DAVID Y. IGE
GOVERNOR

NOLAN P. ESPINDA
DIRECTOR

Maria C. Cook
Deputy Director
Administration

Jodie F. Maesaka-Hirata
Deputy Director
Corrections

Renee R. Sonobe Hong
Deputy Director
Law Enforcement

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

No. _____

December 12, 2019

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Thirtieth State Legislature
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.

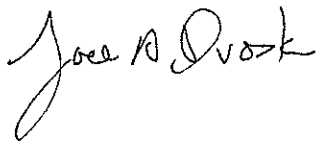
9. The process for involuntary medication administration is cumbersome and time-consuming., and appears to be much more restrictive than required by constitutional law (see, e.g., *Harper v. Washington*) and processes used in other states. While I agree that involuntary medication should never be a first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