	24		20	26	27	27
August	28		21	25	28	27
September	27		20	21	22	22
October	24		20	21	21	21

Quality Assurance data from January 2017 through July 2017 showed Discharge Plans were not completed at OCCC as required by National Correctional Mental Health Standards (see Table 8 below). Over the seven-month period, January-July 2017, only 9% of OCCC Discharge Plans were completed. In September 2017, action by Mental Health Administration resulted in significantly improved completion rates for the provision of discharge plans. Since January 2018, OCCC has demonstrated overall sustained compliance and significant improvement with the requirement of providing discharge planning for individuals in custody with serious mental health needs.

Table 8. Percentage of Discharge Plans Completed at OCCC.

Discharge Plans Completed (%)					
Month	**2017**	**2018**	**2019**	**2020**	**2021**
January	11%	100%	100%	100%	100%
February	12%	100%	100%	100%	100%
March	7%	100%	100%	100%	100%
April	10%	100%	100%	100%	100%
May	5%	100%	100%	100%	100%
June	10%	100%	100%	100%	100%
July	9%	100%	100%	100%	100%
August	14%	100%	100%	100%	100%
September	52%	100%	100%	100%	100%
October	78%	100%	100%	100%	100%
November	90%	100%	100%	100%	
December	98%	100%	100%	100%	

Table 9 shows Quality Assurance data for Discharge Plan completion rates at WCCC and HCF beginning July 2018. WCCC and HCF have been in sustained 100% compliance. In April 2020, KCCC began tracking Discharge Plan completion rates. KCCC has since demonstrated a 100% completion rate.

Table 9. Percentage of Discharge Plans Completed at WCCC, HCF, and KCCC.

Discharge Plans Completed (%)			
2018	**WCCC**	**HCF**	**KCCC**
July	100%	100%	
August	100%	100%	
September	100%	100%	
October	100%	100%	
November	100%	100%	
December	100%	100%	
2019	**WCCC**	**HCF**	**KCCC**
January	100%	100%	
February	100%	100%	
March	100%	100%	
April	100%	100%	
May	100%	100%	
June	100%	100%	
July	100%	100%	
August	100%	100%	
September	100%	100%	
October	100%	100%	
November	100%	100%	
December	100%	100%	
2020	**WCCC**	**HCF**	**KCCC**
January	100%	100%	
February	100%	100%	
March	100%	100%	
April	100%	100%	100%
May	100%	100%	100%
June	100%	100%	100%
July	100%	100%	100%
August	100%	100%	100%
September	100%	100%	100%
October	100%	100%	100%
November	100%	100%	100%
December	100%	100%	100%
2021	**WCCC**	**HCF**	**KCCC**
January	100%	100%	100%
February	100%	100%	100%
March	100%	100%	100%
April	100%	100%	100%
May	100%	100%	100%
June	100%	100%	100%
July	100%	100%	100%
August	100%	100%	100%
September	100%	100%	100%
October	100%	100%	100%

Suicide Prevention

State Mental Health Directors and Health Authorities at the National Commission on Correctional Health Care, the American Correctional Association, and the National Institute of Corrections continue to report increasing rates of suicide in correctional facilities nationwide. The Department is dedicated to the continued commitment of suicide prevention in our correctional facilities. As the nation and the Department continue to uncover additional considerations of risk for suicide, our efforts in implementing suicide prevention strategies to address new knowledge persist. Our ongoing goal of developing an infallible suicide prevention program remains unchanged.

The Department administers a comprehensive and multifaceted team approach to the Suicide Prevention Program, which includes the following components: training, identification, referral, evaluation, treatment, housing, monitoring, communication, intervention, notification, reporting, review, and postvention. Individuals in custody receive three levels of screening for the identification of suicide risk. Upon admission to the correctional system, all individuals in custody receive Intake Screening for the identification and immediate referral of urgent health care needs, including suicide risk. Individuals in custody also receive the Nursing Intake Assessment and the Post-Admission Mental Health Screen within fourteen (14) days of admission to the correctional system. Individuals in custody identified as having a serious mental health need are referred to a Qualified Mental Health Professional or Licensed Mental Health Professional for further evaluation and/or intervention.

Table 10 shows the percentage of Post-Admission Mental Health Screens completed at OCCC, WCCC, HCF, HCCC, and KCCC. Over the last year, OCCC, WCCC, and HCF have demonstrated a sustained 100% completion rate. To expand and measure compliance at Neighbor Island facilities, the Department initiated data tracking at HCCC and KCCC in April 2019. The data shows HCCC and KCCC have also maintained a 100% completion rate.

Table 10. Percentage of Post-Admission Mental Health Screens Completed.

PAMHA Completed (%)					
2017	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
November	99%				
December	100%				
2018	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%				
February	100%		100%		
March	100%	79%	94%		
April	100%	100%	100%		
May	100%	100%	100%		
June	100%	93%	100%		

July	100%	91%	100%		
August	100%	100%	100%		
September	100%	100%	100%		
October	100%	100%	100%		
November	100%	100%	100%		
December	99%	100%	100%		
2019	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	99%	97%	100%		
February	99%	100%	100%		
March	99%	100%	100%		
April	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%
November	100%	100%	100%	100%	100%
December	100%	100%	100%	100%	100%
2020	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%	100%	100%	100%	100%
February	100%	100%	100%	100%	100%
March	100%	100%	100%	100%	100%
April	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%
November	100%	100%	100%	100%	100%
December	100%	100%	100%	100%	100%
2021	**OCCC**	**WCCC**	**HCF**	**HCCC**	**KCCC**
January	100%	100%	100%	100%	100%
February	100%	100%	100%	100%	100%
March	100%	100%	100%	100%	100%
April	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%

In 2018, the Department's Clinical Psychologists received Suicide Risk Evaluation training. Table 11 shows the completion rates of Suicide Risk Evaluations for infirmary admissions and discharges. Since August 2017, OCCC has demonstrated a sustained 100% completion rate. WCCC and HCF have maintained the 100% completion rate for Suicide Risk Evaluations on admission and discharge since July 2018. To expand and measure compliance at Neighbor Island facilities, the Department initiated

data tracking at HCCC in April 2019. The data shows HCCC has maintained a 100% completion rate.

Table 11. Percentage of Suicide Risk Evaluations Completed.

2017	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
August-December	100%	100%						
2018	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
January	100%	100%						
February	100%	100%	**Suicide Risk Evaluations Completed (%)**					
March	100%	100%						
April	100%	100%						
May	100%	100%						
June	100%	100%						
July	100%	100%	100%	100%	100%	100%		
August	100%	100%	100%	100%	100%	100%		
September	100%	100%	100%	100%	100%	100%		
October	100%	100%	100%	100%	100%	100%		
November	100%	100%	100%	100%	100%	100%		
December	100%	100%	100%	100%	100%	100%		
2019	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
January	100%	100%	100%	100%	100%	100%		
February	100%	100%	100%	100%	100%	100%		
March	100%	100%	100%	100%	100%	100%		
April	100%	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%
November	100%	100%	100%	100%	100%	100%	100%	100%
December	100%	100%	100%	100%	100%	100%	100%	100%
2020	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
January	100%	100%	100%	100%	100%	100%	100%	100%
February	100%	100%	100%	100%	100%	100%	100%	100%
March	100%	100%	100%	100%	100%	100%	100%	100%
April	100%	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%
November	100%	100%	100%	100%	100%	100%	100%	100%
December	100%	100%	100%	100%	100%	100%	100%	100%

2021	OCCC		WCCC		HCF		HCCC	
	Admit	D/C	Admit	D/C	Admit	D/C	Admit	D/C
January	100%	100%	100%	100%	100%	100%	100%	100%
February	100%	100%	100%	100%	100%	100%	100%	100%
March	100%	100%	100%	100%	100%	100%	100%	100%
April	100%	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%

Upon discharge from infirmary level care, individuals in custody are provided Caring Contact in-person follow-up services at two periods: 1-3 days and 7-10 days post-discharge. Table 12 shows the percentage of Caring Contacts completed during both periods. Over the last year, OCCC, HCF, WCCC, and HCCC have demonstrated sustained 100% completion rates.

Table 12. Percentage of Caring Contact Follow-Up Completed.

Caring Contact Follow-Up Completed (%)								
2017	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
July	93%	100%						
August	100%	91%						
September	100%	100%						
October	98%	100%						
November	100%	100%						
December	100%	100%						
2018	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
January	94%	100%						
February	100%	100%						
March	100%	91%						
April	100%	100%						
May	100%	100%						
June	100%	100%						
July	100%	100%	100%	100%	100%	100%		
August	100%	100%	100%	90%	100%	100%		
September	100%	100%	100%	100%	100%	100%		
October	100%	100%	100%	100%	100%	100%		
November	100%	100%	100%	100%	100%	100%		
December	100%	100%	100%	100%	90%	90%		

2019	OCCC		WCCC		HCF		HCCC	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
January	100%	100%	100%	100%	100%	100%		
February	100%	100%	100%	100%	100%	100%		
March	100%	100%	100%	100%	100%	100%		
April	100%	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%	92%
June	100%	100%	100%	100%	100%	100%	100%	90%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%
November	100%	100%	100%	100%	100%	100%	100%	100%
December	100%	100%	100%	100%	100%	100%	100%	100%
2020	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
January	100%	100%	100%	100%	100%	100%	100%	100%
February	100%	100%	100%	100%	100%	100%	100%	100%
March	100%	100%	100%	100%	100%	100%	75%	100%
April	100%	100%	100%	100%	100%	83%	100%	88%
May	100%	100%	100%	100%	100%	88%	86%	100%
June	100%	100%	100%	100%	100%	95%	100%	100%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%
November	100%	100%	100%	100%	100%	100%	100%	100%
December	100%	100%	100%	100%	100%	100%	100%	100%
2021	**OCCC**		**WCCC**		**HCF**		**HCCC**	
	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days	1-3 days	7-10 days
January	100%	100%	100%	100%	100%	100%	100%	100%
February	100%	100%	100%	100%	100%	100%	100%	100%
March	100%	100%	100%	100%	100%	100%	100%	100%
April	100%	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%	100%	100%	100%
July	100%	100%	100%	100%	100%	100%	100%	100%
August	100%	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	100%	100%	100%	100%	100%	100%
October	100%	100%	100%	100%	100%	100%	100%	100%

Since December 2017, the Department has demonstrated significant improvements in several other mental health service areas. The following highlights the Department's accomplishments since the previous report:

- To improve upon the administration of the Suicide Risk Evaluation, all Clinical Psychologists completed training in the Chronological Assessment of Suicide Events (the CASE Approach).

- Through ongoing participation in the Prevent Suicide Hawaii Task Force, PSD mental health employees continued completion of Applied Suicide Intervention Skills Training (ASIST).

- Through an ongoing agreement with the Western Interstate Commission for Higher Education (WICHE), the Department offers American Psychological Association Accredited Clinical Psychology Internship positions at the Oahu Community Correctional Center and the Maui Community Correctional Center (new training site).

- As a component of the PSD COVID-19 Pandemic Response Plan to implement social distancing strategies, the Health Care Division employed four 0.5 FTE psychiatrists to provide telepsychiatry services at the Oahu Community Correctional Center, Halawa Correctional Facility, Hawaii Community Correctional Center, Kauai Community Correctional Center, and Waiawa Correctional Facility. The Maui Community Correctional Center, Women's Community Correctional Center, and Kulani Correctional Facility have also implemented telehealth services.

- The Mental Health Branch provides ongoing training on the COVID-19 Pandemic Response Plan for purposes of implementation of the plan and modification to existing practices. As the Centers for Disease Control and Prevention (CDC) updated guidance to COVID-19 over time, training and procedural modifications to mental health service delivery have been revised accordingly and continue to the present day.

b. Psychiatric Services

Psychiatry positions are aligned within the Medical Services Branch of the Health Care Division. A significant challenge for the Department is the recruitment and retention of experienced and qualified licensed health care professionals, particularly psychiatrists. The national shortage of physicians and psychiatrists has been well documented. The American Medical Association (AMA), the Health Resources and Services Administration (HRSA), and the Association of American Medical Colleges (AAMC) have projected an ongoing deficit in physicians and psychiatrists.

While many causes have been identified as contributors to the problem, the baby-boomer generation has reached retirement age, and the large size of this group has had unavoidable impact. Statistical data on physician shortage numbers presented at the 2019 Hawaii Health Workforce Summit showed a dismal projection in which 50% of Hawaii physicians are age 55 and over. Over the last two years, the Department lost 1.75 FTE Physician to retirement, 1.0 FTE Psychiatrist to retirement, and 1.0 FTE Psychiatrist to another higher paying department. To compete in the national market for the recruitment and retention of psychiatrists, an increase in budgeted salary is needed to match local and national demand.

c. Student Education Partnerships

In partnership with the University of Hawaii John A. Burns School of Medicine (JABSOM) and the Queen's Health Systems (QHS), the Department provides an opportunity for JABSOM residents to complete clinical rotations in psychiatry at the Oahu Community Correctional Center. Additional funding to match JABSOM and QHS cost increases will be required to continue these contractual agreements.

Through an ongoing agreement with the Western Interstate Commission for Higher Education (WICHE), the Department offers American Psychological Association (APA) Accredited Clinical Psychology Internship positions with preference to Hawaii residents or individuals who intend to practice in Hawaii. The Department also offers a Post-Doctoral Clinical Psychology fellowship through the WICHE program. Along with the Department of Education and the Child and Adolescent Mental Health Division of the Department of Health, the Department of Public Safety is subject to increased costs associated with participation in the Hawaii Psychology Internship Consortium (HIPIC). Additional resource requirements are also needed to expand the APA accredited Clinical Psychology internship opportunities for residents of Hawaii.

The Department serves as a Practicum Training Site for the Hawaii School of Professional Psychology at Chaminade University of Honolulu (formerly Argosy University, Hawaii). Licensed Clinical Psychologists provide on-site training for diagnostic, intervention, and advanced practicum graduate students.

2. The use of alternative services, such as telemedicine, to provide mental health services to incarcerated offenders.

In January 2020, the Health Care Division partnered with Dr. Kelley Withy of JABSOM to implement telepsychiatry services at the Hawaii Community Correctional Center, and later at the Oahu Community Correctional Center. The timeliness of the collaborative partnership, predating the onset of the coronavirus pandemic, resulted in the successful implementation of telepsychiatry services. Over the last year, the Health Care Division implemented telehealth capabilities at all correctional facilities statewide.

3. The completion of a departmental training and policy manual.

a. The Department continues to update the training curriculum for Mental Health, Suicide Prevention, and Restraint and Seclusion. Four-hour core courses are offered to all new employees in Mental Health and Suicide Prevention, with two-hour refresher courses in both subject areas every other year. Restraint and Seclusion is a two-hour core course with two-hour refreshers every other year. The trainings are targeted at staff having direct contact with inmates. Additionally, all staff are required to have initial First Aid/CPR training with periodic renewals for certification. The trainings continue to be offered as part of Basic Correctional Training (BCT) and

Corrections Familiarization Training (CFT) for all new uniformed and non-uniformed facility employees, respectively. During FY 2015, Mental Health Services and Suicide Prevention Training was expanded to include the Law Enforcement Division.

b. The Health Care Division has updated many of its policies and procedures contained in the Departmental Policy Manual. All new employees are required to be oriented to this manual.

c. Mental Health Policies and Procedures are reviewed annually. In addition to adherence with State and Federal law, Mental Health Policies and Procedures are revised in accordance with the current version of the NCCHC Standards for Prisons, NCCHC Standards for Jails, and NCCHC Mental Health Standards for Correctional Facilities.

4. The appropriate type of updated record-keeping system.

The existing electronic medical record system is a leading challenge for the Department. The current system lacks the capability to integrate with pharmacy software, which necessitates a dual order system that inefficiently expends valuable psychiatry and nursing staff resources. Prior to the coronavirus pandemic, the Department began working collaboratively with the Department of Health and the Department of Human Services on the procurement of an electronic medical record system that would allow for access to records across departments. This project has been suspended due to the coronavirus pandemic. The Department intends to resume exploration of an alternative electronic medical record system that will meet our anticipated, future needs.

The Hawaii Health Information Exchange (HHIE) is the State's designated entity for health data exchange. HHIE was established to enhance care coordination, improve the health outcomes of Hawaii's patients, and reduce the cost of care for both patients and healthcare providers. In September 2019, the Department completed required system-use trainings and became a receiving participant with HHIE.

5. An update on the feasibility study initiated by the Departments of Health and Public Safety regarding the expansion of Hawaii State Hospital (HSH), to possibly include a wing so as to be able to adequately treat mental health patients who require incarceration.

a. The DOH submitted a 21-year plan to address the census issues related to HSH. It is PSD's understanding that this plan is comprised of three 7-year phases focusing on demolition, replacement, and construction. Presently HSH is "over census" and has been for several years since the inception of the requirement outlined in Act 144. At this time, no capacity exists to entertain the designation of a wing or expansion to treat incarcerated mental health patients.

b. There is an assumption in this requirement that individuals with mental health disorders are not being treated "adequately" in PSD correctional facilities. However, the Department has been able to demonstrate more

than adequate mental health treatment at OCCC for these inmates and despite some of the physical challenges of our antiquated facilities, the care is “adequate” and will continue to improve.

6. Any other suggestions or ideas to improve mental health services to incarcerated individuals to comply with local, state, and federal laws and mandates.

   a. The current number of allotted nursing positions at our neighbor island jail facilities, WCF, and KCF provides nursing services approximately eight to twelve hours a day. An assessment of the health care needs of individuals in custody, however, indicates that the current staffing plan does not fully meet the needs of the comprehensive Suicide Prevention Program. The identified problem is an absence of 24-hour, in-facility health care coverage at our neighbor island jails, WCF, and KCF.

      When an individual in custody is at moderate to high acute risk for suicide, the provision of 24-hour infirmary-level of care monitoring by nursing staff at designated intervals is an essential component of the Suicide Prevention Program. Additionally, nursing staff must be available 24-hours a day to provide in-person Mental Health and Medical Crisis Assessment and Intervention, particularly when mental health staff are not on duty. The current system of relying on Security staff to make health care decisions when health care staff are not available at the facility is ill-advised.

      In order to provide 24-hour nursing services at HCCC, MCCC, KCCC, KCF, and WCF, an additional 16.0 FTE Registered Nurse III positions are needed to provide the missing weekday and weekend coverage.

   b. Over the last several years, Lindsey Hayes, the Prevent Suicide Hawaii Task Force, and Correctional Health Authorities across the country have reported that the national suicide rate has been on the rise. Despite the overwhelming concern, there are still only three empirically supported therapy approaches for suicide prevention: Dialectical Behavior Therapy (DBT), Beck’s Cognitive-Behavioral Therapy (CBT), and Collaborative Assessment and Management of Suicidality (CAMS). Due to difficulties in adapting DBT and CAMS to the correctional environment, Beck’s CBT has proven to have the greatest utility in our correctional settings. In September 2019, certification in Beck’s Cognitive-Behavioral Therapy became available. As part of the Zero Suicide Initiative, resources are needed to support Clinical Psychologists in becoming certified in Beck’s CBT. Certification is the preferred method for demonstrating and ensuring competence in the therapy.

   c. As identified by Dr. Dvoskin in his 2018 Expert Report, the Department’s mental health staff is in need of additional resources for ongoing training in order to improve the quality of psychosocial treatment groups. These training needs and the attendant problems of suicide and treatment of other psychological issues in Hawaii’s correctional facilities will persist in the absence of increased funding for ongoing training.

DEPARTMENT OF PUBLIC SAFETY
REPORT TO THE 2023 LEGISLATURE

IN RESPONSE TO
ACT 144, SESSION LAWS OF HAWAII, 2007
MENTAL HEALTH SERVICES FOR COMMITTED PERSONS

December 2022

Annual Report to the Legislature
In response to Act 144, Session Laws of Hawaii, 2007
Mental Health Services for Committed Persons

Introduction

This report is hereby submitted to fulfill the requirements outlined in Act 144, Session Laws of Hawai'i, 2007, specifically:

(1) The Department of Public Safety shall submit a report to the Legislature no later than twenty days prior to the commencement of the 2008 regular session and every session thereafter…

(2) This written report shall be submitted in a form understandable by lay readers and made available to the public.

Itemized Report

As outlined in Act 144, Session Laws of Hawai'I (SLH), 2007, the Department shall report on six (6) specific items of concern. These six items are listed below (as extracted from the statute), followed by the Department's status report on each item.

1. Assessment of the Department's existing resources and staffing, and or additional resources and staffing needed to bring mental health services up to standard and to keep up with future demands.

    a. The focus on the federal investigation and subsequent Settlement Agreement between the State of Hawaii, Department of Public Safety (PSD) and the Federal Department of Justice (DOJ) was to bring the Oahu Community Correctional Center (OCCC) up to national standards for correctional mental health care. In 2015, the Department successfully disengaged from an extended Corrective Action Plan with the DOJ. However, during the maintenance period over the next two years, the Mental Health Branch failed to remain compliant with the standards agreed upon with the DOJ, necessitating programmatic and structural changes, that included changes to the Branch's leadership. Since the 2018 fiscal year, mental health services at OCCC significantly improved and demonstrated sustained compliance with the DOJ requirements for the provision of mental health services. This success has informed the Department's expansion of compliance efforts at other Hawaii facilities.

Mental Health Staffing

On June 30, 2017, there were thirty-nine (39) vacant positions and thirty-eight (38) filled positions in the Mental Health Branch statewide (see Table 1 below), as compared with the current eighteen (18) vacant positions and fifty-five (55) filled positions in the Mental Health Branch statewide. All vacant positions are in active recruitment.

Table 1. Comparative Statewide Mental Health Branch Staffing.

	July 1, 2017		**November 30, 2022**		**Comments**
Positions by Classification	**Vacant**	**Filled**	**Vacant**	**Filled**	All vacant positions currently in active recruitment.
Psychology	10	6	2	14	
Social Services	16	17	11	25	
Nursing	3	6	3	7	
Occupational Therapy	2	1	0	0	
Recreation	2	1	0	2	
Office Support	6	7	2	7	
TOTAL	**39**	**38**	**18**	**55**	

Recruitment and retention at the Maui Community Correctional Center (MCCC) have been particularly challenging; 28% of the Department's mental health staffing vacancies are at the Maui Mental Health Section. The Department has employed various means for improving recruitment efforts (e.g., obtaining eligibility as a National Health Service Corps loan repayment program site, accreditation by the American Psychological Association through HIPIC and WICHE as a clinical psychology internship site, and funding to support the DHRD licensed health care professional pilot project). In addition, the Health Care Division suggests the following to improve recruitment:

(1) **Recruitment Above the Minimum**: Over the last five (5) years, the Health Care Division recommended hiring 13 social services applicants to be physically located at MCCC. Twelve (12) applicants declined the position due to the low rate of pay; one (1) applicant was employed but resigned in less than a month. Additional resources are needed to support the application of recruitment above the minimum for social services candidates.

(2) **Review of the Existing Recruitment Process**: Since the last MCCC clinical psychologist resigned in February 2022, the program had not received the requested list of applicants within ten (10) months,

lengthening the process of filling the resigned position to more than a year. The emergency hire process for one MCCC applicant recently took approximately six (6) months to complete. Consideration should be given to reviewing existing recruitment requirements and procedures to improve the efficiency of hiring processes.

(3) **Mental Health Office**: Previously employed mental health staff have been assigned office space within locked units/modules creating safety concerns or have been expected to share office space with non-health care staff causing confidentiality issues involving protected health information. Consideration should be given to establish a mental health office at MCCC to improve working conditions and protect sensitive, private health information.

Over the past few years, the Department identified two (2) key areas affecting mental health resource and staffing needs: a) retention of licensed clinical psychologists and b) weekend and relief coverage. The Department greatly appreciates the Legislature's consideration and ongoing effort in providing resources needed for these critical staffing issues.

(1) **Retention of Licensed Clinical Psychologist**: The Department participates in the Statewide DHRD (Department of Human Resources Development) Pilot Project for Licensed Health Care Providers. The program, however, requires the Department to fund the program through non-existent resources. Within the past five years, the Department lost eleven Clinical Psychologists to other agencies that had the resources to competitively recruit licensed providers. In addition, prospective licensed applicants from federal and private agencies have declined Clinical Psychologist positions due to the Department's budgetary constraints and non-competitive salaries. Act 248, SLH 2022, provided the Department with budgetary resources to address the issues of recruitment and retention for Clinical Psychologists. DHRD has been assisting the Department with implementation of the resources to improve recruitment and retention efforts and become salary competitive with other State, Federal, and local agencies. Implementation of the recruitment and retention plan, however, continues to experience human resources issues within the Department.

(2) **Weekend and Relief Coverage**: As identified by Dr. Joel Dvoskin, in his 2018 Expert Report, the Department is not currently staffed to provide mental health services on weekends. The Department is also not staffed to provide relief mental health coverage for vacation, sick,

and other time-off. The current number of allotted Clinical Psychologist positions at our correctional facilities statewide was designed by the mental health staffing plan to provide clinical psychology services during normal business hours (i.e., Monday through Friday, 0745 to 1630). An assessment of the mental health needs of individuals in custody, however, indicates that the current staffing plan does not fully meet the needs of the comprehensive Suicide Prevention Program, as evidenced by the absence of evening and weekend Clinical Psychology services at our Mental Health Sections statewide.

Individuals in custody do not only become suicidal and do not only require therapeutic intervention for the reduction of suicide risk during normal business hours. Presently, an individual being monitored for suicide risk over the weekend must wait until the next business day for evaluation and treatment of suicide risk. An individual who enters a correctional facility during the evening and exhibits suicide warning signs must wait until the next business day for a Suicide Risk Evaluation. These scenarios requiring urgent psychological evaluation and intervention are common problems identified in the Suicide Prevention Program as caused by the limitations of available Clinical Psychology positions. Act 248, SLH 2022, allotted the addition of one Clinical Psychologist at six correctional facilities (i.e., Halawa Correctional Facility (HCF), Oahu Community Correctional Center (OCCC), Women's Community Correctional Center (WCCC), Hawaii Community Correctional Center (HCCC), Maui Community Correctional Center (MCCC), and Kauai Community Correctional Center (KCCC), to enable the Department to begin addressing the urgent need for evening and weekend mental health services.

Mental Health Services

Over the past year, Quality Assurance data continued to demonstrate overall sustained compliance with DOJ requirements for the provision of mental health services at OCCC, HCF, WCCC, HCCC, and KCCC. The identified facilities showed continued compliance in treatment plan completion rates and discharge plan completion rates. Temporary eligibility determinations for community-based case management services provided by the Adult Mental Health Division shifted from use of the WHODAS 2.0 to the LOCUS without incident. OCCC, HCF, and WCCC showed ongoing compliance with the provision of psychosocial treatment group activities in designated residential mental health modules for individuals in custody who have been diagnosed with severe and persistent mental illnesses.

Despite the successes in the provision of mental health services, the continuous quality improvement program identified a new area of concern: maintaining inclusion and exclusion criteria for housing individuals in

custody in the designated residential male mental health module (i.e., module 11), at OCCC. The purpose of Module 11 at OCCC was to establish and maintain a safe and therapeutic environment and milieu for vulnerable individuals diagnosed with severe and persistent mental illnesses. Housing violent predatory individuals with gang affiliations in the same module, which occurred over the past year, contradicts the intent of the housing and the ability to deliver effective mental health interventions. Resources are needed to address the adverse impact of overcrowding at PSD facilities statewide.

a. Suicide Prevention

State Mental Health Directors and Health Authorities at the National Commission on Correctional Health Care, the American Correctional Association, and the National Institute of Corrections continue to report increasing rates of suicide in correctional facilities nationwide. The October 2021 Bureau of Justice Statistics report confirmed increases in deaths by suicide of 85% in state prisons and 13% in local jails between 2001 and 2019. In comparison to other combined jail and prison systems (i.e., Alaska, Connecticut, Delaware, Rhode Island, and Vermont), **Hawaii had the lowest average rate of suicide per 100,000 prisoners for the period 2015-2019**. The Department is dedicated to the continued commitment of suicide prevention in our correctional facilities. As the nation and the Department continue to uncover additional considerations of risk for suicide, our efforts in implementing suicide prevention strategies to address new knowledge persist. Our ongoing goal of developing an infallible suicide prevention program remains unchanged.

The Department administers a comprehensive and multifaceted team approach to the Suicide Prevention Program, which includes the following components: training, identification, referral, evaluation, treatment, housing, monitoring, communication, intervention, notification, reporting, review, and postvention. Individuals in custody receive three levels of screening for the identification of suicide risk. Upon admission to the correctional system, all individuals in custody receive Intake Screening for the identification and immediate referral of urgent health care needs, including suicide risk. Individuals in custody also receive the Nursing Health Assessment and the Post-Admission Mental Health Screen within fourteen (14) days of admission to the correctional system. Individuals in custody identified as having a serious mental health need are referred to a Qualified Mental Health Professional or Licensed Mental Health Professional for further evaluation and/or intervention.

Over the past year, quality assurance data showed continued compliance at OCCC, HCF, WCCC, HCCC, and KCCC with the administration of Post-Admission Mental Health Screens, Suicide Risk Evaluations, and

Caring Contact Follow-ups. Due to recruitment and retention issues at MCCC, implementation of the MCCC suicide prevention program has been limited by consistent mental health staffing.

b. Psychiatric Services

Psychiatry positions are aligned within the Medical Services Branch of the Health Care Division. A significant challenge for the Department is the recruitment and retention of experienced and qualified licensed health care professionals. The national shortage of physicians and psychiatrists has been well documented. The American Medical Association (AMA), the Health Resources and Services Administration (HRSA), and the Association of American Medical Colleges (AAMC) have projected an ongoing deficit in physicians and psychiatrists.

While many causes have been identified as contributors to the problem, the baby-boomer generation has reached retirement age, and the large size of this group has had unavoidable impact. The projection on the Hawaii healthcare workforce shortage presented at the 2022 Hawaii Health Workforce Summit was dismal. Over the last two years, the Department lost a 0.5 FTE Psychiatrist to another higher paying agency. In order to compete in the national market for the recruitment and retention of psychiatrists, an increase in budgeted salary is imminently needed to match local and national demand.

c. Student Education Partnerships

In partnership with the University of Hawaii John A. Burns School of Medicine (JABSOM) and the Queen's Health Systems (QHS), the Department provides an opportunity for JABSOM residents to complete clinical rotations in psychiatry at the Oahu Community Correctional Center. Additional funding to match JABSOM and QHS cost increases will be required to continue these contractual agreements.

Through an ongoing agreement with the Western Interstate Commission for Higher Education (WICHE), the Department offers American Psychological Association (APA) Accredited Clinical Psychology Internship positions with preference to Hawaii residents or individuals who intend to practice in Hawaii. The Department also offers Post-Doctoral Clinical Psychology fellowships through the WICHE program. Along with the Department of Education and the Child and Adolescent Mental Health Division of the Department of Health, the Department of Public Safety is subject to increased costs associated with participation in the Hawaii Psychology Internship Consortium (HIPIC). Additional resource requirements are also needed to expand the APA accredited Clinical Psychology internship opportunities for residents of Hawaii.

The Department serves as a Practicum Training Site for the Hawaii School of Professional Psychology at Chaminade University of Honolulu (formerly Argosy University, Hawaii). Licensed Clinical Psychologists provide on-site training for diagnostic, intervention, and advanced practicum graduate students. The Department has also been engaged in partnership discussions with the Psychology Department at the University of Hawaii Manoa Campus to become a possible Practicum Training Site.

2. The use of alternative services, such as telemedicine, to provide mental health services to incarcerated offenders.

   In January 2020, the Health Care Division partnered with Dr. Kelley Withy of JABSOM to implement telepsychiatry services at the Hawaii Community Correctional Center, and later at the Oahu Community Correctional Center. The timeliness of the collaborative partnership, predating the onset of the coronavirus pandemic, resulted in the successful implementation of telepsychiatry services. In 2021, the Health Care Division implemented telehealth capabilities at all correctional facilities statewide.

3. The completion of a departmental training and policy manual.

   a. The Department continues to update the training curriculum for Mental Health, Suicide Prevention, and Restraint and Seclusion. Four-hour core courses are offered to all new employees in Mental Health and Suicide Prevention, with two-hour refresher courses in both subject areas every other year. Restraint and Seclusion is a two-hour core course with two-hour refreshers every other year. The trainings are targeted at staff having direct contact with inmates. Additionally, all staff are required to have initial First Aid/CPR training with periodic renewals for certification. The trainings continue to be offered as part of Basic Correctional Training (BCT) and Corrections Familiarization Training (CFT) for all new uniformed and non-uniformed facility employees, respectively.

   b. The Health Care Division has updated many of its policies and procedures contained in the Departmental Policy Manual. All new employees are required to be oriented to this manual.

   c. Mental Health Policies and Procedures are reviewed annually. In addition to adherence with State and Federal law, Mental Health Policies and Procedures are revised in accordance with the current version of the NCCHC Standards for Prisons, NCCHC Standards for Jails, and NCCHC Mental Health Standards for Correctional Facilities.

4. The appropriate type of updated record-keeping system.

   The existing electronic health record system is the leading challenge for the Health Care Division. The current system has been inoperable since June 2022. Prior to the coronavirus pandemic, the Department began working collaboratively

with the Department of Health (DOH) and the Department of Human Services (DHS) on the procurement of an electronic health record system that would allow for access to records across departments. This project was suspended due to the coronavirus pandemic. The Department has been actively exploring procurement alternatives for an electronic health record system that will meet our anticipated, future needs. The Department is simultaneously awaiting vendor quotes from the SPO Vendor List Contract No. 17-18 (NASPO Valuepoint Cloud Solutions) and scoring the unfunded Corrections Collaboration Project RFP that would provide both offender management and electronic health record systems.

The Hawaii Health Information Exchange (HHIE) is the State's designated entity for health data exchange. HHIE was established to enhance care coordination, improve the health outcomes of Hawaii's patients, and reduce the cost of care for both patients and healthcare providers. In September 2019, the Department completed required system-use trainings and became a receiving participant with HHIE.

5. An update on the feasibility study initiated by the Departments of Health and Public Safety regarding the expansion of Hawaii State Hospital (HSH), to possibly include a wing so as to be able to adequately treat mental health patients who require incarceration.

   a. The DOH submitted a 21-year plan to address the census issues related to HSH. It is PSD's understanding that this plan is comprised of three 7-year phases focusing on demolition, replacement, and construction. In April 2022, HSH opened a new 144-bed psychiatric facility. Presently, HSH is "over census" and has been for several years since the inception of the requirement outlined in Act 144. At this time, no capacity exists to entertain the designation of a wing or expansion to routinely transfer incarcerated individuals to HSH for mental health treatment. Court-mandated transfers to HSH via the Clark Amended Permanent Injunction continues to contribute to HSH census issues.

   b. There is an assumption in this requirement that individuals diagnosed with mental health disorders are not being treated "adequately" in PSD correctional facilities. However, the Department has been able to demonstrate more than adequate mental health treatment at OCCC for these inmates and despite the physical challenges of our antiquated facilities, the care is "adequate" and will continue to improve.

6. Any other suggestions or ideas to improve mental health services to incarcerated individuals to comply with local, state, and federal laws and mandates.

   a. The current number of allotted nursing positions at the minimum-security facilities, WCF and KCF, and our neighbor island jail facilities provides nursing services approximately eight to twelve hours a day. An assessment of the health care needs of individuals in custody, however,

indicates that the current staffing plan does not fully meet the needs of the comprehensive Suicide Prevention Program, due to the absence of 24-hour, in-facility health care coverage.

When an individual in custody is at moderate to high acute risk for suicide, the provision of 24-hour infirmary-level of care monitoring by nursing staff at designated intervals is an essential component of the Suicide Prevention Program. Additionally, nursing staff must be available 24-hours a day to provide in-person Mental Health and Medical Crisis Assessment and Intervention, particularly when mental health staff are not on duty. The current system of relying on Security staff to make health care decisions when health care staff are not available at the facility is ill-advised.

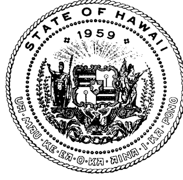
Act 248, SLH 2022, established the nursing positions needed to provide the missing weekday and weekend nursing coverage at PSD facilities statewide. The allotted positions (6- or 9-month funding delays) are currently in the process of classification and recruitment.

b. Over the last several years, Lindsey Hayes, the Prevent Suicide Hawaii Task Force, and Correctional Health Authorities across the country have reported that the national suicide rate has been on the rise. Despite the overwhelming concern, there are still only three empirically-supported therapy approaches for suicide prevention: Dialectical Behavior Therapy (DBT), Beck's Cognitive-Behavioral Therapy (CBT), and Collaborative Assessment and Management of Suicidality (CAMS). Due to difficulties in adapting DBT and CAMS to the correctional environment, Beck's CBT has proven to have the greatest utility in our correctional settings. In September 2019, certification in Beck's Cognitive-Behavioral Therapy became available. As part of the Zero Suicide Initiative, resources are needed to support Clinical Psychologists in becoming certified in Beck's CBT. Certification is the preferred method for demonstrating and ensuring competence in the therapy.

c. As identified by Dr. Dvoskin in his 2018 Expert Report, the Department's mental health staff is in need of additional recurring resources for ongoing training in order to improve the quality of psychosocial treatment groups.

The Health Care Division has taken many steps to strengthen the delivery of mental health services to those incarcerated in Hawaii facilities. However, the lack of recurring financial resources remains a key obstacle in the hiring, retention, and ongoing training requirements of professional staff and in ensuring that 24-7 mental health services are available to support the comprehensive Suicide Prevention Program as well as to address other serious mental health needs of inmates.

JOSH GREEN, M.D.
GOVERNOR OF HAWAII
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI



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Testimony COMMENTING on S.C.R. 89
REQUESTING THE DEPARTMENT OF HEALTH AND
THE DEPARTMENT OF PUBLIC SAFETY TO WORK IN COLLABORATION
TO PRESERVE THE HEALTH AND SAFETY OF SPECIAL NEEDS INMATES
AND OTHERS IN THE STATE'S JAILS AND PRISONS

SENATOR JOY A. SAN BUENAVENTURA, CHAIR
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

SENATOR GLENN WAKAI, CHAIR
SENATE COMMITTEE ON PUBLIC SAFETY AND INTERGOVERNMENTAL AND MILITARY AFFAIRS

Hearing Date, Time and Room Number: Friday, March 24, 2023, 2:00 p.m., Rm. 225/VIDEO

1 **Fiscal Implications:** Undetermined.

2 **Department Position:** The Department of Health ("Department") supports intent of this
3 measure and offers comments.

4 **Department Testimony:** The Adult Mental Health Division (AMHD) provides the following
5 testimony on behalf of the Department.

6 The purpose of this resolution is to request the Department and the Department of
7 Public Safety (PSD) to work in collaboration to preserve the health and safety of special needs
8 inmates and others in the jail and prison system with an emphasis on mental and behavioral
9 health.

10 The Department has been actively collaborating with PSD on health and mental health
11 issues including response during the COVID-19 pandemic. The Department is committed to
12 continuing to collaborate with PSD to preserve the health and safety of special needs inmates

1 and others in the State's jails and prisons. This commitment includes supporting PSD's efforts
2 to provide mental health education, treatment and rehabilitation services that align with their
3 corrections administration policy. The Department is ready and available to respond to PSD's
4 requests for technical assistance and consultation.

5 **Offered Amendments:** None.

6 Thank you for the opportunity to testify on this measure.

SCR-89
Submitted on: 3/21/2023 9:12:03 PM
Testimony for PSM on 3/24/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Louis Erteschik	Testifying for Hawaii Disability Rights Center	Support	Written Testimony Only

Comments:

In support.