REPORT TO THE TWENTY-FOURTH LEGISLATURE
STATE OF HAWAII
2008

PURSUANT TO S.C.R. NO. 117, S.D. 1, H.D. 1
REGARDING THE FINAL REPORT OF THE TASK FORCE CONVENED TO EVALUATE AND RECOMMEND POSSIBLE PROCEDURAL, STATUTORY, AND PUBLIC POLICY CHANGES TO MINIMIZE THE CENSUS AT HAWAII STATE HOSPITAL AND PROMOTE COMMUNITY-BASED HEALTH SERVICES FOR FORENSIC PATIENTS

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Following Review by the S.C.R. No. 117 Task Force
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II. Enabling Legislation

Senate Concurrent Resolution No. 117 S.D.1, H.D.1 (2006) requested that the Governor convene a task force to evaluate and recommend possible procedural, statutory, and public policy changes to minimize the census at Hawai`i State Hospital and to promote community-based health services for forensic patients.

III. Executive Summary

During its 2006 Session, the Legislature considered several legislative proposals which would have affected Department of Health (DOH) functions in public mental health, and especially in forensic mental health services ranging in scope from abolition of the affirmative criminal defense of physical or mental disease, disorder or defect at one end of the spectrum to a legislatively mandated increase in the fees paid to private forensic examiners at the other. The disparate proposals seemed to indicate a wide range of approaches to improving state operated and funded mental health services, both in Hawaii's sole state operated inpatient facility, Hawaii State Hospital (HSH), and in community based programs, without any assurance that the several proposals, if enacted, would accomplish those goals.

Rather than engage in piecemeal decision making concerning the 2006 proposals, the members of both the Senate and House indicated their preference for a more studied approach by passing Senate Concurrent Resolution No. 117, S.D. 1, H.D. 1 (SCR No. 117). Based on the premise that "the number of individuals with mental illnesses that come into contact with the criminal justice system may be reduced by coordinated efforts of the mental health and the criminal justice systems," SCR No. 117, page 1, lines 11 -14, the Legislature requested that the Governor to convene a task force to evaluate and recommend possible procedural, statutory, and public policy changes to minimize the census at Hawaii State Hospital and promote community based health services for forensic patients.

The Governor convened the SCR No. 117 Task Force by inviting the several representatives described in SCR No. 117 to participate in monthly meetings, beginning in October 2006. After more than a year of monthly meetings, the SCR No. 117 Task Force (Task Force) is pleased to present its final report to the legislature. The final report addresses each of the topics enumerated in SCR No. 117. Several reports describe progress already realized through on-going DOH Adult Mental Health Division (AMHD) initiatives. These reports each include a final section titled "Next Steps and Recommendations." Most of those recommendations are programmatic, and have already been funded by the Legislature.

In three areas – HRS Chapter 704 Timeframes, Orders to Treat (involuntary medication), and Mental Health Examinations – the Task Force established separate Work Groups to study the issues in depth, and to recommend specific changes to help minimize the HSH census, and to promote community based services for forensic patients. The bulk of the Task Force's recommendations for public policy, statutory, and procedural changes come from the three Work Groups, and are set forth at the conclusion of each Work Group's report.

Generally, the single public policy change reported by the Task Force is to reserve the current criminal processes in mental health cases for criminal actions in which the defendant is prosecuted for violent nonfelony charge(s) and all felony charge(s), and to develop alternative, faster-tracked processes for defendants arrested for non-violent, nonfelony charges (for example; trespass, drug and alcohol related charges, property crimes). If there is sufficient support for such a development, much additional work will need to be completed, but the payoff in terms of decreasing exposure of mentally non-criminal to the criminal

process, and the optimal use of Hawaii's most expensive mental health services might be well worth the effort.

It is recommended that the Judiciary consider seeking funding to expand the Mental Health Court, and for fully developed video teleconferencing capability linking HSH to the circuit and district courts that commit patients to the hospital.

It is recommended that ongoing training and education for all judges and other participants in the judicial proceedings be developed, and that this include focus on mental illness, as well as relevant laws and procedures.

The recommendations concerning Chapter 704, HRS, timeframes are as follows:

1. **Policy** - The Work Group has determined as a policy statement that it may be worthwhile to further differentiate judicial procedures between those charged with misdemeanors from those charged with felonies, and between those charged with crimes against a person from those not charged with such offenses. We propose that data be collected to identify possible distinctions for example, regarding time frames an individual can continue unfit given a misdemeanor charge.
2. **Procedure** - That consideration is given to possible policy and procedure development and implementation, including the use of templates, for standard judicial orders for forensic examinations, which templates would include the provision for systematically accessing relevant records, and standard procedures for the development, signing and issuing of orders, which explicit timelines, and specifically to include orders to permit AMHD to release records to Adult Client Services Branch (ACSB) for examinations pursuant to HRS § 704.
3. **Procedure** - That there be consideration given to developing and adopting DOH, AMHD, HSH Policy and Procedures (in consultation with staff of the Attorney General's Office) giving guidance to how treatment teams make explicit and operationalize the definition of "reasonable time" as this is used in HRS § 704-406(3) and HRS § 704-406(4) (current statute pertaining to how long an individual can remain unfit), prior to requesting a judicial determination as to whether the patient is fit or, if not, whether the patient meets criteria for involuntary civil commitment. Specifically, for instance, the treatment team, in consideration of clinical status and relevant history, could, through the Special Deputy Attorney General and Public Defender (either/both), trigger a process of judicial review.
4. **Procedure or Statute** - That consideration be given to HSH (and other units of AMHD e.g., Courts and Corrections) producing an annual report summarizing critical features of relevant data regarding (forensic) admissions, discharges, utilization of HSH by forensic commitment section, committing courts, county of origin to show all stakeholders how long defendants/parties remain pending completion of examination, unfit, acquitted and committed, and hospitalization after CR revocation. Report would be a state of the HSH review and would be widely distributed. Discussion and input from stakeholders would be requested each year. Annual Report Outline would include, but not be limited to:
   Admissions and Discharges,
   Length of stay by forensic status
   Admissions by court, county and forensic status
   Forensic status and reference charge (by categories crimes against person, versus not, Felony, Misdemeanor, Petty Misdemeanor)

5. **Procedure or Statute** - That there be consideration given either to encouraging the judiciary to develop a policy, or to recommending a statutory change that would require a periodic judicial callback for each individual on status HRS § 704-413(3) and HRS § 704-411(1)a. For example, for individuals whose initial charge was a misdemeanor the frequency of periodic review would be every six months, for individuals with initial felony C charges periodic review would be scheduled yearly, for Felony B and A, every two years. The purpose of this review is to determine whether criteria for commitment continue (cannot safely be discharged to existing community based supports dangerous by reason of mental illness).
   Statute - A related specific alternative which would require a specific statutory change is the example that after revocation of Conditional Release is a 30 day hospitalization with discharge when clinically ready with a report to court and possible judicial review to amend conditions of release.
6. **Follow up analysis** - That consideration is given to further researching and discussing a future statutory change making explicit the language of HRS § 704-413 requiring a finding of dangerousness by reason of mental illness. At minimum and initially promote increase use of post acquittal hearing pursuant to HRS § 704-411(2) to establish linkages between Mental Illness and dangerousness, to permit the increased use of acquittal and conditional release.
7. **Procedure** - That consideration be given to consistent implementation (and enforcement) of the provisions of HRS § 704-406 that attach all required reports to the order finding a defendant unfit and committing them to custody of DOH. The Work Group also recommends that consideration be given to extending this requirement to other dispositional orders based upon those reports.
8. **Statute (Funding)** - That consideration is given to an expansion of the mental health court, and/or a mental health calendar, and with a limited number of judges specializing in these cases, unless court of original jurisdiction elects to continue.
9. **Statute** - That consideration is given to a statutory change granting the Director of Health the authority and permitting her to apply for discharge from Conditional Release for a person served by AMHD.

The recommendations concerning orders to treat (involuntary medication) are as follows:

1. **Procedure** - A majority of the IM Work Group recommends for those adjudicated Unfit to Stand Trial under HRS § 704-406 that the Court adopt a procedure for setting a hearing on applications for the administration of involuntary medications (IM) within 72 hours. This procedure would be analogous to the expectations of a 72 hour hearing in the case of potential orders for temporary hospitalization.
2. **Procedure** -A majority of the IM Subgroup recommends that a Calendar for hearings on applications for the administration of IM be administratively developed to consolidate such requests into one venue, provided that individual courts could elect to continue presiding over a case. (This would support the development of legal and clinical expertise on the part of all participants and streamline communication and logistical expectations.) The expansion of this recommendation beyond persons on HRS § 704-406 (unfit to proceed) status was not fully discussed, and some members felt that there should be further discussion.
3. **Procedure** - A consensus of the IM Work Group strongly recommends ongoing training and education for all judges and other participants in the judicial proceedings be developed, and that this include focus on mental illness, as well as relevant laws and procedures. Examples of new thoughts that should be covered in the training include:

a. Consideration of "reasonable decision making capacity" (IM Work Group term) of an individual facing an Order to Treat hearing, in conjunction with the danger the person represents/faces. Elements to consider in determining this might include that the person has the ability to comprehend and weigh the nature of the illness, the nature of the treatment, the benefits, the risks and the alternatives, including the alternative of no treatment.
b. A majority of the IM Work Group recommends a Calendar for hearings on applications for the administration of IM be administratively developed to consolidate such requests into one venue, provided that individual Courts could elect to continue presiding over a case. (This would support the development of legal and clinical expertise on the part of all participants and streamline communication and logistical expectations.) The expansion of this recommendation beyond persons on HRS § 704-406 (unfit to proceed) status was not fully discussed and some members felt that there should be further discussion.
c. A consensus of the IM Work Group strongly recommends ongoing training and education for all judges and other participants in the judicial proceedings be developed, and that this include focus on mental illness, as well as relevant laws and procedures. Examples of new thoughts that should be covered in the training include:
    - Consideration of "reasonable decision making capacity" (IM Subgroup term) of an individual facing an Order to Treat hearing, in conjunction with the danger the person represents/faces. Elements to consider in determining this might include that the person has the ability to comprehend and weigh the nature of the illness, the nature of the treatment, the benefits, the risks and the alternatives, including the alternative of no treatment.
    - Recognition of whether there may be medical danger to self for a person suffering from psychosis without treatment, and that the degree of danger this represents, and how highly to weigh this, needs to be considered on a case-by-case basis.

The recommendations concerning improvement of mental health examinations are as follows:

1. **Procedural Change**: Courts and Adult Client Services Branches (ACSB) collaborate on the drafting and distribution of, and training on a single page form notice that alerts ACSB of the court's order for an examination in a particular case. Upon same-day receipt of the notice, the appropriate ACSB supervisor assigns the case immediately to the appropriate ACSB officer. The court clerk completes the single page notice (similar to the notice used when the court orders a defendant to probation) while the court is in session, and the completed notice is thereafter transmitted immediately to the ACSB office by interoffice delivery on the same day as the judge's ruling. The notice does not replace the order for examination.
2. **Procedural Change**: Courts and counsel uniformly accept the use of standardized form orders that are completed and filed before defendant leaves court in each case involving mental health processes.
3. **Procedural Change**: Standardized form orders are updated, and distributed regularly; and the out-dated forms are discarded immediately.

4. **Procedural Change**: On-going training is offered by an interdisciplinary team of trainers in the use of standardized form orders for attorneys, judges, bailiffs, ACSB officers, and all others involved in the process.
5. **Procedural Change**: The standard form order for examination is revised to provide for an explicit release of confidential records in the custody of public agencies. Suggested language for the authorization of release of confidential records is attached in the Appendices.
6. **Alternative Procedural Change:** Alternatively, the court orders the defendant subject to the examination to present himself to the ACSB office prior to departure from court, the ACSB office completes an immediate intake interview, and obtains signed waivers of confidentiality allowing for the collection of records. This is an alternative proposal because it will tax the current resources of the ACSB offices, and may not be necessary if the widespread adoption of the recommendations concerning the notice of examination, and the standardized form orders are accomplished.
7. **Procedural Change**: To facilitate the use of standardized form orders in all courts, formation of an ongoing committee with representatives from each judicial circuit to supervise completion of developing standardized form orders, plan the rollout of new or revised forms, and offer the requisite training. As the Third Circuit's Chapter 704 Committee has made significant progress in this area, all ongoing efforts should be coordinated closely with the Third Circuit's Chapter 704, HRS, Committee.
8. **Procedural Change**: Widespread adoption of the communication process between ACSB officers and examiners concerning completion of the record collection, as described above.
9. **Suggested Judiciary Administrative Change**: That the Judiciary consider increasing the fee for private mental health examiners be raised from $500 without reimbursement for travel costs to $1,000 with reimbursement for travel costs. Specific legislation is not needed to change the rate. Administrative action – the revision of the relevant portion of the Judiciary Financial Administration Manual is needed to change the rate.
10. **Suggested Judiciary Funding Request**: This Work Group recommends that the Judiciary consider submitting within its budget a proposed appropriation amount sufficient to compensate the private mental health examiners at the higher rate described above and that the Legislature approve such a request.
11. **Policy:** This Work Group recommends to the Task Force that it support and encourage the efforts of the Department of Public Safety (PSD) and AMHD personnel who have been meeting together recently by recommending that the committees described above continue to meet to resolve clinical and forensic issues related to detention, care and release of detainees and prisoners with mental health problems.
12. **Procedural Change**: Determining when AMHD Courts & Corrections can release copies of the reports prepared by its examiners depends on how the courts in each circuit handle the reports. This Work Group recommends that the Department of the Attorney General work with the Judiciary staff attorney to clarify current practices, and determine legal requirements concerning confidentiality of the reports or the duty to produce the reports. If appropriate and necessary, the Judiciary staff attorney will issue written guidance to the courts.
13. **Procedural Change**: As Courts & Corrections does not maintain copies of the private examiners' reports, it appears to this Work Group that consistent implementation of the provisions of HRS § 704-406(1) concerning attachments of copies of the report(s) to the operative order, if permissible, will promote the goal of providing as much information as

possible about the defendant/patient's forensic status, and clinical situation to his or her treatment team.

14. **Possible Statutory Change**: If competing laws or regulations trump the disclosure provision of HRS § 704-406(1), a statutory amendment might be needed. As the issue is not clear at this time, the Work Group is not in a position to recommend a particular legislative proposal at this time.
15. **Administrative Rulemaking**: AMHD establish, through rulemaking, a certification, training and oversight process for mental health examiners.
16. **Legislative Funding Request**: This Work Group also supports the funding of a Courts & Corrections manager position to oversee quality and timeliness of all examinations and reports, serve as the executive director of the certification process, and provide annual training and relevant conferences to improve the quality of the services offered to the courts.

It was noted that this Final Report is largely a consensus report of the Task Force participants. Not all participants were at all of the Task Force meetings, and they were participating as individuals. No endorsement by them individually or by the agencies they represent is implied by the specific recommendations being included in the Final Report, or in their participation in the Work Groups, or on the Task Force.

IV. Introduction

This report responds to the request set forth in Senate Concurrent Resolution No. 117, S.D. 1, H.D. 1 (2006) (SCR No. 117) that the Governor convene a Task Force involving consumers of public mental health services, Hawaii State Hospital (HSH) staff members, and representatives of State and County government agencies, and advocacy agencies to consider ways in which to minimize the census of HSH, as well as to promote development of community based services for forensic mental health consumers.

The Governor convened the SCR No. 117 Task Force (Task Force), which met for the first time on October 21, 2006, and has continued to meet monthly since then. The Task Force concluded its monthly meetings on November 8, 2007. Senator Rosalyn H. Baker and Representative Josh Green, M.D. served as Co-Chairpersons of the Task Force. The Governor's Policy Office provided the services of one of its Policy Analysts to support the work of the Task Force. The Task Force participants are identified in the list appended to this report.

This report describes the processes employed by the Task Force co-chairs and members to educate themselves about the issues enumerated in SCR No. 117 and includes detailed descriptions of the background, current status and future initiatives concerning each of these issues, as follows:

- Development of community based forensic public mental health services for forensic patients conditionally released by the courts into the community, with specific attention to supervision and monitoring of forensic patients;
- Further and enhanced use of mental health interventions and jail diversion programs to assist persons with mental illness who come into contact with the criminal justice system;
- Collaboration with the Judiciary to expand and enhance the Mental Health Court statewide;
- Review of Chapter 704, Hawaii Revised Statutes, "Penal Responsibility and Fitness to Proceed" for possible revisions, including by not limited to:
    - Clarification of the time frames for persons held pursuant to Chapter 704;
    - Simplification of the process by which the hospital obtains authorization for involuntary administration of psychiatric medication in non-emergency situations;
    - Clarification of the revocation process for forensic patients on conditional release in the community;
- Use of videoconferencing for Neighbor Island court appearances by mental health inpatients committed to hospitals on Oahu;
- Improvement of forensic mental health examiner training content, selection, oversight, continuing education, management, and continuous quality improvement processes; and
- Improvement of the post-release after-care services for incarcerated severely and persistently mentally ill individuals.

As required by SCR No. 117, this report includes the Task Force's recommendations for procedural, statutory and public policy changes to address the problems identified by the Task Force within these several topics. The Task Force includes a discussion of some recommended legislation with this report. It is anticipated that draft legislative proposals will be forthcoming as we move toward the 2008 Session of the Legislature.

BACKGROUND INFORMATION FOR THE TASK FORCE

The Task Force held its first meeting at the Hawaii State Hospital (HSH) Auditorium, in Kaneohe, Hawaii. The HSH Administrator and Medical Director provided a history of the facility, including the building of the newer units on the lower part of the campus completed in the early 1990s, the more recent court ordered repairs to the fifty year old Guensberg Building located on the upper campus, and the on-going challenges presented by the structural limitations of the units as they are currently configured. The Task Force also received a briefing on the improvements to staffing of the hospital and the recovery oriented treatment now offered to HSH patients. A tour of the facility was offered to Task Force participants. See Orientation to Hawaii State Hospital – Powerpoint Presentation appended to this report.

In subsequent meetings, the Task Force received information on:

- The Department of Health (DOH) Adult Mental Health Division (AMHD) forensic caseloads;
- The relationship between provision of public mental health services (both inpatient and outpatient), and the prosecution of criminal matters in which mental health is at issue;
- The provisions of Chapter 704, Hawaii Revised Statutes, which govern in criminal cases involving mental health issues;
- Risk management in community based AMHD services;
- The AMHD Forensic Statewide Service Plan;
- The timeline for implementation of the Forensic Statewide Service Plan;
- Medical information on untreated psychosis, and other issues related to involuntary administration of psychiatric medications in non-emergency, inpatient situations;
- Comparative information on other states' laws governing forensic mental health, and related information; and
- Litigation affecting the delivery of public mental health services in Hawaii, including *Clark v. State of Hawaii*, Civil No. 99-00885 in the U.S. District Court for the District of Hawaii (the permanent injunction ordered in this case mandates timeframes for the transfer of mental health defendants from custody of the Department of Public Safety to Department of Health), and *United States of America v. State of Hawaii*, Civil No. 91-00137 in the U.S. District Court for the District of Hawaii (the federal action prosecuted by the Department of Justice challenging conditions at HSH, and requiring development of community based public mental health services).

Copies of the briefing materials provided to Task Force members concerning these and other topics are appended to this report.

FORMATION OF WORK GROUPS

Upon review of the several specific issues enumerated for Task Force consideration by SCR No. 117, the Task Force determined that the DOH, through AMHD had already made significant progress concerning several of the issues and assigned knowledgeable persons to draft reports to the Task Force outlining relevant background information, current status and future initiatives related to each of those issues.

In three areas, (1) HRS Chapter 704 timeframe issues, (2) orders to treat (involuntary medication), and (3) mental health examiners, the Task Force established Work Groups to consider and recommend procedural, statutory and/or public policy changes to address the

problems noted during discussions at the monthly Task Force meetings. The reports and recommendations of these Work Groups are summarized in the Executive Summary on pages 5-8.

HAWAII STATE HOSPITAL

It is the mission of the HSH "to provide safe, integrated, evidence-based psychiatric treatment and rehabilitation to individuals suffering from mental illness and co-occurring disorders. Self-directed recovery and community integration are the primary goals." Mission Statement of Hawaii State Hospital (2003). A safe environment for patients, their families and visitors, and the hospital staff members is of paramount importance. The limits of the facility to house increasing numbers of patients have been taxed severely in recent months. The optimal census is approximately 168, and the existing facilities can accommodate readily 178 patients. HSH is licensed to accept a maximum of 202 patients. DOH augments its capacity to care for persons committed to the Director's custody by contracting with Kahi Mohala Behavioral Health for 32 inpatient beds.

DOH also contracts with The Queen's Medical Center ("QMC"), Castle Medical Center ("CMC") and the Hawaii Health Systems Corporation ("HHSC") for inpatient psychiatric beds. The ability of QMC, CMC and HHSC hospitals to admit patients committed to the Director's custody, however, does not meet the current demand for inpatient psychiatric services.

An increase in the HSH census over 178 presents challenges for hospital staff as additional patients must be accommodated in bedrooms that do not comply strictly with the square footage requirements of DOH's Office of Health Care Assurance (OHCA). HSH has applied for and obtained licensing waivers for use of the additional non-conforming bedrooms ("waived beds"), but a census above 178 taxes use of the current bathroom facilities, and programming spaces. On July 25, 2007, OHCA granted a time limited license allowing HSH to admit up to 196 patients through the period ending November 30, 2007. Thereafter, effective as of August 28, 2007, OHCA increased HSH's licensed capacity to 202 through the period ending November 30, 2007.

With priority given by necessity to admissions of patients committed to the custody of the Director of Health for detention before trial, custody after acquittal on account of physical or mental disease, disorder or defect, detention pending conditional release revocation, and custody after conditional release revocation ("forensic admissions") on account of the transfer timeframes mandated in *Clark v. State of Hawaii,* the volume of forensic admissions limits HSH's ability to admit persons subject to involuntary civil commitment by the Family Courts, and now effectively precludes voluntary admission of persons who need longer term psychiatric rehabilitation. Forensic admissions have accounted for 80% to 90% or more of the HSH census for at least the past ten (10) years.

In addition, the use of criminal processes to effect the hospital admission of persons suffering with severe and persistent mental illnesses results in an unnecessary but pervasive "criminalization" of mental illness, compounding the stigma associated with mental illness to the detriment of persons who, on account of their mental illnesses, need acute inpatient psychiatric treatment, and intensive inpatient rehabilitation.

AMHD has determined that beginning in March 2007, the HSH census has been trending upward due to increased admissions. In August, for the first time since 1994, the HSH census hit 202. Minimizing the HSH census while demand for public inpatient psychiatric services appears to be on the rise is a tremendous challenge. As the HSH census increased, Task Force members were briefed monthly on the development, and the additional challenges it posed for the hospital staff.

In early August 2007, media coverage called attention to a January 2007 incident involving injury to an HSH nurse by one of her patients, and the resignation of the President of the Medical Staff on account of her safety concerns. However, HSH data reports for the recent months in which the census has been the highest (March through August 2007) show that the incidents of patient to patient assaults and patient to staff assaults *trended downward* as the census trended upward. The data show, therefore, what appears to be an inverse relationship between the census and assaults. These observations and conclusions based on contemporaneous data reported and compiled in the regular course of business at HSH are presented here not to diminish the importance of the January 2007 incident and the former Medical Staff President's concerns. Rather, these problems, combined with the seemingly paradoxical relationship between the recent census trend and the recent assault trend illustrate the complexity involved in understanding true causes and effects in the hospital environment, and underscore the need for careful and thorough root cause analyses of assaults involving injury in order to improve the quality of care at HSH.

As a result of briefings on the current HSH safety and census issues, Task Force members were mindful of both the need to increase safety in the hospital while attending to their legislative mandate to recommend changes that may minimize the HSH census. The recommendations set forth in this report, therefore, address not only ways in which the Legislature, the involved Executive Branch agencies, and the Judiciary can change public policy, statutes and procedures to minimize the census at HSH and increase forensic placements in community based services; but also how doing so will increase HSH's ability to ensure a safe environment for patients, their families and visitors, and HSH staff members.

V. Task Force Reports and Recommendations

A. Community Based Mental Health Services for Forensic Patients

i. Executive Summary

(*approved June 14, 2007, updated October 11, 2007)*

Issues

The census at Hawaii State Hospital (HSH) is often high, with long lengths of stays for many patients. The majority of patients at HSH are on some sort of forensic status. In reality, most admissions and discharges from HSH are court-ordered; while clinicians certainly play a vital role in forensic cases, the ultimate admission and release decisions are made by criminal and family court judges.

It is incumbent for AMHD to provide as much ancillary forensic support and service in the community, so that forensic consumers can be ready for discharge in a timely fashion and remain in the community without requiring readmission to HSH. In short, judges may be more likely to discharge a patient if they are confident that the person can be managed with adequate forensic treatment and supervision. This report summarizes the current and proposed AMHD community-based forensic services. This information is expanded in the set of attached reports. As a point of clarity, the term "HSH" is used throughout this report to refer to the Hawaii State Hospital, and will also be defined to include contracted or replacement beds at other inpatient hospitals (i.e., Kahi Mohala Behavioral Health, etc.)

Current status

Currently, the largest facet of the AMHD community-based forensic services is the Conditional Release (CR) program. There are approximately 500+ individuals in the AMHD CR program (100+ inpatient, 400+ outpatient). The CR program provides individualized services and additional support staff to each person on CR, and it facilitates timely discharges from HSH, manages risk for CR consumers, and prevents unnecessary hospitalizations in times of crisis. The CR program is staffed primarily by 9 forensic coordinators (1 at HSH, 8 in the community), who in the last quarter of 2006 and first quarter of 2007 diverted 48 unnecessary HSH hospitalizations and consulted on 35 discharges. The estimated savings of hospital days saved is conservatively placed at $10 million in that quarter alone.

Several specialized programs provide specific services to unique forensic sub-populations. The Hale Imua program is a 24-hour group home that provides housing and intensive treatment services exclusively to CR consumers. It has served 35+ consumers since March 2006. The replacement bed program was founded when a contract with community and private hospitals was signed, allowing for local hospitals to admit and treat certain AMHD forensic consumers. These hospitals have served 30+ consumers since Fall 2006.

Also, the community-based fitness restoration program began in August 2007 and currently engages two participants who would otherwise be hospitalized. The program provides housing and fitness restoration services to a maximum of five individuals. It is expected that this program will expand its scope rather quickly, so that participants will be diverted from admission to HSH and into the program. The statewide jail diversion programs steer consumers away from jail and into treatment, and have engaged more than 200 individuals

statewide in the past year. Finally, the Conditional Release Exit Support and Transition (CREST) program has been implemented on Oahu and Kauai. The program helps consumers on CR prepare for life after CR, and assists them with the legal discharge process. The program started in August 2007 and has served nine individuals—two of which who have been discharged from their CRs.

It is also important to understand the nature of urban versus rural forensic services. Many of the programs and services on Oahu are not available on neighbor islands. Conversely, mental health workers may have closer professional ties with court personnel on neighbor islands than could be expected on Oahu. AMHD community-based forensic services have worked hard to ensure that models and programs are planned and implemented in ways that fit for one particular county versus another. It will be important to maintain this policy as future forensic programs are rolled out.

Future plans

Other community-based forensic programs are in development and slated for implementation. A secure residential facility (SRF) is slated for implementation in early 2008. It will house and treat 20+ individuals currently at HSH who no longer need hospital-level care but who are not amenable to existing community housing and treatment services. Also, an ongoing cooperative effort between AMHD and Department of Public Safety will result in implementation of a program for consumers being released from jail or prison. The program will identify incarcerated consumers, link them with support services while incarcerated, and provide them with support services and housing upon release. The program is expected to launch in early 2008.

Next Steps and Recommendations

DOH-AMHD requested and received funding in the Executive Biennium Budget to fund positions for the above programs. Specific position requests are outlined in subsequent reports on the individual programs. With this funding, the above programs can be implemented in a timely manner and provided the support and resources needed to adequately serve the population that might otherwise reside in HSH.

Also, a special project to reduce the HSH census was approved by the Department of Human Resources and Development (DHRD). The special project will allow AMHD to establish exempt positions for all of the above programs, as well as establish positions including an Oahu District Court court-based clinician and a forensic examiner supervisor.

AMHD will establish, recruit, and fill the above positions to ensure that the programs described will continue to provide effective services to forensic populations.

ii. Hale Imua

(*approved June 14, 2007, updated October 11, 2007)*

Description of Problem/Issue

1. Hawaii State Hospital has many patients who may not need hospital-level care and may be ready for conditional release (CR), except that appropriate housing is not available. Historically, these patients have been difficult to place because of long-standing symptoms of mental illness, substance abuse, and criminal histories.
2. A need exists for relatively high-intensity services and supervision in the community to address the needs of the above population. If this combination were to exist in the community, the HSH census could be lowered by moving members of the above population into these housing and service programs.

Description of DOH-AMHD Action Plan

1. AMHD should develop a 24-hour group home designed to address the supervision and treatment needs of inpatients ready for discharge on CR who are responsive to treatment but traditionally difficult to place in existing programs.
2. AMHD will place members from this sub-population into the 24-hour group home and provide on-going supervision and treatment services.
3. Revise 24-hour group home program data to maximize efficiency and utility.

Status of Action Plan Implementation

1. AMHD created a 24-hour group home in March 2006. It is called "Hale Imua" and is designed to meet the supervision and treatment needs of the above population. It has been operating continuously since its inception. Hale Imua runs through the collaboration of Steadfast Housing, Windward CMHC treatment services, and the Ko'olau Clubhouse.
2. Hale Imua has 24 beds, 22 of which are currently filled.
3. Hale Imua has served 35 consumers since March 2006. 28 have been discharged on CR from HSH (or Kahi Mohala Behavioral Health replacement beds), while 7 have been placed as a diversion from HSH. These diversions are consumers on CR in the community, at risk for returning to HSH on a 72-hour hold or CR revocation unless adequate housing and services are provided.
4. 13 Hale Imua participants have returned to HSH for various reasons related to their clinical functioning or compliance with CR.
5. Performance indicators and data collection strategy revised and implemented.
6. AMHD has increased capacity for diverting probable admissions to HSH by designating a 4-bedroom cottage at Hale Imua as short-term stabilization housing for CR consumers in the community at risk for rehospitalization. Hale Imua has operated in this manner intermittently since its inception, with approximately 7 diverted hospitalizations total. By formally designating "Cottage D" as specialized housing to serve this CR subpopulation, however, AMHD expects that the numbers of appropriate diversions from HSH will increase.

Next Steps and Recommendations

1. AMHD will promote full utilization of Hale Imua beds.
2. Develop a step-down program for graduates of the Hale Imua program.
3. DOH-AMHD requested and received funding in the Executive Biennium Budget to fund dedicated housing and the following 5 positions for the Hale Imua program: 1 full-time program coordinator, 3 full-time social worker/human service professionals, and 1 full-time peer specialist.
4. AMHD will recruit staff to fill the above Hale Imua staff positions.

iii. Community Based Fitness Restoration

(*approved June 14, 2007, updated October 11, 2007)*

Description of Problem/Issue

1. Hawaii State Hospital (HSH) has served as the primary setting for individuals found unfit to proceed by the court. Typically, individuals who are found unfit to proceed are transferred to HSH for fitness restoration activities, and they remain at HSH for an average of more than three months.
2. Currently, HSH has 42 patients at some stage of the fitness restoration process. Kahi Mohala Behavioral Health has approximately 12 individuals at some stage of the fitness restoration process.
3. Kahi Mohala Behavioral Health could benefit from increased programmatic support regarding fitness restoration activities.
4. Hawaii law allows for individuals who are unfit to proceed to be released on conditions into the community, if their danger to self or others can be managed.
5. No formal program, housing, or supervision currently exists within AMHD to allow for individuals released on conditions to receive the benefit of fitness restoration activities, though such a program may be able to reduce the census at HSH.

Description of DOH-AMHD Action Plan

1. Provide training and resources for complete fitness restoration program to Kahi Mohala Behavioral Health, modeled after the successful program at HSH.
2. Create an outpatient fitness restoration program to allow for the transfer or diversion of unfit to proceed individuals from HSH to a community setting, also modeled after the HSH program.
3. Dedicate housing and staff for the community-based fitness restoration program (CBFR program).
4. Collect and analyze fitness restoration program data to maximize efficiency and utility.

Status of Action Plan Implementation

1. AMHD forensic services has placed one forensic specialist at Kahi Mohala Behavioral Health part-time on a weekly basis since November 2006. She has analyzed current fitness restoration program needs and aided current fitness restoration needs.
2. Training and resources for Kahi Mohala Behavioral Health fitness restoration program finalized, including fitness restoration materials, fitness assessment instruments, critical pathways, support documentation, and identified staff.
3. Formal training and program implementation at Kahi Mohala Behavioral Health completed April 2007.
4. Data collection and analysis of Kahi Mohala Behavioral Health program began June 2007.
5. CBFR program Work Group, comprised of AMHD and HSH staff, has been meeting since July 2006.
6. National literature review has been completed to update current program materials.
7. CMHC staff, housing location, transportation, and potential consumers were identified for the CBFR program.

8. The CBFR program finished its development phase and was implemented in August 2007. A 5-bedroom cottage on the grounds of HSH, near to the Hale Imua cottages, has been designated, fitted, and staffed for the program. However, placing participants in the program has been more difficult than anticipated, for a variety of reasons. The CBFR program committee continues to revise its procedures as needed, and continues to attempt to find appropriate referrals and place individuals in the program. In spite of these barriers, the first two participants were placed into the program in early September 2007. Several referrals are pending.
9. Performance indicators and data collection strategy identified and implemented.

Next Steps and Recommendations

1. DOH-AMHD requested and received funding in the Executive Biennium Budget to fund the following position for the fitness restoration program at Kahi Mohala Behavioral Health: 1 half-time forensic coordinator at Kahi Mohala Behavioral Health (Oahu).
2. DOH-AMHD requested and received funding in the Executive Biennium Budget to fund the dedicated housing and the following 4 positions for the community fitness restoration program:1 full-time Qualified Mental Health Professional, 2 full-time social worker/human service professionals, and 1 full-time peer specialist.
3. Analyze outcome data for fitness programs at HSH, Kahi Mohala Behavioral Health, and CBFR program.
4. Continue to identify appropriate referrals for CBFR program.
5. Education and outreach to treatment teams, judiciary, and mental health examiners regarding the implementation of CBFR program.
6. If program proves successful, replicate CBFR program on appropriate neighbor island(s).

iv. Conditional Release Program: Tracking and Monitoring of CR Consumers
(*approved June 14, 2007, updated October 11, 2007)*

Description of Problem/Issue

1. Generally, individuals who have been acquitted of a crime by reason of physical or mental disease, disorder, or defect may be placed in the community on a "Conditional Release (CR)," if the court is satisfied that the person will not be a danger to self or others. CR may be granted immediately after acquittal or after a minimum 90-day period of commitment to the custody and care of the Director of Health.
2. Currently, AMHD serves 510 CR consumers in both inpatient and outpatient settings. CR consumers originate from each county (295 from Oahu, 140 from Hawaii, 40 from Maui, and 35 from Kauai). Both felony and misdemeanor charges can result in a CR (323 from Circuit Court, 137 from District Court, 25 from Family Court, and 13 with multiple referral courts).
3. Community-based CR services are critical to reducing the HSH census in two ways: 1) allowing for the timely discharge of CR consumers from HSH by setting up appropriate treatment services and supervision, and 2) avoiding the rehospitalization of CR consumers by successfully maintaining their tenure in the community.
4. Community-based CR services help HSH CR consumers prepare for and manage their discharges from HSH. Currently, there are approximately 100 individuals hospitalized at HSH (with additional consumers in replacement beds at Kahi Mohala Behavioral Health) who may be released on a CR in the future, with approximately 15-20 that may receive a CR in the reasonably near future. Between October 2006-August 2007, 71 consumers were discharged from HSH on a CR. Increasing the efficiency and scope of community-based forensic services would likely increase the frequency of discharges from HSH, thereby reducing the overall census.
5. Community-based CR services also help CR consumers avoid readmission to HSH by helping them maintain tenure in the community, even in times of crisis. All CR consumers receive the services of a case manager, psychiatrist, and forensic coordinator (FC) through AMHD. FCs track and monitor each CR consumer's case, including risks for violence and recidivism as well as placement options in times of crisis (i.e., finding viable alternatives to HSH admissions).
6. Caseloads for psychiatrists, case managers, and forensic coordinators are high. For example, FC caseloads range from 35 to 83, with an average size of 64. The highest caseloads are on Oahu and the Big Island. Additionally, CR consumers often require the highest level of treatment services (ACT level services)—approximately 30% of all CR cases are at an ACT level.
7. In some sense, each of the 410+ CR consumers in the community is potentially at risk for readmission to HSH (or other inpatient setting). FCs and treatment teams work hard to help their CR consumers maintain successful tenure in the community. Even with the above caseloads, FCs diverted approximately 48 cases slated for hospitalization away from HSH and into other appropriate placements between October 2006-March 2007. This translates into a conservative estimate of $10 million savings for the state. Unfortunately, approximately 42 CR consumers were returned to HSH during that same period. Increasing the resources and supports for community-based forensic services would likely decrease the frequency of CR consumers returning to HSH, thereby reducing the overall census.

8. Finally, some CR consumers may be ready for legal discharge from CR. Unfortunately, due to high caseloads and other work demands, many treatment professionals and court personnel are not able to devote time to this sub-population of "successful" CR consumers. Between October 2006-March 2007, FCs participated in legally discharging 14 CR consumers from their CRs entirely—a number that certainly would be higher if additional resources and supports were available.

Description of DOH-AMHD Action Plan

1. Expand scope and utility of FCs by holding trainings and workshops across Hawaii.
2. Involve FCs in every HSH discharge, HSH admission, and community crisis event for CR consumers.
3. Collect and analyze CR program data to maximize efficiency and utility.
4. Prepare formal program for to aid appropriate CR consumers in seeking legal discharge from CR.

Status of Action Plan Implementation

1. Trainings and workshops scheduled completed as of May 2007. Trainings addressed need to involve FCs in all HSH discharges, HSH admissions, and community crisis events of CR consumers
2. CR program data collected and analyzed quarterly since October 2006.
3. Formal program for legal dismissal of CR completed.
4. A Conditional Release Exit Support and Transition (CREST) program began August 2007 on Oahu and Kauai. The program takes voluntary CR consumers who are interested in potential legal discharge from CR and provides them with a multi-week group program designed to highlight their warning signs, triggers for violence and/or recidivism, crisis plans, symptom management, and other issues. Program leaders facilitate the entire process of legal discharge from CR, including assisting consumers / treatment teams and following up with defense counsel. CREST groups have engaged nine participants thus far with three graduates, each of whom are in some stage of the discharge process.

Next Steps and Recommendations

1. Continue to monitor effectiveness of CR programs through data collection and analysis.
2. Replicate the CREST program to Maui and Hawaii.
3. DOH-AMHD requested and received funding in the Executive Biennium Budget to fund the following positions for the conditional release program: 1 full-time forensic coordinator (Oahu), 1 half-time CR program manager (Oahu), and 1 half-time forensic coordinator at Kahi Mohala Behavioral Health (Oahu).
4. AMHD has proposed the establishment of a court-based clinician position. This position will place a psychologist, familiar with forensic issues and available mental health resources, at the District Court of the First Circuit to provide assistance to the court as needed. It is expected that this position will most commonly interface with cellblock defendants and defendants at their first appearances, to help gather mental health history and status in order to advise the court as to placement and available resources. The position was included in a special project to reduce the HSH census DHRD but has not yet been approved. Upon approval, the position will be established, recruited, and filled.

v. Replacement Bed Program

(approved June 14, 2007, updated October 11, 2007)

Description of Problem/Issue

1. Hawaii State Hospital (HSH) has served as the primary (and at times, the only) setting for criminal court commitments. HSH houses several distinct forensic populations, including those awaiting court-ordered evaluations (404 exams), those on a temporary suspension of their Conditional Release (72-hour hold or extended 72-hour hold), and those pending release to the community on a CR, among others.
2. Currently, HSH (no replacement bed data included) has 26 patients awaiting 404 exams, 25 patients on an extended 72-hour hold, and up to 15 patients awaiting potential release on a CR.
3. In many cases, these specific forensic sub-populations could be effectively served at other locked psychiatric inpatient units across Hawaii.
4. Contractual agreements and formal trainings need to occur before these patients can be effectively served at other hospital units.
5. Kahi Mohala Behavioral Health contracts 32 beds to AMHD under an existing contract, and requires continued training, oversight, and resources from AMHD to operate maximally.

Description of DOH-AMHD Action Plan

1. Create contracts between AMHD and Queen's Medical Center, AMHD and Castle Medical Center, and AMHD and HHSC hospitals statewide to treat AMHD forensic consumers under the three situations described above.
2. AMHD will provide resources, support, and trainings for the staff of each participating hospital.
3. Forensic consumers awaiting 404 exams or held on a 72-hour (or extended) hold will be able to be treated at participating community hospitals in lieu of HSH.
4. Forensic consumers who are ready for potential release on CR, and who seem likely to be discharged in the immediate future, can be transferred from HSH into a participating hospital in that consumer's community or county to aid in discharge planning and continuity.
5. Provided continued training, oversight, and resources to the replacement bed program at Kahi Mohala Behavioral Health.
6. Collect and analyze replacement bed program data to maximize efficiency and utility.

Status of Action Plan Implementation

1. Contracts have been signed among AMHD and Queen's Medical Center, Castle Medical Center, Samuel Mahelona Hospital, Maui Memorial Hospital, Kona Community Hospital, and Hilo Medical Center to take patients within the above three sub-populations.
2. These hospitals have admitted patients with some of the above forensic encumbrances prior to receiving formal procedures or training from AMHD.
3. Training resources and materials completed.
4. Support staff identified to oversee each forensic admission (community forensic coordinators).

5. Performance indicators and data collection strategy identified.
6. Formal trainings and workshops at contracted hospitals completed May 2007.
7. Data collection begun May 2007.

Next Steps and Recommendations

Performance indicators to be collected and analyzed to determine opportunities for program improvement.

vi. Community Secure Residential Program

(approved June 14, 2007, updated October 11, 2007)

Description of Problem/Issue

1. Hawaii State Hospital (HSH) houses several patients who clinically do not need hospital-level treatment (i.e., are treatment refractory), but who remain at HSH as a default location because no other secure location exists for these patients. These patients may be compliant with treatment recommendations, but do not see improvements in behaviors or symptomology for a variety of reasons.
2. This sub-population of patients remains at HSH because HSH is the only state-owned psychiatric facility. Keeping this population at hospital-level of care, even when lower levels of care may be equally effective, is expensive. It can also lead to morale and safety issues for both patients and staff if prolonged over an extended period of time.

Description of DOH-AMHD Action Plan

1. AMHD should create a Secure Residential Program (SRP) to house and service the above sub-population.
2. AMHD should identify staff, housing, necessary security features, program materials, and potential participants for the program.
3. The facility should be licensed as a residential program, since all programming will occur within the secure facility.

Status of Action Plan Implementation

1. Housing location has been identified. The facility will be placed at the current location of the CARE Cottages on the HSH grounds. It will house approximately 20 consumers.
2. HSH will coordinate a planning group comprised of AMHD personnel to identify program needs and set parameters for implementation.

Next Steps and Recommendations

1. Assist CARE Hawaii to coordinate the transition and transfer of current CARE cottage residents to alternative sites and services.
2. Work with licensing and accrediting agencies.
3. Obtain adequate security and supervision for the facility.
4. HSH to develop programs and identify appropriate participants for the program.
5. The SRP has a proposed implementation date of early 2008, as unforeseen licensing and physical plant issues have made an earlier start date unattainable.
6. Begin data collection and analysis of community secure residential program to begin early 2008.

B. Jail Diversion Programs

(*approved June 14, 2007, updated October 11, 2007)*

Description of Problem/Issue

1. Criminalization of the mentally ill has become a focus of national attention in the fields of criminal justice, corrections, and mental health. Over the past 10-15 years, experts have begun to re-examine the high costs of incarceration and the "revolving-door" court appearances of mentally-ill defendants. One of the most successful interventions has been jail diversion programs. Jail diversion programs now exist in nearly every state in the United States.
2. In short, jail diversion programs typically divert an offender with mental illness into case management and treatment settings, rather than sending the offender to jail. A term of supervised release is ordered that is akin to a sentence of probation. Should the offender complete the term of supervision, the "sentence" will expire; otherwise, the offender may be given one of many sanctions, including jail time. Successful jail diversion programs show decreases in rates of recidivism and arrests.
3. The Department of Health (DOH), Adult Mental Health Division (AMHD) operates two types of jail diversion programs: pre-booking jail diversion and post-booking jail diversion.
4. The pre-booking jail diversion program is a joint system operated by the Honolulu Police Department (HPD) and DOH-AMHD's Crisis Mobile Outreach services. Implementation of the pre-booking jail diversion program began in December 2006. HPD officers can call one of three HPD staff psychologists to assess a person at the crime scene to determine if hospitalization and/or continued community crisis services should be implemented rather than formal arrest and booking. The program is averaging approximately 75 calls per month, with rates of emergency hospitalization slightly increased.
5. DOH-AMHD also operates a statewide post-booking jail diversion program through the DOH Community Mental Health Centers (CMHC) on the islands of Maui, Hawaii (East and West), Kauai, and Oahu. Implementation of the post-booking jail diversion program began in September 2006.
6. Each post-booking jail diversion program consists of a jail diversion program coordinator and at least one jail diversion program specialist. The forensic coordinators for each CMHC provide consultation to the jail diversion program coordinators. Persons who are arrested for misdemeanor and petty misdemeanor offenses are eligible for participation in post-booking jail diversion programs.
7. During June 2007, participation in post-booking jail diversion programs was encouraging: Maui (11 participants), Kauai (28 participants), Hawaii (23 participants), and Oahu (2 participants). The low number of participants on Oahu at this time is due to staff shortages. The existing Oahu post-booking jail diversion program specialist estimates that he sees approximately 15 defendants per month who may be potentially eligible for the program.
8. Neighbor island post-booking jail diversion programs offer slightly different roles and emphases than the Oahu post-booking jail diversion program. As of June 2007, staff working at neighbor island jail diversion programs have experienced closer working relationship with the courts and have tended to offer more inclusive services, given the lack of certain clinical services and programs that exist exclusively on Oahu. However,

providing more intensive services on islands with a smaller spectrum of supports and services may be a challenge for jail diversion program staff and participants.

Description of DOH-AMHD Action Plan

1. Operate pre-booking jail diversion programs on Oahu, with coordinated efforts between HPD and DOH-AMHD.
2. Operate post-booking jail diversion programs in each county, hiring one jail diversion program coordinator and at least one jail diversion program specialist for each county program.
3. Develop jail diversion program manual of procedures for referral, entry, and discharge from jail diversion program, including individualized procedures for neighbor islands as may be appropriate.
4. Seek island-specific input regarding the operation of jail diversion programs from representatives of relevant agencies and consumer groups.
5. Monitor the statewide and county-specific effectiveness of DOH-AMHD jail diversion programs.

Status of Action Plan Implementation

1. Pre-booking jail diversion program implemented December 2006.
2. Post-booking jail diversion program implemented in Maui, Kauai, and Hawaii in September 2006, with requisite positions hired. Oahu had several open positions until September 2007.
3. Training of Hilo police officers by the Hawaii County jail diversion program working group and consumers in Summer 2006.
4. Manuals created and modified as was needed following consultation with representatives of relevant agencies and consumer groups.
5. Regular meetings with representatives of relevant agencies and consumer groups have promoted cooperative group problem solving.
6. County-specific data collected and analyzed for pre- and post-booking jail diversion programs.
7. DOH-AMHD requested and received funding in the Executive Biennium Budget to fund the following positions for the post-booking jail diversion programs: 6 specialist positions (2 positions for Oahu; 3 positions for Hawaii; and 1 position for Maui); and 1 coordinator position for Hawaii.

Next Steps and Recommendations

1. Collect ongoing data on pre-booking jail diversion program.
2. Based on data of pre-booking jail diversion program, replicate the pre-booking jail diversion program on neighbor islands as may be appropriate, with any requisite individualized procedures and scopes of services.
3. Implement post-booking jail diversion model on Oahu in October 2007.
4. Implement identified data collection strategy for post-booking jail diversion statewide in October 2007.

5. Now that the DOH-AMHD budget and staffing request has been approved, DOH-AMHD will actively hire and replace "borrowed" positions to staff the county-specific post-booking jail diversion programs.
6. Housing opportunities should be explored for jail diversion program participants, especially on neighbor islands.
7. Consider whether to add certain non-violent felony charges to eligibility criteria for jail diversion programs.
8. Utilize jail diversion programs and other DOH-AMHD data to implement future jail diversion programs and program-related services as appropriate to individualized county needs.

C. First Circuit Mental Health Court Pilot Program

(*approved August 9, 2007)*

IT SHOULD BE STATED AT THE OUTSET THAT THE CURRENT OAHU MENTAL HEALTH COURT PILOT DOES NOT IN ANY SIGNIFICANT MEASURE ADDRESS THE ISSUES OF THE POPULATION AT THE HAWAI'I STATE HOSPITAL OR ANY OF ITS CONTRACTED FACILITIES. The current Mental Health Court (MHC) Pilot Project qualifying criteria eliminate any person who is unfit to proceed to trial and who chooses to raise a Chapter 704, HRS, "lack of penal responsibility" defense. Thus, MHC clients do not come from the hospitalized/hospital-eligible population.

Description of Problem/Issue

1. Mental Health Courts were established to address the specific issues of the mentally ill populations in our jails, prisons, who, with proper supervision and treatment, could be reintegrated into their communities, balancing community safety and the integrity and needs of the mentally ill offender.
2. Since the focus was on the jail populations, of which more than 16% of adults incarcerated in the United States have a serious and persistent mental illness (SPMI), the issues of the hospitalized were not, at least initially, the focus of attention. What drew attention was the imprisonment of the mentally ill and the burden it places on correctional institutions. This was and is not unwarranted, though it clearly should not be the only focus of attention. It should also be noted that it is estimated that 40% of persons with SPMIs will come into contact with the criminal justice system at some point in their lives, which, when custody results, can only result in incarceration or hospitalization.
3. Incarceration of those persons with SPMIs creates its own host of problems. Almost half of the persons with SPMIs are incarcerated for non-violent offenses, yet, according the U.S. Department of Justice, they are often charged with more serious crimes than others arrested for similar behaviors. They are likely to serve longer terms, as they tend to get "written up" for infractions—both real (e.g., manifestations of the mental illness—argumentative, getting into altercations, etc.) and illusory (e.g., talking too loud, perceived as difficult to manage). They are also at least more likely to become victimized themselves, due to heightened vulnerability when untreated, not properly treated, and/or in the absence of a needed therapeutic environment within the correctional facility.
4. It has been shown that participants in any MHC program, show significantly lower rates of recidivism, incarceration, and hospitalization than similar populations not participating in such a program. Currently, as noted above, though the Oahu MHC population does not initially come from HSH, there have been two emergency procedure forensic hospitalizations, for brief periods. It is believed that this is consistent with MHC statistics of reduced hospitalizations.

Description of the current First Circuit Mental Health Court Pilot Program

1. In response to the general success of "treatment courts," including drug courts in Hawaii, the First Judicial Circuit (Oahu) planned and implemented the state's first Mental Health Court. Planning began February 2004 and implementation began with the acceptance of the first client in May of 2005.
2. The planning phase was funded by the Byrne Memorial Formula Grant Program. The initial research indicated that, with available funds, 30 non-violent offenders with SPMIs could be

diverted from incarceration and even that small number could result in significant cost savings to the state, provide better outcomes for persons with SPMIs, and enhance future public safety by significantly reducing recidivism.

3. The second year, also funded by the Byrne Grant Program, saw the inception of the program, with a target population of 30 qualifying participants. The judiciary hired a MHC Coordinator and probation officer/case supervisor (although not all participants are on probation status). Other partnerships were also added, including the Department of Prosecuting Attorney (provided a deputy specially assigned to the court, Office of Public Defender (also provided a specially tasked deputy), probation office policy liaison, and AMHD representatives.
4. There is also a MHC advisory committee, which includes representation by consumers, consumer advocacy groups, private mental health care providers, community mental health care providers, Department of Public Safety, Honolulu Police Department, Office of the Attorney General, Department of Prosecuting Attorney, Office of the Public Defender and Adult Client Services Branch, chaired by the presiding judge of the MHC.
5. Admission criteria are set: some are absolutely exclusive (not fit, no SPMI, existence of penal responsibility defense, disqualifying offense). Other than those, other apparently qualifying petitioners are screened by an AMHD doctor (also specially assigned to the MHC) and then by other MHC team members. Current policy considers only applicants with pending qualifying felony charges.
6. Applicants are eligible for admission at any stage of their criminal proceeding—pre-charge, pre-trial, upon guilty plea, post-previous sentencing (i.e., facing probation revocation).
7. The MHC meets weekly, with consistent team participation. Prior to court, cases are reviewed with the judge by the team, including the client's case manager. Clients are initially required to attend court every week, and as the client progresses, court appearances are reduced.
8. MHC is a "phase-based" program. Each phase represents the level of supervision assessed to be necessary; progression is an incentive, eventually leading, following Phase IV, to graduation. Upon graduation, charges may be dismissed or probation terminated, depending upon the stage in the criminal justice system the client was in upon entry.

Current Mental Health Court Implementation

1. This is MHC's third year under Byrne Grant Funding (through September 2007).
2. Statistics are changeable, but as of this writing, there are currently 28 participants, and the first graduation of 2-4 clients is anticipated to take place later this year.
3. Clients are in various placements, levels of care, and supervision. The MHC utilizes residential placements (e.g., Po'ailani, Sand Island Treatment Center), 8-16 hour group homes, 24 hour group homes, care home, and independent living. On occasion, one may be in OCC pending placement, or in emergency hospitalization. MHC has "terminated" one client, and two are currently "whereabouts unknown," having left residential treatment without approval.
4. Nearly all MHC participants are in full time treatment, employed, volunteering, participating in AMHD clubhouse, and/or providing peer specialist services to other SPMI individuals not in the MHC program.
5. Since the program's inception, four participants have spent time in community hospitals. Only one has been admitted to HSH, as an MH9 (agency) transfer from OCCC.

6. Several (4-5 participants) have spent a brief time in OCCC, for a variety of reasons. Length of stay is generally dependent difficulty in meeting the needs of the client for community placement.
7. Three clients have been arrested and received short jail sentences for petty misdemeanor offenses while in the MHC program.

Next Steps and Recommendations

1. Continue to work with AMHD to improve efficiency and timeliness of treatment and placements to expedite defendants' release from jail, into community based treatment.
2. Reinforce relationships and communications between OCCC, case managers, placement providers, treatment providers and the courts to ensure seamless, timely and effective community-based service.
3. Continue to refine MHC strategies, policies and procedures, including memorializing consistent outcome and performance standards.
4. **Explore expansion of the MHC** model into the hospitalized population, many of whom, with the extended supervision and monitoring that the MHC model can provide, might *sooner* succeed in a community-based treatment milieu.

It is understood that this means funding for additional court personnel, including probation, and also additional position/s in the Office of the Prosecuting Attorney and Office of the Public Defender, and possible purchase of service funding. What is most important to understand when considering this expansion is that nearly all of the potential Conditional Release population emerging from a hospital commitment will need community-based services. Thus, appropriated funds ALONE will not solve the housing/placement issues.

D. Review of Chapter 704 Hawaii Revised Statutes

(Approved October 11, 2007)

i. Timeframes for Criminal Process Under Chapter 704

Membership:

Mark Fridovich HSH Administrator, convener
Dudley Akama, Deputy Attorney General,
Ann Andreas, Deputy Attorney General,
Malina Kaulukukui, National Association of Social Workers
Alex Lichton, HSH Forensic Coordinator
Liesje Cattaneo, Adult Services
The Honorable Marcia J. Waldorf, (Judge [retired])
Charlene Iboshi, East Hawaii Prosecutor's Office
Wayne Law, CMHC Assistant Administrator

Additional Stakeholders:

- Courts and corrections examiners
- Adult Client Services Branch
- Office of the Public Defender
- Office of the Prosecuting Attorney
- Circuit Court Judge
- Hawaii State Hospital

Report:

1. Description of Problem(s) Presented: The charge of the SCR 117 is to address the Hawaii State Hospital Census. Clarifying timeframes and procedural issues as these apply to individuals committed to Hawaii State Hospital pursuant to HRS Chapter 704 may be one of the ways to achieve this. That is the focus of this Work Group. There is significant legal and operational complexity in these areas and this Work Group considered the following areas to be the primary ones to focus on:
    a. Process changes that do not require statutory change and can be accomplished through "streamlining" of the existing process.
    b. Consideration of specific timeframes pertaining to individuals committed as Unfit to Proceed (HRS § 704-406), especially in consideration or relative to their charge, their length of stay in HSH, and assessed clinical needs.
    c. Consideration of specific timeframes pertaining to the length of time an individual subject to conditions of release (HRS § 704-415) can continue in this status, including explicit provision for timelines or specific procedures regarding discharge from CR process.
    d. Consideration of specific timeframes pertaining to the length of time an individual committed pursuant to HRS § 704-413(3) can continue in that status, absent continuing need for inpatient treatment, without further judicial review.
    e. The language of HRS § 704-607 does not align precisely with that of Chapter 334, HRS. Therefore this Work Group discussed a proposal to change the language of HRS § 704-607 as this language differs from civil commitment under Chapter 334,

HRS. Specifically, Courts may be more willing to order civil commitments if the language was changed (more closely aligned between the statutes). Again, we did not have consistent representation from stakeholder groups who may have relevant input. Civil commitment statutes could be discussed by the affected parties, but we assessed that there will have to be an ongoing forum of meetings in which this can occur.

2. Description of Plan to Address Problem(s):
    a. A review of prior legislative efforts and other relevant information.
    b. A review of other state's experience in these areas
    c. Changes that may be relevant to Hawaii will be collected and new or other ideas will be considered for inclusion in a set of proposed changes.
    d. A final report of the 704 Work Group will include recommendations for change to the full Task Force.
    e. *It was noted that while this final Work Group Report is largely a consensus report of the participants, not all participants were at all the meetings and they were participating as individuals. No endorsement by them individually or by the agencies they represent is implied by the specific recommendations being included in the final report, or in their participation in the Work Group, or on the task force.*

3. Relevant Data & Status of Implementation of Plan:

    a. The review of prior legislative efforts was completed and identified the strategies used in those sessions to address the question of consistent applications of more specific timelines pertaining to forensic commitments especially HRS § 704-406 (unfit to stand trial), the period of time which a person can continue. A preliminary review of data from current HSH inpatients revealed that as of October 1, 2007, there were 49 persons then committed pursuant to section 406 (of 185 patients total, or 26 %); their average length of stay as of that date was 179 days (approximately nine months), the shortest hospitalization was about two weeks, the longest for an individual in this status was over 4 years, and 8 patients were then (10/1/2007) on HRS § 704-406 for one year or longer. As of October 1, 2007 the median length of stay for an individual committed pursuant to HRS § 704-406 is 89 days, across all charges.

    Similarly a very large cohort of patients continues in the status of HRS § 704-411(1) a (acquitted and committed after acquittal on account of physical or mental disease, disorder, or defect: MH acquittal). On October 1, 2007 there were 62 patients committed under this section, their average length of stay as of that date was over 8 years, the range was one month to over 30 years; there were 14 individuals whose hospitalization was over ten years on HRS § 704-411(1)a. Across all charges the median length of stay in HSH for individuals committed pursuant to HRS § 704-411(1)a is 1187 days (over four years). Unless the individual patient or the Director of DOH makes an application on their behalf for Conditional Release, there is no judicial review for any of these individuals.

    b. For patients on extended 72 hour hold pursuant to HRS § 704-413(1) and conditional release full revocations per HRS § 704-413(3) the analogous data are as follows:

HRS § 704-413(1)	23 patients, median length of stay 123 days (briefest, 2 weeks, approximately 4 persons with length of stay of one year or longer)
HRS § 704-413(3)	24 patients, median length of stay 1623 days (over 4 years: briefest 4 months, longest approx. 25 years, 5 patients with length of stay of 10 years or longer).

These data combine across all types of initial charges, but these two groups were individuals for whom Conditional Release was initially granted, who were returned to HSH for reasons which had to do with non compliance with conditions of release. The 23 individuals committed pursuant to HRS § 704-413(3) absent action by either their legally authorized representative or special Deputy Attorney General acting under authority of Director, Department of Health, there is no regularly scheduled periodic judicial review.

c. Initial review of input from significant stakeholders was elicited and analyzed regarding practice in these areas and potential recommendations for procedural, statutory, and public policy changes.

d. Statutory language from other states was collected and analyzed. (Thanks to the Governor's Office and the Honolulu Prosecutor's Office for assistance with this)
    i. Regarding timelines in which an individual can continue as unfit, it may be worthy of consideration to review the experience in other states. Information about other states' practices, through a survey of forensic directors, was presented at our July meeting. Added information was obtained regarding two states, Ohio and Massachusetts. In Ohio and in a number of other states there is a limit on the time which a person can remain as unfit, which time may be different for differing initial charges. In Massachusetts the typical time an individual can remain as incompetent to stand trial (that State's alternative to "unfit") is one half the maximum sentence they would have received for the most serious crime for which they were charged, if they had been found guilty. The logic behind this formulation is that period of time in involuntary criminal commitment is roughly consistent with what a non mentally ill defendant would have served as a sentence.
    ii. Regarding the timelines in which an individual can continue as a CR, since Hawaii may be amongst a relatively small number of states which maintain conditional release for individuals charged as misdemeanants.

e. The Work Group continued to explore options regarding differing treatments for individuals charged with Petty Misdemeanors and Misdemeanors, as differentiated from Felonies, especially for individuals committed and presenting with organic changes to central nervous system (e.g. dementia) or other conditions which might make fitness or compliance with conditions problematic (e.g. mental retardation) for instance, to stipulate at the time of the initial order if other placement would be adequate, to permit release to this other placement when available. It was identified by some work group members, but not all, that involuntary forensic commitment in HSH is the result for some because of the relative absence of other, less restrictive placement options (e.g. nursing home, placements for individuals whose primary

problem is substance abuse in the absence of serious and persistent mental illness.) There was no a consensus achieved on these issues, but this may be a promising area for future work.

f. Options for change were discussed. To the degree that changes are recommended, these are listed below. Numerous other options were discussed, but rejected.

4. Recommendations:

1. **POLICY** - The Work Group has determined as a policy statement that it may be worthwhile to further differentiate judicial procedures between those charged with misdemeanors from those charged with felonies, and between those charged with crimes against a person from those not charged with such offenses. We propose that data be collected to identify possible distinctions for example, regarding time frames an individual can continue unfit given a misdemeanor charge.
2. **PROCEDURE** - That consideration is given to possible policy and procedure development and implementation, including the use of templates, for standard judicial orders for forensic examinations, which templates would include the provision for systematically accessing relevant records, and standard procedures for the development, signing and issuing of orders, which explicit timelines, and specifically to include orders to permit AMHD to release records to Adult Client Services Branch for examinations pursuant to HRS § 704.
3. **PROCEDURE** - That there be consideration given to developing and adopting DOH, AMHD, HSH Policy and Procedures (in consultation with staff of the Attorney General's Office) giving guidance to how treatment teams make explicit and operationalize the definition of "reasonable time" as this is used in HRS § 704-406(3) and HRS § 704-406(4) (current statute pertaining to how long an individual can remain unfit), prior to requesting a judicial determination as to whether the patient is fit or, if not, whether the patient meets criteria for involuntary civil commitment. Specifically, for instance, the treatment team, in consideration of clinical status and relevant history, could, through the Special Deputy Attorney General and Public Defender (either/both), trigger a process of judicial review.
4. **PROCEDURE or STATUTE** - That consideration be given to HSH (and other units of AMHD e.g., Courts and Corrections) producing an annual report summarizing critical features of relevant data regarding (forensic) admissions, discharges, utilization of HSH by forensic commitment section, committing courts, county of origin to show all stakeholders how long defendants/parties remain pending completion of examination, unfit, acquitted and committed, and hospitalization after CR revocation. Report would be a state of the HSH review and would be widely distributed. Discussion and input from stakeholders would be requested each year. Annual Report Outline would include, but not be limited to:
   Admissions and Discharges,
   Length of stay by forensic status
   Admissions by court, county and forensic status
   Forensic status and reference charge (by categories crimes against person, versus not, Felony, Misdemeanor, Petty Misdemeanor)
5. **PROCEDURE or STATUTE** - That there be consideration given either to encouraging the judiciary to develop a policy, or to recommending a statutory change that would require a periodic judicial callback for each individual on status HRS § 704-413(3) and HRS § 704-411(1)a. For example, for individuals whose initial charge was a misdemeanor the frequency of periodic review would be every six months, for individuals with initial felony C charges periodic review would be scheduled yearly, for Felony B and A, every two years. The

purpose of this review is to determine whether criteria for commitment continue (cannot safely be discharged to existing community based supports dangerous by reason of mental illness).

STATUTE - A related specific alternative which would require a specific statutory change is the example that after revocation of Conditional Release is a 30 day hospitalization with discharge when clinically ready with a report to court and possible judicial review to amend conditions of release.

6. **FOLLOW UP ANALYSIS** - That consideration is given to further researching and discussing a future statutory change making explicit the language of HRS § 704-413 requiring a finding of dangerousness by reason of mental illness. At minimum and initially promote increase use of post acquittal hearing pursuant to HRS § 704-411(2) to establish linkages between Mental Illness and dangerousness, to permit the increased use of acquittal and conditional release.
7. **PROCEDURE** - That consideration be given to consistent implementation (and enforcement) of the provisions of HRS § 704-406 that attach all required reports to the order finding a defendant unfit and committing them to custody of DOH. The Work Group also recommends that consideration be given to extending this requirement to other dispositional orders based upon those reports.
8. **STATUTE (FUNDING)** - That consideration is given to an expansion of the mental health court, and/or a mental health calendar, and with a limited number of judges specializing in these cases, unless court of original jurisdiction elects to continue.
9. **STATUTE** - That consideration is given to a statutory change granting the Director of Health the authority and permitting her to apply for discharge from Conditional Release for a person served by AMHD.

ii. Orders to Treat (Involuntary Medication)
(Approved October 11, 2007)

Membership:

Rupert Goetz, MD (Hawai`i Psychiatric Medical Association [Chair]), Susan Arnett (Office of the Public Defender), Douglas Chin (Office of the Prosecuting Attorney, Honolulu, Kathleen Delahanty (Hawai`i Disability Rights Center), Marya Grambs (Mental Health America in Hawai`i), Gary Smith (Hawai`i Disability Right Center), Lani Tsuneishi, RPN (HGEA Steward, HSH Staff), The Honorable Marcia J. Waldorf, (Judge [retired])

Additional Stakeholders:

Robert Burns, RN (Hawai`i State Hospital Staff), Mark Fridovich, PhD (Hawaii State Hospital Administrator; Guest to final meeting), Debra Loy (Office of the Public Defender), Teri Marshall (Hawai`i Public Defender's Office), Lois Perrin (American Civil Liberties Union), Marion Poirier (National Alliance on Mental Illness, Hawai`i), Kevin Takata (Office of the Prosecuting Attorney, Honolulu)

Report:

1. Description of Problem(s) Presented: As the charge of the Task Force is to address the HSH census, arguably, streamlining or improving the involuntary treatment process (also referred clinically to the Order to Treat [OTT] process) may be one way to support this. Therefore, this Involuntary Medication (IM) Work Group was formed. Systematically, problems with the process might be delineated into: a) problems related to the threshold at which involuntary medications are adjudicated to be necessary; b) problems related to the application process; and c) problems related to the court process. Given the enormous clinical and legal complexity in these areas, the group decided that it should focus on the following two areas:

    a. Process changes that do not require statutory change and can be accomplished through "streamlining" of the existing process.
    b. Changes related to the use of IM in cases adjudicated to be Unfit to Proceed (HRS § 704-406). As these persons have already been found unfit (and thereby may have impaired ability to participate in a usual informed consent clinical process), this represents the "cleanest waters" in which to consider changes.

2. **Description of Plan to Address Problem(s):**

    a. A review of prior legislative efforts was done.
    b. A review of other states' and federal language, in particular since the Supreme Court decision in *Sell v. United States*, 539 U.S. 166 (2003), was accomplished.
    c. A language underlying decisions in Hawai`i, in particular the decision in *State of Hawaii v. Kotis*, 91 Hawaii 319 (1999), was considered.
    d. Changes to the IM process suggested by the review above were discussed.
    e. This Final Report of the IM Work Group was developed, using a monthly updated "living draft" process that incorporated discussion from each meeting.

f. *The Work Group acknowledged that each of its members was lending its own expertise and opinion to the subgroup and accordingly spoke as individuals. It should be noted that keeping a particular recommendation in the final draft would not be considered an endorsement by the agency each individual represented.*

3. <u>Status of Implementation of Plan</u>:

a. The review of prior legislative efforts was completed and identified the strategies used in those sessions to address the question of involuntary medication. Primarily, they included proposing an Administrative Rule change process, a process for IM consideration at the time of hearing for involuntary commitment, and the development of a previous Work Group (under HCR 156 (2005))
b. Initial review of clinical information about the danger of untreated psychosis was undertaken. Besides the slides from a presentation by James Westphal, MD that was made to the whole Task Force, a summary of related material can be found at: http://www.cnsspectrums.com/aspx/articledetail.aspx?articleid=1033.
c. Statutory language from other states was collected and analyzed. (Thanks to the Honolulu Prosecutor's Office.) A rough summary of the all principles and thresholds for adjudication resulted and was discussed. A series of e-mail summaries of the IM process from several states around the country was received and discussed at the last meeting. (Thanks to Deputy Attorney General Ann Andreas and NASMHPD.)
d. Options for change were discussed. To the degree that changes are recommended, these are listed below. Numerous other options were discussed, but rejected.

4. **<u>Recommendations</u>**:

a. A majority of the IM Work Group recommends for those adjudicated Unfit to Stand Trial under HRS § 704-406 that the Court adopt a procedure for setting a hearing on applications for the administration of involuntary medications (IM) within 72 hours. This would be analogous to the expectations of a 72 hour hearing in the case of potential orders for temporary hospitalization.
b. A majority of the IM Work Group recommends a Calendar for hearings on applications for the administration of IM be administratively developed to consolidate such requests into one venue, provided that individual Courts could elect to continue presiding over a case. (This would support the development of legal and clinical expertise on the part of all participants and streamline communication and logistical expectations.) The expansion of this recommendation beyond persons on HRS § 704-406 (unfit to proceed) status was not fully discussed and some members felt that there should be further discussion.
c. A consensus of the IM Work Group strongly recommends ongoing training and education for all judges and other participants in the judicial proceedings be developed, and that this include focus on mental illness, as well as relevant laws and procedures. Examples of new thoughts that should be covered in the training include:
    - Consideration of "reasonable decision making capacity" (IM Subgroup term) of an individual facing an Order to Treat hearing, in conjunction with the danger the person represents/faces. Elements to consider in determining this

might include that the person has the ability to comprehend and weigh the nature of the illness, the nature of the treatment, the benefits, the risks and the alternatives, including the alternative of no treatment.

- Recognition of whether there may be medical danger to self for a person suffering from psychosis without treatment, and that the degree of danger this represents, and how highly to weigh this, needs to be considered on a case-by-case basis.

iii. Clarification of the Revocation Process for Patients on Conditional Release
(*approved June 14, 2007, updated October 11, 2007)*

Description of Problem/Issue

1. Generally, individuals who have been acquitted of a crime by reason of physical or mental disease, disorder, or defect may be placed in the community on a "Conditional Release (CR)," if the court is satisfied that the person will not be a danger to self or others. CR may be granted immediately after acquittal or after a minimum 90-day period of commitment to the custody and care of the Director of Health.
2. The CR revocation process is a statutorily-driven process by which a court may rescind a person's ability to remain in the community on a CR for violating the terms and conditions of the CR. If the court orders a CR revocation, the consumer is placed in the care and custody of the DOH for a minimum of 90 days.
3. If a CR consumer violates the terms and conditions of the CR, the treatment team or a treating mental health professional contacts the person's probation officer. If the probation officer determines that CR revocation is appropriate, the probation officer will take the consumer into custody and then contact the county prosecutor to file a motion for revocation of the CR. If the court orders that the CR be revoked, the consumer is mandated to a minimum 90-day in care and custody of DOH, typically at Hawaii State Hospital (HSH).
4. After the initial 90-day period, the consumer or the Director of Health can request a hearing before the court for a reinstatement of the CR. At that hearing, a mental health examination may be ordered to determine appropriateness of reinstatement of CR. The mental health examination will be conducted by 1 examiner (1-panel) for consumers who were charged with misdemeanors. For consumers who were charged with felony charges, a panel of 3 examiners (3-panel) will examine the appropriateness of releasing the consumer and reinstating the CR. The 1-panel and 3-panel exams cannot be conducted until after the consumer's medical records are obtained, which frequently delays the mental health examination of a consumer.
5. After the mental health exam is completed and sent to the court, the consumer will be brought before the court at a second hearing at which time the court decides whether to reinstate the CR and release the consumer. This entire process typically takes a minimum of one year, even if the person's mental status clears up within a short period of time after admission to HSH.
6. The CR revocation process is often confused with other types of involuntary hospitalizations of forensic consumers. At times, a person may have a CR revoked, when other hospitalization options could have provided necessary services and supervision more efficiently and with less cost.
7. CR revocation is not the same as a 72-hour hold (or extended hold) of a person on CR. CR revocation mandates a 90-day minimum stay in the care and custody of DOH, followed by a hearing at which the revocation may be extended for various amounts of time. A 72-hour hold mandates a maximum 72 hours in the care and custody of DOH, followed by a hearing at which the court may extend the hold for additional various amounts of time. Unfortunately, treatment teams that do not understand the difference may recommend a CR revocation even when a 72-hour hold would have addressed the clinical and supervision needs in a more timely and cost-effective manner. A consumer who is admitted for a 72-hour hold does not lose the CR status, and the consumer may be

discharged when clinically appropriate. The court is usually informed of the discharge at a status hearing but does not need to approve the release.

8. CR revocation is not the same as probation revocation. CR revocation mandates a 90-day minimum stay in the care and custody of DOH. A person does not have to be fit to have a CR revoked. Probation revocation may be followed by resentencing, including incarceration in a correctional institution and/or extension of current probation period on more stringent terms. However, a person must be fit to proceed with probation revocation. If the probationer is unfit at the time that a probation revocation is sought, the consumer may be placed in the care and custody of DOH for fitness restoration. Unfortunately, some individuals in the past have been held as "unfit to proceed" for a CR revocation, which has resulted in a long and costly stay at an inpatient hospital while the legal status of the consumer is straightened out.
9. Overall, the CR revocation process is costly and labor-intensive. A revocation mandates an extended stay in HSH, and often results in very long stays at HSH while the court processes continue. The cost of a CR revocation to HSH can easily approach $200,000 before the person is re-released to the community on CR. Also, the process is cumbersome in that the court must revoke and thereafter consider the reapplication for CR using the lengthy 1-panel or 3-panel examination process and the associated series of motions and hearings, rather than simply keeping the person's CR in effect until clinical ready for release (as in a 72-hour hold).

Description of DOH-AMHD Action Plan

1. Provide training to service agencies regarding the differences among CR revocation, the 72-hour hold, and probation revocation.
2. Provide training to service agencies to carefully consider and document other stabilization and hospitalization options before considering a CR revocation.
3. Continue to work closely with the Judiciary's Adult Client Services Branch (ACSB) to alert all parties involved in the event that a CR revocation is requested.
4. Increase the efficiency for CR reapplications in cases of consumers with revoked CRs, when appropriate.
5. Collect and analyze data relating to CR revocations.

Status of Action Plan Implementation

1. Training of service agencies has begun and will continue through April 2007.
2. AMHD forensic coordinators and ACSB probation officers currently communicate about each revocation request, with revocation applications proceeding only with authorization from respective supervisors. Between October to December 2006, 19 CR revocations were averted through this collaborative process, diverting the consumers into community services or less intensive hospitalizations.
3. Data is being collected and analyzed on all revocations and revocation requests.

Next Steps and Recommendations

1. Continue training of service agencies on a continual basis.
2. Consider statutory amendment to reduce the statutorily-mandated minimum of 90 days.
3. Encourage greater use of the 72-hour hold, and extended 72-hour holds, instead of CR revocations in appropriate cases.

4. Encourage applications for release after revocation by the Director of Health, using the services of the special deputy attorney general in appropriate cases.
5. Continue to collaborate with the Task Force "704 timeframe" Work Group.
6. Clarify the 72-hour hold extension section in the Hawaii Revised Statutes, Chapter 704.

E. Videoconferencing for Court Appearances

(Approved October 11, 2007)

Description of Problem/Issue

Prior to the inception of video teleconferencing of court hearings in May, 2005, patients needed to be transported via sheriff's vehicles and commercial airlines from the Hawaii State Hospital ("HSH") to attend all hearings which were held at neighbor island courts. (Occasionally, staff from HSH and Kahi Mohala Behavioral Health transport patients to court hearings).

Due to the sheriff's procedural requirements, patients were always shackled (arms and legs) when transported, although clinically, while at HSH, they did not require restraints. They were often picked up at 3:00 or 4:00 a.m. in the morning in order to arrive at the airport in time for their flights. Patients were always accompanied by two sheriffs. The combination of fear and anxiety, fatigue, lack of staff support, and not being able to take their medications could result in decompensation while enroute. Characteristically, this decompensation would result in dangerous, aggressive, or at the least, annoying behaviors. One major local carrier has issued an outright ban on transporting any mental patients because of an incident which occurred with a patient while enroute to a hearing.

Five or six hours later, once at their destinations, patients would then have to often wait hours for their court hearings in a detention cell, shared by other "custody" defendants from prison or off the street. Hearings could be brief, often just to continue status, then they would then have to make the journey back to HSH. Patients would typically be away from their units for 12 to 15 hours.

Not only was the process detrimental to the well-being of patients, and a risk to public safety, but it was extremely costly. Two sheriffs were always required, who, most of the time, were on overtime status. This meant 3 roundtrip airfares. If the treating doctor or staff was needed to also attend the hearings, then the cost of having them on transport detail, as opposed to being on their units, in addition to airfare and car rental fees, would have to be added. Although difficult to estimate, it cost approximately $1,000.00 each time a patient was transported to a neighbor island hearing. There were approximately 120 neighbor island hearings in 2004, so the annual cost for transporting patients in 2004 prior to video teleconferencing was around $120,000.00.

Description of DOH-AMHD Action Plan

In August, 2004, an action plan was formulated to institute video teleconferencing at HSH. Kahi Mohala Behavioral Health also instituted video teleconferencing. The plan was as follows:

1) Contact neighbor island courts via judges who either had a mental health calendar, or who would be hearing Chapter 704, HRS, matters.
2) Contact county public defenders to obtain consent to have their clients appear via video teleconferencing as opposed to appearing live.
3) Contact county prosecuting attorneys.
4) Determine whether links were available from HSH or Kahi Mohala Behavioral Health to neighbor island courts.
5) Acquire equipment at HSH and at Kahi Mohala Behavioral Health to enable video teleconferencing hookup.

6) Establish a temporary link via the Department of Accounting and General Services, Information & Communication Services Division (ICSD) sites for transitional use until equipment was acquired and set up at HSH. (This enabled having hearings in downtown Honolulu at the ICSD video teleconferencing centers temporarily, requiring only transportation via sheriff's vehicles, and eliminating air transport to the neighbor islands).
7) Train personnel to staff and operate equipment for hearings, both at HSH and at remote neighbor island sites.

Status of Action Plan Implementation

Implementation of the action plan was successful, and within 8 months, on May 31, 2005, the first video teleconference court hearing was held with Judge Barbara Takase's court in Hilo. (Judge Takase now schedules hearings two days each month, for an average of 12 to 15 patients every month.)

Once equipment was acquired and set up on-site at HSH on September 27, 2005, hearings were held with patients no longer having to be transported downtown, only walked over to a specially-facilitated video teleconferencing room.

Provision is made at each hearing to enable person-to-person contact between patients and their attorneys either previous to the hearing by telephone, or on camera, when the room is vacated so patient and attorney are enabled a private conversation. If needed, recesses are taken for attorney/patient private contact.

Contact is also enabled between treatment teams and the judge. It is common that social workers or treating physicians have face-to-face conferences with the judge (patient's attorney also present in the courtroom), which is not feasible with live court. This was an unintended benefit.

Other districts and circuits were added over time, and at the present time, all neighbor island courts conduct video-teleconferenced hearings with patients.

In 2005, 62 patients had video-teleconferenced hearings (starting in May). Nearly 130 patients had hearings in 2006, and it is estimated that in 2007, that number will increase to over 175. Conservatively, this will result in a cost savings of over $350,000.00 by the end of this year.

Next Steps and Recommendations

Contact has been made with Judge Derrick Chan, the administrative judge of the First Circuit Court (Oahu), who has been responsive to holding non-evidentiary hearings via video-teleconferencing.

To date, two hearings have been held. Presently, in the First Circuit (Oahu), only Judge Chan's courtroom is facilitated for video teleconferencing, and since the retirement of Judge Marcia Waldorf, all cases arising under Chapter 704, HRS, have been re-distributed to the courts where the patients' charges originated. Lack of equipment and the dissemination of Chapter 704 cases to all criminal judges make it difficult to increase facilitation of video-teleconferenced hearings on Oahu. The largest volume of Chapter 704, HRS, hearings are held in the First Circuit, still requiring transport of patients by sheriffs, who are understaffed and often unable to timely effect

transport. Enhancements are critically needed to enable efficient video teleconferencing between the Hawaii State Hospital and Kahi Mohala Behavioral Health and the First Circuit Court.

The District Courts on Oahu have no video teleconferencing capability, so no hearings have been held via video teleconferencing. Until equipment is acquired and set up, and until mental health calendars are consolidated at the District Court level on Oahu, patients will need to be transported to the respective courts via the sheriffs. Patients can typically arrive one to three hours late for their hearings. The sheriffs require a transport order for each patient transported to District Court hearings. When these orders are not prepared in a timely manner, sheriffs refuse to transport. Unavailability of deputy sheriffs and procedures (for example, not transporting male and female patients in the same van), cause delays, and hearings need to be re-scheduled because patients are not taken to court, even with transport orders.

The following are recommendations which should be made by this committee:

1. Consider funding and facilitating every circuit and district court in the First Circuit with video teleconferencing capability. This includes acquisition costs and maintenance for equipment once acquired. Concerns for patient's welfare and public safety, along with cost savings of not having to transport patients downtown would provide justification for this funding.
2. Consider upgrading the video teleconferencing program at Hawaii State Hospital.
3. Consider centralizing the assignment of 704 cases to one judge in Circuit Court, or to a panel of several judges in District Court.
4. Enable the sheriff's department, either by funding or prioritizing staffing, capability to deliver patient/defendants in a timely manner to court.

F. Improving Mental Health Examinations in Criminal Cases

(approved October 11, 2007)

I. Introduction

The statutes, procedures and policies concerning metal health examiners and examinations in criminal cases are key areas in which "the number of individuals with mental illnesses that come into contact with the criminal justice system may be reduced by coordinated efforts of the mental health and criminal justice systems." SCR No. 117, pg. 1, lines 11-14 (2006). The mandate that the Task Force "review Chapter 704 Hawaii Revised Statutes" as well as "[i]mprove forensic mental health examiner training-content, selection, oversight, continuing education, management, and continuous quality improvement processes" prompted the formation of the separate Work Group on Mental Health Examiners.

The following members of the Task Force identified several issues presented by current statutes and processes, provided additional information which informed the Work Group's discussions, and participated in the consensus building process that resulted in the recommendations set forth in this report:

- W. Neil Gowensmith, Ph.D., AMHD Forensic Director, who served as the convener of the Work Group
- Marcia J. Waldorf, First Circuit Court Judge (retired)
- Liesje Cattaneo, Adult Client Services, Hawaii Judiciary
- Thomas Cunningham, Ph.D., Courts and Corrections Psychologist
- Ann V. Andreas, Deputy Attorney General

In addition, the convener and the members of the Work Group consulted with the following:

- Dennis Donovan, Ph.D., Courts and Corrections Psychologist
- Mike Compton, Ph.D., Courts and Corrections Psychologist
- Olaf Gitter, Ph.D., Courts and Corrections Psychologist
- Gary Farkas, Ph.D., Courts and Corrections Psychologist
- Richard Kappenberg, Ph.D., Courts and Corrections Psychologist
- June Tavares, Department of Public Safety
- William Sheehan, AMHD Medical Director
- Alex Lichton, Hawaii State Hospital Forensic Coordinator

II. Goal: Reduction of Delays in Data Collection

A. Background

Forensic examinations are conducted pursuant to court order: (1) when a criminal defendant gives notice of intent to rely on the defense that defendant's physical or mental disease, disorder, or defect excludes defendant's responsibility (MH defense)[1]; (2) there is reason to doubt the

[1] Hawaii law provides "[a] person is not responsible, under [the Penal] Code, for conduct if at the time of the conduct as a result of physical or mental disease, disorder, or defect the person lacks substantial capacity either to appreciate the wrongfulness of the person's conduct or to conform the person's conduct to the requirements of law.

defendant's fitness to proceed; and (3) when there is reason to believe that the defendant's physical or mental disease, disorder, or defect will become an issue in the case. HRS § 704-404(1). The court is empowered to order examination(s) and report(s)[2] concerning the physical and mental condition of the defendant, HRS § 704-404(2), and in conjunction with that order, the court is required to obtain relevant records as follows:

> The court shall obtain all existing, medical, mental health, social, police, and juvenile records, including those expunged, and other pertinent records in the custody of public agencies, notwithstanding any other statutes, and make such records available for inspection by the examiners.

HRS § 704-404(8) (Supp. 2006)[3].

The court's written order for forensic examination usually includes a provision that tracks the language of HRS § 704-404(8). The Adult Client Services Branch (ACSB) (formerly Adult Probation Division) of the court that ordered the examination is charged with the responsibility of obtaining the records, and making them available for the examiners' inspection.

Forensic examiners' and others' reports to the Task Force show that completion of the record collection is affected by numerous factors including:

- Delay in the drafting, filing, and distribution of the order for examination.
- Delay in the Adult Client Services Branch (ACSB) officer's interview of the defendant to determine sources of relevant records and obtain defendant's written waiver of confidentiality (due either to the ACSB officer's heavy case load, or the defendant's refusal to present himself to the ACSB office for interview when defendant is not in custody of either PSD or DOH pending the completion of the examination, report, and ruling on the fitness and penal responsibility issues).
- In the case of additional prosecutions against a defendant who recently received a forensic examination, exclusion of records collected in the prior recent case(s) unless defendant signs another waiver of confidentiality.

In some circumstances (involving both felony and nonfelony prosecutions) the court, counsel, the ACSB officer, and the examiner(s) simply assume that it will take about sixty (60) days to complete the record collection; which is a significant delay when defendant is confined in a

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HRS § 704-400(1). "An abnormality manifested only be repeated penal or otherwise anti-social conduct[,]" HRS § 704-400(2) is not included in the terms physical or mental disease, disorder or defect.

[2] The Court appoints three (3) examiners in felony cases, and one (1) examiner in non-felony cases. HRS § 704-404(2).

[3] The court may order similar reports at other points in the criminal process in cases involving a mental health defense, (MH defense), including (1) after acquittal but prior to commitment or conditional release, HRS § 704-411(3); and (2) prior to ruling on an application for discharge or conditional release after acquittal or modification of conditions of release, HRS § 704-414. Records collection precedes each of the examinations in these instances as well.

psychiatric hospital at state expense,[4] or awaiting completion of this process while confined in jail.[5]

B. Current Initiatives

1. The use of standardized form orders which either counsel or court personnel complete, the judge signs and the clerk files prior to defendant's departure from the courtroom cuts delay in relationship to several aspects of the forensic process. Counsel and the court use either the pre-printed forms available in court (most often used in district courts) or the order is prepared from an electronic macro by the judge's law clerk (usually in circuit court)). Some courts still rely on counsel to prepare orders after the hearing, in which case, the delay is usually significant.
2. Some ACSB officers send to the forensic examiners written notice as to when the ACSB officer expects to complete the record collection. On the stated date, some examiners follow up with a call to the ACSB officer to confirm whether the records are ready for review in the ACSB office. If all records are available, the examiner then schedules a time to review them. If some records are still missing, the ACSB officer and the examiner discuss whether the missing records are crucial, in which case the records review is delayed pending their receipt, or whether the records are not necessary, in which case, the examiner will proceed with scheduling an appointment to review the records. Note: One set of all records collected is made available for the examiners' review at the ACSB office. Due to the confidential nature of the records and the issues involved in the chain of custody of the records, and the volume of records in some cases, the Work Group agrees that examination of one set of records at the ACSB office is preferable to distribution of records to the examiners at their offices. Note: The Work Group discussed whether the procedural or statutory designation of a minimum record set would satisfy the requirements of due process while reducing delay in the records collection process, and decided there is no guarantee that a required minimum set of records for the examination provides the process due the defendant, or reduces delay in the records collection process. In some cases, it might extend the time needed for record collection, and in most cases, would increase the complexity of the process. Instead, the Work Group endorses the current method of communication between ACSB officers and examiners as a good way to keep track of the ACSB officer's progress, and recommends its wider adoption among ACSB officers and forensic examiners.

C. Recommendations

1. **Procedural Change**: Courts and ACSB collaborate on the drafting and distribution of, and training on a single page form notice that alerts ACSB of the court's order for an examination in a particular case. Upon same-day receipt of the notice, the appropriate ACSB supervisor assigns the case immediately to the appropriate ACSB officer. The court clerk completes the single page notice (similar to the notice used when the court

[4] Calculations completed by the DOH AMHD in early September 2007 reveal that the per diem rate for inpatient psychiatric care totals $870 (not just a figure used for budgeting purposes but a real cost due to the fact that DOH contracts with other hospitals for inpatient psychiatric beds to supplement the capacity of Hawaii State Hospital [HSH]).

[5] The court may release the defendant on his own recognizance or on bail to be examined at the examiner(s)' office(s). The defendant's non-compliance with the terms of such an "outpatient exam" order also adds to the examination time.

orders a defendant to probation) while the court is in session, and the completed notice is thereafter transmitted immediately to the ACSB office by interoffice delivery on the same day as the judge's ruling. The notice does not replace the order for examination.

2. **Procedural Change**: Courts and counsel uniformly accept the use of standardized form orders that are completed and filed before defendant leaves court in each case involving mental health processes.
3. **Procedural Change**: Standardized form orders are updated, and distributed regularly; and the out-dated forms are discarded immediately.
4. **Procedural Change**: On-going training is offered by an interdisciplinary team of trainers in the use of standardized form orders for attorneys, judges, bailiffs, ACSB officers, and all others involved in the process.
5. **Procedural Change**: The standard form order for examination is revised to provide for an explicit release of confidential records in the custody of public agencies. Suggested language for the authorization of release of confidential records is attached in the Appendices.
6. **Alternative Procedural Change:** Alternatively, the court orders the defendant subject to the examination to present himself to the ACSB office prior to departure from court, the ACSB office completes an immediate intake interview, and obtains signed waivers of confidentiality allowing for the collection of records. This is an alternative proposal because it will tax the current resources of the ACSB offices, and may not be necessary if the widespread adoption of the recommendations concerning the notice of examination, and the standardized form orders are accomplished.
7. **Procedural Change**: To facilitate the use of standardized form orders in all courts, formation of an ongoing committee with representatives from each judicial circuit to supervise completion of developing standard form orders, plan the rollout of new or revised forms and offer the requisite training. As the Third Circuit's Chapter 704 Committee has made significant progress in this area, all ongoing efforts should be coordinated closely with the Third Circuit's Chapter 704, HRS, Committee.
8. **Procedural Change**: Widespread adoption of the communication process between ACSB officers and examiners concerning completion of the record collection, as described above.

III. Goal: Increased Participation by Private Forensic Examiners

A. Background

In felony cases in which the defendant's mental health is at issue, the court appoints three examiners; at least one psychiatrist, and at least one licensed psychologist. The third member may be a psychiatrist, licensed psychologist, or qualified physician. One of the three shall be a psychiatrist or licensed psychologist designated by the Director of Health (Director) from within the Department of Health (DOH). HRS § 704-404(2). The Director's designees are licensed psychologists employed by the Courts and Corrections Branch of the AMHD (Courts & Corrections). Accordingly, in felony cases, the court must appoint a psychiatrist and licensed psychologist or qualified physician from private practice in addition to the Courts & Corrections psychologist. Most, if not all of the court's appointees from private practice are either psychiatrists or licensed psychologists.

The rate of compensation for the private court-appointed examiners has not been changed for approximately 20 years. Each private examiner receives $500 for his or her records review,

examination, and report. Currently, no travel costs are reimbursed. Due to this very low rate of compensation, certain examiners, especially those based on Neighbor Islands have declined appointment by the court, and some private examiners are not inclined to take cases in which they will incur interisland travel costs. It is fair to say that courts are regularly hard pressed to appoint a full panel of examiners due to the shortage of willing psychiatrists and licensed psychologists.

B. Current Initiatives

During the 2006 Legislature, the Hawaii Disability Rights Center proposed legislation that would have increased the compensation for private court-appointed examiners in an effort to attract more examiners to the work, and in turn, decrease the delay in completing three-panel examinations. The bill was not passed, but its introduction was one of the legislative initiatives that lead to the formation of this Task Force.

C. Recommendations

1. **Suggested Judiciary Administrative Change**: That the Judiciary consider increasing the fee for private mental health examiners be raised from $500 without reimbursement for travel costs to $1,000 with reimbursement for travel costs. Specific legislation is not needed to change the rate. Administrative action – the revision of the relevant portion of the Judiciary Financial Administration Manual is needed to change the rate, and this Work Group recommends that the Task Force include this procedural change in its final recommendations.
2. **Suggested Judiciary Funding Request**: This Work Group recommends that the Judiciary consider submitting within its proposed budget an appropriation request with an amount sufficient to compensate the private mental health examiners at the higher rate described above and that the Legislature approve the funding request.

IV. Goal: Reduce Delays in Completion of Examinations by Improving Coordination between Court-Appointed Examiners and Correctional Facilities

A. Background

Many defendants are placed in PSD facilities pending completion of the examination process, usually at one of the Community Correctional Centers. Each Community Correctional Center has different policies, procedures, and protocols for the examiner's meeting with and interview of the defendants subject to MH examinations. Lack of uniformity in hours of access, unexpected lock downs, and lack of private interviewing spaces all complicate, and may delay completion of the interview phase of the examination process.

B. Current Initiatives

1. The AMHD convened a monthly meeting of an interdepartmental committee with representatives from Department of Public Safety (PSD) and Department of Health to work on community reintegration of discharged PSD detainees and prisoners who have mental health problems and need public mental health services. Though charged with a different task, the committee also took the first steps toward improving coordination, access, and the availability of interview space within PSD facilities. These issues have

not yet been resolved, and committee meetings have been suspended due to changes in PSD personnel. AMHD will reconstitute the committee as soon as the PSD positions are filled.

2. Representatives of PSD mental health services, and other PSD administrators have met with AMHD administrators infrequently to discuss several issues related to the HSH census, but have yet to establish an on-going working group with representatives from both departments meeting regularly. The next of these interdepartmental meetings is, however, scheduled for mid-September.

C. Recommendations

This Work Group recommends to the Task Force that it support and encourage the efforts of PSD and AMHD personnel who have been meeting together recently by recommending that the committees described above continue to meet to resolve clinical and forensic issues related to detention, care and release of detainees and prisoners with mental health problems.

V. Goal: Clarify the Confidentiality of Examiners' Reports

A. Background

When a court finds a defendant unfit to proceed, the court must also determine whether to: (1) commit the defendant to the custody of the Director of Health to be placed in an appropriate institution for detention care and treatment; or (2) release the defendant on conditions the court determines necessary if the defendant can be released without danger to self, others or the property of others. In addition, **"[a] copy of the report filed pursuant to section 704-404 shall be attached to the order of commitment or order of release on conditions." HRS § 704-406(1).** Some courts attach copies of the report or reports to the order, and others do not. Some courts consider the reports confidential even after ruling on all of the issues addressed in the report(s), and finding the defendant unfit.

When the inpatient facility and the defendant's treatment team (or the outpatient facility and treatment team) receive the order without the evaluator(s)' report(s) attached, they are understandably "in the dark" about the nature of the charge that started the criminal proceeding, the opinions of the evaluator(s), the facts upon which the opinions are based, and the particular legal, psychiatric, and social issues that must be addressed for the court to later find the defendant fit to proceed. Therefore, the failure to attach the mental health examiners' reports can cause a delay in treatment, which adversely impacts the census at HSH.

B. Current Initiatives

1. On a case by case basis, clinicians have requested copies of the evaluators' reports from the court and received them. The courts that treat the evaluators' reports as confidential are not responsive to such requests.
2. Often, Courts & Corrections staff is asked to provide copies of the evaluators' reports. The conundrum for the Courts & Corrections staff is, then, whether they should release documents that a particular court has not agreed to release. On the other hand, sound clinical practice would indicate that the current treatment team should have as much information about their patient's condition as possible.

C. Recommendations

1. **Procedural Change**: Determining when AMHD Courts & Corrections can release copies of the reports prepared by its examiners depends on how the courts in each circuit handle the reports. This Work Group recommends that the Department of the Attorney General work with the Judiciary staff attorney to clarify current practices, and determine legal requirements concerning confidentiality of the reports or the duty to produce the reports. If appropriate and necessary, the Judiciary staff attorney will issue written guidance to the courts.
2. **Procedural Change**: As Courts & Corrections does not maintain copies of the private examiners' reports, it appears to this Work Group that consistent implementation of the provisions of HRS § 704-406(1) concerning attachments of copies of the report(s) to the operative order, if permissible, will promote the goal of providing as much information as possible about the defendant/patient's forensic status, and clinical situation to his or her treatment team.
3. **Possible Statutory Change**: If competing laws or regulations trump the disclosure provision of HRS § 704-406(1), a statutory amendment might be needed. As the issue is not clear at this time, the Work Group is not in a position to recommend a particular legislative proposal at this time.

VI. Goal: Certification of Forensic Examiners, and Appropriate Staffing for AMHD to Manage the Certification Process and Supervise Courts & Corrections Psychologists

A. Background

Hawaii law provides that "[a]ll examiners shall be appointed from a list of certified examiners as determined by the department of health." HRS § 704-404(2). Despite AMHD past efforts to establish the certification process by the adoption of appropriate rules, the rulemaking process has not been completed.

B. Current Initiatives

For the past several years, AMHD has sponsored an annual conference for mental health examiners. Participation has been voluntary, and many of the persons who serve as court appointed examiners have participated. AMHD certifies their participation in the annual training.

C. Recommendations

1. **Administrative Rulemaking**: AMHD establish, through rulemaking, a certification, training and oversight process of mental health examiners.
2. **Legislative Funding Request**: This Work Group also supports the funding of a Courts & Corrections manager position to oversee quality and timeliness of all examinations and reports, serve as the executive director of the certification process, and provide annual training and relevant conferences to improve the quality of the services offered to the courts.

VII. Topics Discussed by the Work Group for which the Work Group has no Recommendations for Procedural, Statutory, or Public Policy Changes

A. Chapter 704, HRS, now requires the court to appoint three examiners in felony cases. The Work Group received information about delays in the completion of forensic exams in felony cases, which delays may extend the defendants' stays in the hospital. Despite an interest by some of the members of the Work Group to recommend that the court be required to appoint only one examiner in felony cases (while retaining the option for either the defendant or the State hiring additional examiner(s) or experts), the Work Group did not reach a consensus on this issue, and therefore does not recommend a reduction in the statutory requirement that the court appoint three examiners in felony cases.

B. Mandatory bifurcation of the fitness and penal responsibility portions of the forensic examination is not recommended by the Work Group. Experience shows that in some cases, the examiner has no choice but to assess fitness first, and revisit the defendant after treatment sufficient to stabilize his or her mental illness to determine penal responsibility at the time of the conduct. If the defendant is confined in the hospital, the two step evaluation process inevitably *lengthens* the defendant's hospital stay. As the purpose of the Task Force is to consider changes that may minimize the HSH census, the Work Group will not recommend a change that is known to lengthen individual inpatients' lengths of stay in the hospital. The relevant provisions of Chapter 704, HRS allow for bifurcation of the two distinct inquiries, but such bifurcation should not be mandated in all cases.

C. The Work Group received information that many defendants subject to forensic examinations in a criminal action have been the subjects of previous forensic examinations in other criminal actions within a recent period of time. The Work Group considered and discussed suggested procedural and statutory changes requiring expedited examinations for defendants subject to multiple and closely consecutive examinations. The Work Group's consensus is that the value of considering each case on its merits would not be served by changes requiring expedited examinations in subsequent cases. For example, the subsequent case might involve more serious charges than the prior cases, and therefore require as thorough an examination process as in the prior case(s) to comport with the requirements of due process.

D. The Work Group also considered, and did not adopt a suggestion for a statutory change to set a maximum time limit for completion of each forensic examination. Work Group members doubted that the defendants' rights to due process could be adequately protected in an examination process truncated in the interest of saving time.

G. Coordinate Post-Release After-Care Upon Release From Jail

(approved May 10, 2007, updated October 11, 2007)

Description of Problem/Issue

1. Individuals with mental illness who are already enrolled in the Department of Health (DOH), Adult Mental Health Division (AMHD) and who are receiving community mental health services are frequently disconnected from community service providers upon incarceration. When the community service provider does remain engaged with the individual during incarceration, there is no mechanism to permit the community provider to participate with the Department of Public Safety (PSD) treatment staff in discharge planning. Both scenarios result in inmates being released back to the community with no connection to or arrangements for follow up treatment or services to support a successful transition.
2. For severe and persistently mentally ill individuals who were not already enrolled in AMHD at the time of incarceration, the State is not taking advantage of the opportunity to enroll the individuals in AMHD and connect the individual to a community behavioral health service provider prior to release in order to facilitate the individual's transition back to the community and engagement in community-based behavioral health and other support services.

Description of DOH-AMHD Action Plan

1. Draft and implement a Memorandum of Understanding (MOU) between DOH and PSD that includes policies and procedures which permit and promote the following collaborative actions: (i) identify mentally ill consumers who may meet AMHD eligibility criteria; (ii) enroll eligible individuals in AMHD; (iii) refer eligible individuals to an appropriate AMHD community-based service provider; and (iv) support the community service provider's visitation of consumers in jail/prison and participation in PSD treatment team discharge planning.
2. Develop and implement a community re-integration pilot project on Oahu. The pilot will consist of two components: dedicated housing for newly released inmates and specialized treatment programming that targets the unique needs and issues of mentally ill inmates transitioning back into the community.

Status of Action Plan Implementation

1. A Community Re-integration Work Group, comprised of representatives from DOH-AMHD and PSD, has been meeting at least monthly since July 18, 2006.
2. An MOU between DOH and PSD has been signed.
3. DOH-AMHD and PSD have drafted 75% of the procedures that have been identified as necessary to support the activities listed in the MOU.
4. The Work Group recommended the "Brief Jail Mental Health Screen" to PSD for use by PSD in identifying male inmates at intake who should be referred to AMHD for an eligibility determination. This recommendation was rejected by PSD.
5. A national literature search was conducted to seek information about community reintegration program designs, considerations, and outcomes. An outline of recommended treatment programming, based on the results of the literature search and successful program components of the Hale Imua Conditional Release Program that

would also apply to the jail release population, has been developed and approved by the Work Group.

6. Loss of key members of the Work Group (due to medical leaves or resignation) during the pilot program implementation planning phase has delayed progress in finalizing procedures and pilot program materials while replacement members are sought.

Next Steps and Recommendations

1. The Legislature approved funding for five (5) dedicated 24-hour group home beds in FY2008 and four (4) 24-hour group home beds in FY2009 to house newly released inmates and an additional five (5) positions for the CMHCs to conduct specialized treatment programming necessary to implement the community re-integration pilot.
2. AMHD has designated the house(s) and DOH Community Mental Health Center (CMHC) that is to be involved in the pilot project.
3. In September of 2007, DOH and PSD initiated monthly meetings of senior leadership with one standing agenda item focused on the community integration program, in order to ensure support for the program and funding from the highest levels of both departments.
4. The Community Reintegration Work Group will recruit replacement members from PSD and DOH, and seek the addition of a member from Adult Client Services, in order to finalize the pilot's specialized treatment programming to coincide with a proposed pilot start date of December 1, 2007.
5. The Community Reintegration Work Group has recommended that PSD be provided with additional resources to support the development of a database and ongoing data entry to track and monitor the status of mentally ill inmates and their assessments, AMHD eligibility status, assigned community service providers, treatment plans, anticipated release dates, discharge plans, performance indicators, and outcomes measures related to community re-integration.
6. The Community Reintegration Work Group will identify, implement, and conduct scheduled analysis of a standard set of process and outcomes performance measures related to (a) identification of SPMI consumers in jail/prison population, (b) referral of SPMI consumers to AMHD for eligibility determination assessment and linkage to community behavioral health services, (c) outcomes of consumers post-release, including recidivism.

H. Progress in Service Development While the Task Force has been Meeting and Plans for the Coming Year

Many of the Adult Mental Health Division (AMHD) services and programs described as recommendations and action items in the several sections of this Final Report have been implemented since the Task Force first convened, or are planned for implementation within the coming year. The lists which follow identify and describe briefly the services and programs, and the specific reports compiled in the Final Report provide more detail about the services and programs implemented since September 2006, or scheduled for implementation in the near future.

AMHD Services and Programs Implemented since September 2006 through October 2007

The following services and programs have been implemented while the Task Force has been meeting:

• **Community Based Fitness Restoration**: This new program provides a structured, outpatient alternative to the traditional inpatient fitness restoration program. Participants live in a 5-bedroom cottage adjacent to the Hawaii State Hospital (HSH) campus. The housing contractor provides supervision services in the twenty-four hour group home setting. Each participant has recovered sufficiently so as not to require inpatient care, and has been granted a release on specified conditions by the court. Each participant follows a daily and weekly schedule of fitness restoration activities. The program welcomed its first participant in August 2007. AMHD received approval for and thereafter established four full-time staff positions to support this program.

• **Statewide Post-Booking Jail Diversion**: This program provides mentally ill defendants charged with misdemeanors and petty misdemeanors an opportunity to engage in treatment in lieu of jail time. Results have been extremely promising, with improvements in quality of life as well as reductions in recidivism and homelessness. Post-booking jail diversion has been implemented on the Neighbor Islands since September 2006, and is being implemented on Oahu in October 2007. AMHD received approval for and thereafter established five full-time staff positions to support jail diversion.

• **Pre-booking Jail Diversion**: This program links mentally ill individuals who have engaged in problematic behavior in the community with resources from the Honolulu Police Department (HPD) and AMHD's Crisis Mobile Outreach teams. The program helps avoid arrests of mentally ill consumers, providing them instead with treatment and crisis support, and has shown very good results thus far. One indicator of the success of the program is a significant decrease in the number of MH1 transfers by HPD to The Queen's Medical Center Emergency Room pursuant to HRS § 334-59 (transport to a psychiatric facility for emergency examination and hospitalization). Pre-booking jail diversion began in December 2006.

• **Replacement bed program**: This program provides additional hospital capacity for forensically-encumbered mental health consumers. Neighbor Island community hospitals, as well as Castle Medical Center and The Queen's Medical Center on Oahu, provide additional

capacity to treat AMHD forensic consumers under certain circumstances. Since September 2006, more than 30 consumers have been diverted from an HSH admission as a result of this program since September 2006.

• **CREST (Conditional Release Exit Support and Transition) program**: This program provides advocacy and support for outpatient consumers on conditional release who are ready to progress toward and transition to discharge from conditional release. It began in July 2007 and has multiple graduates, including some individuals who have subsequently been legally discharged from conditional release, as well as many more who are in process.

• **Hale Imua**: This program provides community based housing in a twenty-four hour group home adjacent to HSH, and structured day programming for each participant on conditional release (CR) who would otherwise have few placement options in the community. Typically, the Hale Imua participants have experienced difficulty in adjusting to community living previously, and have been readmitted to the hospital. Hale Imua has increased its percentage of filled beds significantly since September 2006. Additionally, since July 2007, Hale Imua has designated one of its cottages (a 4-bedroom residence) exclusively for housing of mental health consumers on CR who are at risk for rehospitalization. This cottage provides increased supervision and treatment options, and has shown good results thus far in averting rehospitalization for several consumers. For this program, AMHD received approval for and established 5 full-time staff positions.

• **Training in forensic mental health**: AMHD forensic coordinators have provided more than 500 hours of trainings and presentations to community treatment providers, the Judiciary, probation, hospitals, housing agencies, consumer organizations, and other interested agencies. Content focused on forensic issues, legal procedures, and the assessment and management of risks for violence, recidivism, and psychiatric decompensation.

• **Mental Health Calendars**: AMHD has partnered with the District Court of the Second Circuit (Maui County) to implement a mental health calendar. All criminal cases involving mentally ill defendants in Wailuku District Court are now heard by a designated judge who is supported by the same contingent of court personnel. Designation of a mental health calendar within a single court expedites processes in cases involving mental health issues, and builds greater familiarity with the unique judicial procedures used in such cases.

• **Special project to address HSH census**: AMHD requested thirty-three exempt positions via a Special Project designed to reduce the high census at HSH. Thirty-two of the positions were approved and have been established. These positions include the ones identified above, as well as multiple psychiatrist positions, 2 forensic coordinator positions (one for the community and one for Kahi Mohala Behavioral Health), and a manager for AMHD Courts and Corrections Branch (which provides forensic examinations to courts). The final position, a court-based clinician for Honolulu District Court, is still under review.

AMHD Services and Programs Planned for Implementation During 2008

The following AMHD services and programs are slated for implementation within the next year:

• **Secure Community Residential Program**: This specialized treatment program will combine community housing with the highest level of supervision, and on-site treatment and day programming in four houses adjacent to Hawaii State Hospital. It is designed for HSH consumers who are expected to be able to obtain conditional release provided they are discharged to a community program with a very high level of supervision. Typically, the participants in this program will not require hospital level care for their mental illnesses, but will not be able to find other community placements due to a history of noncompliance with requirements at their prior housing placements. The Secure Community Residential Program is planned for implementation in early 2008.

• **Community Reintegration Program**: This program will identify AMHD-eligible consumers who are currently incarcerated in jails and prisons, link them with community mental health supports and other resources, and provide housing and services upon their release from correctional settings. AMHD has already identified the first residence that will be used for the housing component of this program. The program will follow national evidence-based practices that have been effective in other, similar settings. Implementation is planned to begin in December 2007.

• **Court-based clinician for Honolulu District Court**: This position will provide assistance and immediate mental health technical support to the Judges of the Honolulu District Court. The forensic psychologist hired into this position will be able to provide: (1) immediate assessment of mental health status of criminal defendants who are present at the courthouse; (2) advice to the court as to appropriate placements for defendants (for example, whether a defendant can be examined in jail or needs hospitalization); and (3) assistance to the court in determining appropriate AMHD community programs for mentally ill defendants. The position is described in the Special Project to Reduce the High Census at HSH, and if approved will be filled within a very short time after approval.

VI. Future Directions

Hawaii is one of only nine states recently awarded a Mental Health Transformation State Incentive Grant (Transformation Grant) by the Substance Abuse Mental Health Services Administration (SAMHSA), an agency of the Center for Mental Health Services of the United States Department of Health and Human Services. The award – over $2 Million per year for five years, or approximately $11 Million – funds development and implementation of a Comprehensive Mental Health Plan for Hawaii (Comprehensive Plan) based on a Needs Assessment and Resource Inventory. The Comprehensive Plan will provide Hawaii's blueprint for reshaping the mental health services delivery infrastructure statewide in ways that advance the vision and the following goals of the final report of the President's New Freedom Commission on Mental Health:

Goal 1: Americans Understand that Mental Health Is Essential to Overall Health
Goal 2: Mental Health Care Is Consumer and Family Driven
Goal 3: Disparities in Mental Health Services Are Eliminated
Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice
Goal 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated
Goal 6: Technology Is Used to Access Mental Health Care and Information.

See Mental Health Transformation State Incentive Grant Fact Sheet in the Appendices to this report.

Hawaii's Mental Health Transformation Grant activities kicked-off on July 11, 2007, and are now in full swing. In addition to the Transformation Working Group convened by the Governor, the following seven planning subgroups with statewide membership will contribute to the Comprehensive Plan:

1. **Promoting and Understanding Mental Health** (stigma reduction, suicide prevention, addressing mental health with the same urgency as physical health);
2. **Consumers and Families as Drivers** (individualized treatment plans with recovery focus, consumers and family members involved in orienting the mental health system toward recovery, alignment of federal programs to improved access to an accountability for mental health services, protection of consumers rights);
3. **Early Intervention** (promotion of mental health of young children, improvement and expansion of school mental health programs, screening for co-occurring mental health and substance use disorders with links to integrated treatment, screening for mental disorders, screening for mental disorders in primary health care, for all ages, with connections to treatment and support);
4. **Accelerating and Expanding Quality Services** (acceleration of research on recovery and resilience, and eventually cure and prevention, promotion of evidence-based practices, improvement and expansion of the workforce4, development of knowledge base in mental health disparities, long-term effects of medications, trauma, and acute care);
5. **High Tech and Local Touch** (utilization of health technology and tele-health to improve access and coordination of mental health care especially for those living

in remote areas, development and implementation of integrated electronic health record and personal health information systems);

6. **Workforce and Community Supports** (development, training and retention of a stable workforce, recruitment and support of individuals and communities who provide natural supports for consumers of mental health services; and
7. **Evaluation** (attention to reliable and effective use of data and information to design the Comprehensive Plan and measure implementation outcomes).

The Hawaii Judiciary will participate in the Transformation Grant process, beginning with a consultation by the National GAINS Center for People with Co-occurring Disorders in the Justice System. The Task Force anticipates that issues raised by its Work Groups that have been identified but not yet addressed, as noted in this report, will receive needed attention during this consultation, planned for late November 2007.

Speaking more generally, future directions for the SCR No. 117 topics include further cross-talk and communication among agencies, collection of data to evaluate programs and services, identification of emerging trends (both positive and negative), and a continuing spirit of cooperation to continuously improve the lives of mental health consumers. Specific recommendations are found throughout this report encouraging the development of ongoing work groups and committees. These work groups and committees will require participants from several disparate agencies—Department of Health, Department of Public Safety, the State Judiciary, Office of the Public Defender, Offices of the Prosecuting Attorney, consumer rights organizations, law enforcement, and others—and will achieve success only if the spirit of cooperation and dedication found in the current Task Force continues onward.

VII. References

The following documents are available online at www.amhd.health.state.hi.us/

- Senate Concurrent Resolution 117 S.D. 1 H.D. 1 2006
- Chapter 704 Hawai`i Revised Statutes
- Report to the Twenty-fourth Legislature, State of Hawaii, 2007
- The Defense of Insanity: Standards and Procedures – Overview by State (Bureau of Justice Statistics, State Court Organization, 2004)
- Mental Health Problems of Prison and Jail Inmates (Bureau of Justice Statistics, State Court Organization, 2006)
- *Clark v. State of Hawai`i*, Stipulation for Amended Permanent Injunction, No. CV 99-00885 DAE/BMK
- *United States of America v. State of Hawai`i*, Order Dismissing Action With Prejudice, Civil No. 91-00137 DAE/KSC
- *State of Hawai`i v. William Kotis*, 91 Hawai`i 319 (1999)
- *Sell v. United States*, 539 U.S. 166 (2003)
- Goals and Recommendations of Achieving the Promise: Transforming Mental Health Care in America, June 14, 2007

VIII. Appendix

- List of Participants
- Array of Services by Island
- Mental Health Examiners Work Group's Recommended Language for the Authorization of Release of Confidential Records in the Custody of Public Agencies
- Orientation to Hawai`i State Hospital - Powerpoint Presentation (Mark Fridovich, Ph.D.)
- Intersection of the Adult Mental Health Division and the Hawai`i Criminal Justice System on Oahu – An Overview (Neil Gowensmith, Ph.D.)
- Community Risk Management Flowchart (Neil Gowensmith, Ph.D.)
- Summary of the AMHD Forensic Statewide Service Plan (Neil Gowensmith, Ph.D.)
- Advances in the Biology of Serious Mental Illness: Legal Implications – Powerpoint Presentation (James Westphal, M.D.)
- Conditional Release and Competency Restoration Statutes-Comparison by State, May 10, 2007.
- Mental Health Transformation Grant State Incentive Grant Fact Sheet