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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.

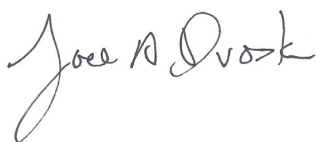
9. The process for involuntary medication administration is cumbersome and time-consuming., and appears to be much more restrictive than required by constitutional law (see, e.g., *Harper v. Washington*) and processes used in other states. While I agree that involuntary medication should never be a first 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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