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Re: *Opulento, et al. v. State of Hawaii, et. al.*
Case Number: 1:19-cv-00315-RT

We have completed our initial assessment regarding the above litigation. The scope of our consultation is summarized in Attachment 1. Sources of information utilized in compiling this report included review of the data and documents produced relevant to our pre-site document request (see Attachment 2) and our site visits to the Halawa Correctional Facility and the Oahu Community Correctional Center from June 16-20, 2025, which included consultation re: relevant policies and procedures at Central Office during June 20, 2025.

Halawa Correctional Facility

During June 16, 17, 2025 we site visited the Halawa Correctional Facility (HCF). During the site visit, we interviewed inmates in the following settings:

1. the Mental Health Module,
2. the infirmary (B ward, which houses inmates with acute mental health issues),
3. 8 Block of the SHU, which houses secure mental health caseload inmates, and
4. 11 mental health caseload inmates receiving an outpatient level care in two group settings.

We also interviewed the line mental health staff in a group setting, two infirmary nurses as well as correctional and health care leadership staff that included the following persons:

1. Shannon S. Cluney, Warden,
2. Maura Tresch, M.D. (Systemwide Medical Director), and
3. Romey Glidewell, N.P. (Corrections Health Care Administrator).

The Halawa Correctional Facility (HCF) consists of the following housing units:

- Four (4) Modules identified as 1,2,3,4,
- Each Module is separated into two (2) Blocks A & B,
- Each Block consists of four (4) Quads, 1,2,3,4
- Each Quad consists of an upper and lower level, a community dayroom

and 1-2 shower stalls,
- Each Module consists of 2-man cells with a capacity of 246 inmates.

Module 1, B-block houses Protective Custody inmates in two (2) Quads, and Mental Health inmates in two (2) Quads.

Module 1 A-block, 2,3, and 4 house General Population inmates.

The HCF Medical Unit consists of two (2) Wards as indicated:

- A-Ward has six (6) rooms that houses twelve(12) and the primary use is for inmates who require infirmary level care,
- B-Ward has twelve (12) single man cells designed for inmates who are on a safety or suicide watch. Each cell has a camera which is monitored by a security officer 24-hours a day.

The Special Needs Unit (SHU) consists of ten (10) Blocks A-H, eight (8) Blocks contain four (4) 1-man cells and two (2) blocks contain six (6) 1-man cells for a total design capacity of forty-four (44). Six (6) cells are dedicated to house Secure Mental Health Inmates who pose a threat to others and the safe operations of the facility.

From January 2025 through May 2025, HCF averages 15 new admissions per month.

As of 04/04/2024 relevant demographics were as follows:

Close Custody: 227
Medium Custody 380
Minimum Custody 169
Disciplinary Segregation: 12
Administrative Segregation: 04
Unclassified 11

The average daily census in the mental health treatment units monthly during the past six months (e.g., intermediate care, Infirmary, GP, etc.) was as follows:

Month	HCF
September	178
October	181
November	192
December	167
January	184
March	183

The above table includes mental health housing units, inmates with a serious and persistent mental illness (SPMI) in general population (GP) housing units and inmates on a suicide or safety watch in the infirmary. However, the psychiatrist prescribes psychotropic medications to about 300 inmates and does not necessarily make a referral to mental health services, which means the above numbers underestimate the total mental health caseload population.

The monthly average for the past 6 months of the percentage of the total population at HCF who is receiving mental health treatment (i.e., the average mental health caseload, MH team only) was as follows:

Month	HCF
September	24%
October	19%
November	20%
December	18%
January	19%
March	19%

The average census at HCF was 750 inmates.

The total number of inmates prescribed medication at HCF was 334 inmates, which represented approximately 45% of the total inmate population. This figure did not include SPMI patients refusing treatment.

The average lengths of stay in suicide/safety watch at HCF was 10 days.

Mental Health Staffing

The central office Director of Mental Health position has been vacant for over 10 years. The central office mental health branch administrator position has also been vacant but a doctorate level psychologist has recently signed a contract for this position.

Psychiatric staffing at HCF was as follows:

Facility	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.
HCF		1. Dr. Nakama		1. Dr. Nakama	1. Dr. Nakama	

The psychiatrist works from 4 p.m.-8 p.m. and provides the equivalent of a 0.3 FTE position. She is currently a contract psychiatrist but is planning to become a state employee in the near future. The psychiatrist is administratively under the medical services division in contrast to mental health services. The psychiatrist does not attend treatment team meetings and has minimal contact with the mental health clinicians due to her work hours. Nursing staff, who schedule appointments for her, report that she generally treats/assesses 4-5 patients per workday with the scheduling process prioritizing patients in the mental health infirmary.

The Medical Director, Dr. Tresch, reported that a 1.5 FTE psychiatrist position is needed for HCF. Currently, the psychiatrist's role involves managing acute/crisis situations in addition to medication management functions for patients in the general population and Mental Health Module.

Within the Hawaii correctional system, only licensed psychologists and psychiatrists can make mental health diagnoses. The psychiatrist does not participate in the weekly treatment team meetings related to both her work schedule and contractor status.

The mental health staffing allocations and vacancies were as follows:

Section Supervisor	Dr. Kinikini	Psy.D
Clinical Psychologist	vacant	
Clinical Psychologist	vacant	
Clinical Psychologist	vacant	
Clinical Psychologist	Vacant	
Clinical Psychologist	vacant	
Social Worker VI	Florencio Magallanes	
Social Worker V	Jacob Torquato	
Social Worker V	Michael Johnson	
Social Worker IV	Tedric Agena (EH)	
Social Worker IV	Sachiko Furuya	Psy.D
Social Worker IV	Veronica Moore	BA
Social Worker IV	Melissa Jarvis	BA
Social Worker IV	Branden Nakamura	BA
Social Worker IV	Dale Komodo	BA
Social Worker IV	Melanie Abad	BA

Related to licensure issues, the section supervisor position will be vacant in the very near future.

The social worker positions, many of which will be converted to Human Services Professional (HSP) positions, were initially reported to be assigned caseloads based on housing units, which means they do not continue to treat their caseload inmates if the inmate is transferred to another housing unit. We later learned that one social worker was assigned to cover all of the general population housing units with the other HSPs focusing on providing coverage within the mental health module and in the SHU. There is not a licensure process for the HSP positions.

Custody Staffing

The percentage of custody officers currently working at each facility who have completed the required suicide training was 10%. It should be noted that all officers had received initial suicide prevention training at the training academy but these numbers are based on recertification.

The correctional officer vacancy rate was 26%. When including correctional officers on long-term leave, the functional vacancy rate was 34%.

The Intake Process

HCF admits parole violators and jail detainees who have recently received sentences with a duration of at least one year. After booking by an adult correctional officer (ACO) in the intake area, inmates are taken to the medical unit for health care screening purposes. All inmates received a medical/dental/mental health intake screening assessment (see Attachments 3) by a R.N., which may result in an expedited referral to mental health based on screening results. It should be noted that such inmates have also undergone similar health care screening at the sending jail facility with the screening forms scanned into the electronic medical record (EMR). It was reported that the screening results at HCF often differ from the screening results at the sending jail facility related, in part, to screening at the sending facility often not being done in a confidential setting and/or the time duration between screening assessments.

All inmates also receive a post admission mental health screening (see Attachment 3a) within 14 days of admission. Positive screens result in a mental health referral, which was reported to occur within 24 hours of the referral.

Custody security levels are based on their security level at the sending jail for inmates recently sentenced. In the case of parole violators, their security level is based upon their security level at the time of their prior discharge from the prison. Housing assignments are made independent of an inmate's security level.

Mental Health Levels of Care

Mental health services provides the following levels of care:

1. Outpatient
2. Infirmary
3. Mental health module (i.e., residential).

Infirmary Level of Care

During the morning of June 16, 2025, we toured the physical plant at the infirmary and briefly talked at the cell front with about six inmates. The mental health side had 11 cells. Only several cells had a bed within the infirmary cells. ModuForm beds were available on site but have not been installed. A work order was placed for installation of these beds about one year ago with the Operations Division. The flooring of several cells was in disrepair. The layout of the jail cell does not allow for inmates to stay in full view of an officer, raising concerns for safety should self-harm occur.

Inmates on suicide watch did not have mattresses during the daytime hours although they

reported having access to mattresses during the evening. They were in suicide smocks without underwear and several of the inmates did not have blankets, which reportedly were made available to them during the evening hours. The temperature within the cells was cold. Staff reported that the blanket and mattress restrictions were due to inmates in the past tearing up the mattress or swallowing pieces of mattresses.

Staff also reported that the harsh conditions of confinement within the mental health infirmary were designed to be a disincentive for some inmates to be admitted to the infirmary for reasons other than mental health purposes.

Some of the inmates reported being very hungry related to small portions of food being served. These inmates reported that they were seen on a daily basis by a mental health clinician. Staff indicated that daily clinical contacts were often cellfront due to the inmates being too unstable to leave the cell. Inmates did not have access to out of cell recreational time while in the infirmary.

Staff reported that it was common for inmates, who had safety issues, to report that they are suicidal in order to be removed from their current housing situation. There was not an efficient mechanism for the safety issues to be resolved by custody staff in a timely fashion while the inmate was housed in the infirmary. There appeared to be an institutional cultural issue of not making the infirmary setting too comfortable for such inmates.

Assessment: The physical plant within the mental health infirmary (B ward) was dismal. The conditions of confinement were equally dismal. All inmates in the infirmary should have a bed (e.g. ModuForm bed-not a hospital bed), blanket, and clothing as clinically appropriate. Suicide smocks should only be used when clinically necessary. Such property should not be available only during evening hours.

Leadership staff indicated that a new infirmary has been funded with a plan for the construction being completed in about two years. Unfortunately, the new infirmary will not have a recreational yard due to space limitations.

We discussed with Warden Cluney issues related to inmates admitted to the infirmary, who fairly rapidly were assessed to have safety issues in contrast to being suicidal or having other mental health issues. Related to both mental health and custody staffing vacancies and limited bed availability, resolution of these custody safety issues remains very problematic.

Related to the mental health staffing vacancies, a treatment team concept within the mental health side of the infirmary has not been implemented. There should be a mental health infirmary treatment team that consists of a psychiatrist, mental health clinician, nursing staff and custody staff. A correctional case manager should be assigned to this team in order to facilitate resolution of safety concerns that often precipitate the infirmary admission. Lack of such a treatment team contributes to the very problematic conditions of confinement within the infirmary.

Steps should be immediately taken to install the available ModuForm beds within the mental health infirmary cells. It was our understanding that the floors of the cells will need to be renovated prior to such installation.

Mental Health Modules

Module 1 houses mental health patients in two Quads with an average daily census totaling 40-42 patients. There were 30 cells in the mental health module-some are single celled and the rest were double celled. Module 1 also houses protective custody inmates in two Quads, which were directly above the mental health modules.

Except during times of custody shortages, these inmates eat separately in a dining hall. They were reported to be offered about 15 groups per week, which occurred either in the Learning Center or in the gymnasium. There had out of cell time equivalent to other general population inmates (from 5 a.m. - 9 p.m.).

During the afternoon of June 16, 2025, we interviewed inmates in the mental health modules in two community meeting-like sessions. These inmates reported previously receiving two groups per weekday (one hour per group) that included inmates from both modules. These groups were located either in the Learning Center or in the gymnasium. The inmates described these group treatments to be helpful. In recent weeks, the number of groups per weekday has decreased to one group per day because the group composition consisted of inmates from only one of the modules.

Inmates indicated that they were seen by the psychiatrist in a confidential setting ranging from once every three months to once every six months. They could be seen earlier if they put in a medical request for services form. They were seen in individual therapy by a mental health counselor upon request although they stated that they generally had some contact with a mental health counselor on a daily basis either via the group treatments or while the counselor was on the unit.

These inmates described the mental health module as being a safer environment as compared to non-mental health general population housing units.

We were scheduled to observe mental health programming within the Learning Center during the morning of June 17, 2025. However, due to custody vacancies that morning the Learning Center was closed. Staff reported that such cancellations commonly occurred. The mental health staff arranged to do a "community meeting" in an attempt to provide some structured activities for inmates in one of the mental health module quads. The inmates were very passive during this brief meeting although it was clear that staff were very familiar with the patients on this unit.

The scheduled afternoon programming within the Learning Center was also canceled due to custody staffing vacancies.

We briefly interviewed on an individual basis three of the more severely ill patients residing in the mental health module. It was very difficult to understand two of the patients interviewed due to their dysarthria and disorganized speech. One of the patients minimized his symptomatology. All of these patients had been diagnosed with schizophrenia and one of the patients also was cognitively impaired related to a stroke in the past that appeared to be unrecognized by staff (i.e., that the impairments were caused by a stroke in addition to the impairments related to his mental illness). Two of these patients were severely functionally impaired.

Assessment: The Mental Health Module clearly provided a protective environment for the patients residing in this housing unit. The patient population was generally an elderly population with clear functional impairments. Many of the patients suffered from a severe and persistent mental illness (SPMI). The mental health staff clearly were familiar with the patient population and attempted to provide structured therapeutic activities for them. Related to the psychologist' staffing vacancies and inadequate psychiatrists' allocations, this unit resembled what used to be considered a "back ward" in state hospitals during the 1960s-70s.

These inmates, who have serious and persistent mental illnesses, are in need of a more therapeutic environment that is provided by a treatment team that should include a psychiatrist, psychologist, nursing staff and Human Service Professionals. Treatment plans need to be reviewed and revised as clinically appropriate at least every 3 to 4 months in contrast to annual reviews. Many of these patients were demonstrating tardive dyskinesia, which is a significant and often permanent movement disorder secondary to the use of antipsychotic medications. It did not appear to us that staff recognized this to be the case.

Based on our interviews with a very small sample of outpatient mental health caseload inmates, it is likely that more Mental Health Module beds are needed at HCF.

Special Housing Unit (SHU)

The SHU had a total of 44 beds with an average length of stay 30-45 days except for a minority of inmates who had very long stays. Related particularly to gang problems, there is another building housing overflow for SHU inmates. A mental health clinician performs rounds on a daily basis in the SHUs.

We observed a portion of mental health rounds being performed in the SHU, which were done in a competent manner. The mental health clinician clearly was familiar with the SHU inmates. She estimated that about 50% of the inmates in the SHU were mental health caseload inmates.

SHU inmates had access to a solo yard for two hours per day and have access to the hallway outside of their cells for another two hours per day on a solo basis.

We briefly talked with six secure mental health inmates in the mental health section of the SHU. These inmates reported that they did not have difficulties with continuity of medications. One inmate described poor access to the psychiatrist despite repeated sick call requests that were self-

generated due to medication side effects. His report regarding access problems to the psychiatrist was confirmed by the SHU mental health clinician.

The mental health clinician, who was a female, reported that she only had access to inmates for individual counseling on the unit from 12:30 to 4:30 p.m. each day due to custody staffing issues, which limited her ability to provide individual counseling in a confidential setting.

Assessment: It was very encouraging that the SHU inmates had access to four hours per day of out of cell time, which is a significant mitigating factor in their harsh conditions of confinement. It was also encouraging that there were only a small number of secure mental health inmates in the SHU. However, the mental health clinician had limited access to providing treatment to these inmates which needs to be remedied.

Outpatient Level of Care

During the morning of June 17, 2025, we interviewed eleven (11) inmates receiving an outpatient level of mental health care in two groups settings. These inmates' presentations were consistent with the presence of a serious mental illness. They had not experienced continuity of medication issues. However, their reported access to the psychiatrist ranged from reasonable to very problematic.

Most of the inmates were not aware of the availability of mental health counseling. Several had obtained short-term counseling via the mental health requests form process. Several of these inmates reported that they were going to be released from prison in the near future. They stated they were not aware of the availability of pre-release planning and reported significant distress regarding the lack of pre-release planning. We were later informed by staff that mental health staff provides pre-release planning during the month prior to an inmate's release.

Assessment: We had planned to interview at least 20 inmates receiving an outpatient level of mental health care in two group settings. However, due to custody shortages our sample was limited to 11 inmates. We were surprised of the severity of the mental illnesses demonstrated by these inmates. A significant number of these inmates appeared to be appropriate for receiving a residential level of mental health care (i.e., Mental Health Module housing) if such a level of care was adequately staffed by mental health clinicians.

Related to the inadequate psychiatrists' allocations, many of these inmates were not being seen by a psychiatrist in a timely manner for medication management purposes. At least two of these inmates reported that they were scheduled to be released in the near future and indicated they were unaware of pre-release planning services that were available. It was our understanding that mental health staff would provide such services (e.g., help with housing and entitlements) within one month of the release related to various regulations. However, these inmates also needed counseling well in advance of one month from release in order to learn to deal with adapting to a community setting. Such counseling was not available related to the psychologists' vacancy issues.

Medication Administration

All psychotropic medications are nurse administered, which includes mouth checks. The morning pill call line occurs after 6:30 a.m. and the "evening" pill call line occurs between 3:30 – 6 p.m. The reason for the early evening pill call line was reported to be "[because] we've always done it that way..."

Assessment: The evening pill call line should begin after 7:30 p.m. in order to increase medication adherence and decrease problematic side effects.

Group Interview with Mental Health Staff

We interviewed about eight line mental health staff in a group setting. Individual counseling sessions occur via inmate request only. Related to work hours, there was minimal communication between the line mental health staff and the psychiatrist. The communication between the psychiatrist and mental health staff was also described as being problematic.

Significant medication continuity issues were not present. In general, the staff reported good working relationships with custody staff. The line mental health staff are not able to make diagnoses. None of the line mental health staff were licensed.

Staff reported that the diagnoses in the medical records for a given patient are often inconsistent with each other. They also indicated that the documentation in the chart from the sending jails was often not helpful. They reported significant difficulties in obtaining records from the state hospital even when a release of information forms had been signed and sent to the hospital.

Inmates in need of inpatient psychiatric care did not have access to a hospital setting, including the state hospital.

In general, mental health system processes are based on practice in contrast to policy and procedures. Staff reported being offered very little continuing mental health education.

When briefly discussing recent suicides, it was the staff's impression that they were related to gang issues although this appeared to be only an impression rather than factually based.

Staff reported attending a weekly treatment team meeting that often included nursing, medical, mental health and correctional staffs that could last for several hours.

In general, inmates' self-harming behaviors consisted of headbanging and swallowing foreign objects in contrast to cutting behaviors. The use of behavioral management plans has occurred in the past.

Additional Information

We were told by leadership staff that the psychiatrist generally did not make diagnoses, partly related to significant substance use among the inmate population and partly because of her lack of correctional experience, and instead focuses on symptomatology. This has led to confusion among non-medical staff as to what the treatment strategy and plan is for an given mental health caseload inmate.

During the afternoon of June 17, 2025, we interviewed two nurses who were involved in scheduling appointments for the psychiatrist. The psychiatrist was reported to see about four or five patients per day during her three-day work schedule. Priority appointments were made for patients in the mental health infirmary, which meant that general population inmates often are not seen for 6-7 months between appointments.

A formal quality improvement program was not present at HCF although data was provided via a spreadsheet regarding treatment hours provided in the Mental Health Module, treatment plan completions, use of seclusion and restraints, serious suicide attempts and discharge planning.

There have been three completed suicides at HCF since January 2025. The death review provided was predominantly an emergency response review and did not include a psychological autopsy. Although mental health staff perceived the suicides to be gang related, such an assessment was not based on factual information. Staff reported there were four or five suicides during the past 12 months. Relevant demographic data was not gathered regarding these suicides.

Prior External Reviews

American Correctional Association

An April 9, 2024 American Correctional Association (ACA) needs assessment report was reviewed. Observations and/or recommendations included the following:

1. The number of contract nurses were staggering and very expensive. A staff utilization analysis is recommended to be conducted by the central office staff. There does not appear to be a base allotment for each institution. A staffing plan should be completed for each health care department at each facility using common definitions.
2. A robust new staff orientation program was lacking.
3. There was an abundance of clutter throughout the health services unit.
4. Patient confidentiality was not being practiced on multiple occasions.
5. The department should contract for access to specialists across the island of Oahu.
6. We did not find any evidence of a quality assurance program for internal review.

Hawaii Correctional System Oversight Commission

A December 19, 2024 report was reviewed which included, but was not limited to, the following observations and/or recommendations:

1. Incorporate therapeutic and rehabilitative practices throughout the facility.
2. Include medical and mental health staff in future construction plans.
3. Increase non-security staff must be a priority for transitioning to a rehabilitative and therapeutic system.
4. Permanently close the Special Needs Facility.
5. Prioritize and expedite capital improvement projects to repair electricity and the perimeter fence.
6. Expand Correctional Industries worklines to include specific training in skilled trades that would lead to gainful employment after incarceration.
7. Increase training and support for uniformed staff.
8. Increase training and support for case/unit managers to better meet the population's needs upon release
9. The department should support legislative efforts towards compassion release or transfer to a more appropriate medical setting for the severely ill.

Summary

The mental health system at HCF is very problematic for the following reasons:

1. Central office mental health leadership positions have been vacant.
2. Significant mental health staffing vacancies at HCF with a focus on vacant psychologists' positions.
3. Inadequate psychiatrists' allocations.
4. Significant line staff ACO vacancies exist, which hinder adequate programming options.
5. Significant physical plant limitations and not enough functional Quad housing cells.
6. Lack of an adequate quality improvement process.

Related to the staffing vacancies and the psychiatrist allocations, a multidisciplinary treatment team model has not been implemented for either the infirmary level of care or the residential level of care (i.e.., Mental Health Module level of care). Many inmates with a serious and persistent mental illness are not receiving timely psychiatric assessments/treatment and accepted mental health treatment modalities are often lacking or being provided by unlicensed clinicians without adequate supervision. As such, the psychiatric care received is inadequate to address the level of severity present in this population.

Oahu Community Correctional Center

During June 18,19, 2025 we site visited the Oahu Correctional Center. The Oahu Community Correctional Center (OCCC), which is the largest jail facility in the state of Hawaii, is located in urban Honolulu. This 980-bed facility houses predominantly pretrial detainees. The term "inmate(s)" will be used to reference the incarcerated persons residing in this facility despite most of them being pretrial detainees.

During the site visit, we interviewed inmates in the following settings:

1. Module 1 (the Mental Health Module),
2. Module 11 (the mental health step-down unit), and
3. 10 mental health caseload inmates receiving an outpatient level care in four group settings.

We also interviewed the following mental health staff:

1. Stephen Lee, Social Worker VI,
2. Bruce Kam, Psy.D.,
3. Ashley Magsanoc,, Psy.D.,
4. Catherine Krueger, R.N., IV,
5. Dr. Chinen (psychiatrist), and
6. two psychiatric residents and one attending psychiatrist from the Queens Medical Center, who were providing treatment to inmates in Modules 1 & 11.

We also had the opportunity to interview the infirmary nursing staff in a group setting.

Correctional leadership staff interviewed included the following persons:

1. Warden John Schell,
2. Chad Kahale (Residency Section Administrator),
3. Heather Kimura (Intake Classification Office), and
4. Jennifer Naumu (Oahu Intake Services Branch Manager).

The inmate count during February 28, 2025 was as follows:

MAIN BUILDING	IN COUNT	CPMC CAP
Module 1- Mental Health 24 cells	34	42
Module 2 - Mental Health/Medical 24 cells	53	48
Module 3 - CLOSED (RENOVATIONS) 30 cells (to be the health services chronic care unit)	0	59
Module 4- 30 cells	48	60
Module 7 12 cells	16	24
Module 8 - Special Housing 12 cells (maximum custody)	12	24
Module 11 24 cells (step-down unit for inmates with significant mental illness)	47	48
Module 13 24 cells	55	48
Module 17 24 cells	53	48
Module 18 36 cells	72	72
Module 19 36 cells	67	72
Holding Unit 36 cells (administrative segregation, disciplinary segregation, keep separate)	47	0
Health Care Unit 3 beds	3	0
TOTAL:	**507**	**524**
Module 5 (Pod)	1	

COMMUNITY BASE BUILDINGS	IN COUNT	CPMC CAP
Annex 1 120 beds (dormitories)	101	84
Annex II 150 beds (dormitories)	148	84
Mauka 48 beds	25	24
Makai 48 beds (sentenced inmates- misdemeanors)	25	24
Laumaka 48 rooms (sentence felons on furloughs)	47	96
Module 20 120 beds (sentence felons on furloughs)	59	84
TOTAL:	**405**	**396**

The inmate Count during June 18, 2025 was 919 with a capacity of 980 inmates..

Statistical information pertinent to the reception center screening of inmates was as follows:

OCCC	MARCH '25	FEB '25	JAN '25	DEC '24	NOV '24	OCT '24	Total 6 mo.
Avg intakes/day	14	14	15	18	16	18	16
Avg intakes/week (4wks/mo)	69	65	81	95	72	105	81
# intakes/month	276	258	324	378	288	418	1942
# OCCC admissions	293	271	339	401	309	431	2044
# intakes MH referral	191	205	253	311	234	347	1541
% intakes w/ MH referral	65.2%	75.6%	74.6%	77.6%	75.7%	80.5%	75.4%
% intakes w/ MH referral	86.8%	86.8%	60.0%				82.8%

The average daily census in the mental health treatment units monthly during the past six months (e.g., intermediate care, Infirmary, GP, etc.) was as follows:

Month	OCCC
September	191
October	193
November	199
December	193
January	191
March	194

The above table includes mental health housing units, SMPI in GP and suicide and safety watch infirmary.

The monthly average for the past 6 months of the percentage of the total population for OCCC who is receiving mental health treatment (i.e., the average mental health caseload, MH team only) was as follows:

Month	OCCC
September	20%
October	20%
November	21%
December	20%
January	20%
March	20%

The average census at OCCC was 950 detainees.

The total number of mental health caseload inmates prescribed medication at OCCC was 336, which was approximately 37% of the population. Not all of the patients receiving psychotropic medications are listed on the mental health caseload, which means the above two tables underestimate the reported caseload statistics.

The average lengths of stay in suicide/safety watch at OCCC was 5 days although it was common for some inmates to have lengths of stay for several months for reasons described later in this report.

Mental Health Staffing

Facility	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.
OCCC	1. Dr. Apana	1. Dr. Apana 2. Dr. Chinen	1.Dr. Yamamoto 3. Dr. Yoneshige 4. Dr. Chinen	1. Dr. Apana 2. Dr. Chinen	1.Dr. Apana 2. Dr. Yoneshige 3. Dr. Yamamoto	1. Dr. Yamamoto

Three psychiatrists provide coverage to psychiatric outpatients from Tuesday through Saturday for the equivalent of a 1.2 FTE psychiatrist. The role of the psychiatrists is medication

management. They generally do not attend treatment team meetings.

Other mental health staffing allocations include the following positions:

Section Supervisor	vacant	
Clinical Psychologist	Dr. Kam	Psy. D
Clinical Psychologist	Dr. Magnasoc	Psy. D
Clinical Psychologist	vacant	
Clinical Psychologist	vacant	
Clinical Psychologist	vacant	
Social Worker VI	Stephen Lee	BA
Social Worker V	Gordon Nahoopii	BA
Social Worker V	Libio Hernandez	BA
Social Worker IV	William Shantz	BA
Social Worker IV	Kimberly Kaahanui	BA
Social Worker IV	Cody Silva	BA
Social Worker IV	Boyd Quintal	BA
Social Worker IV	Christopher McConnell	BA
Social Worker IV	Vacant	
Social Worker IV	Vacant	
Social Worker IV	Vacant	
Social Worker IV	vacant	
RNIV	Catherine Krueger	RN
PMA II	Aracelli Danao	
PMA II	Gertrudes Casuga	
PMA II	Moreen Kea	
PMA II	Tressie Estrella	
PMA II	Margarita Payne	
PMA II	Regina Cruce	
PMA II	Kalikolehua Wilbur	
PMA II	vacant	
PMA II	vacant	

At the time of the site assessment, Stephen Lee (Social Worker VI) and two social workers IV were being pulled part-time to provide mental health coverage at the WCCC.

Custody Staffing

The uniform correctional officer allocations was 420 FTE positions with 100 FTE vacancies, and 13 FTE positions on extended worker's compensation status. Eight FTE positions were designated as no inmate contact due to ongoing investigations. Twelve FTE positions were hired on an 80 day emergency basis.

Warden John Schell stated the average number of ACO's calling in sick on a daily basis was about 20. Central office has issued a directive not to fill "nonessential" posts, which means about 20 posts per day go unfilled.

The percentage of custody officers currently working at each facility who have completed the required suicide training was 80%. It should be noted that all officers have been trained but these numbers were based on recertification.

Inmates are generally on a lockdown status during weekends. It was common for housing units to be on a lockdown status during weekdays related to custody vacancies.

Mental health services provide the following levels of care:

1. Outpatient
2. Mental health module (i.e., residential).

The Intake Process

The intake health care screening is done upon booking by the Oahu Intake Services during regular business hours and by the health care services during off hours. The forms used for health care screening (see Attachments 3 & 3a) are the same regardless of which division performs the health care screening. Over 80% of inmates being admitted from October 2024-March 2025 were referred to mental health services based on a positive mental health screening.

Specialized Mental Health Units

Module 1

Module 1 houses inmates with the most acute psychiatric problems as well as inmates placed on a suicide watch. The inmate count during June 18, 2024 was 42, which included 12 inmates on suicide watch and two inmates on an administrative segregation status.

Staff reported that they attempt to provide 14 hours per week of structured therapeutic activities for inmates on this unit who are not on suicide watch as well as 3 to 4 hours per day of out of cell unstructured time. However, due to custody staffing issues, about 10 hours per week, on average, of structured therapeutic activities are offered and about 15-18 hours per week of out of cell unstructured therapeutic activities. Lockdowns on this unit were not uncommon related to custody staffing issues.

Lieutenant Anderson and Sargeant Silva, who have worked on this unit for many years, were interviewed. It was not uncommon for untrained ACO's to be assigned to this unit, which has periodically resulted in excessive use of force being used via pepper spray. The Warden stated he was unaware of pepper spray being used on this unit except in rare circumstances. During the

evening of June 18, 2025, pepper spray was used on two occasions on a very aggressive inmate that was recently transferred from the state hospital after assaulting a psychiatrist.

We briefly observed inmates in the suicide watch cells (cells 101-108). The cells had small concrete slabs on the floor with a thin mattress. Inmates in the cells had either a tear resistant blanket or a suicide smock for clothing. Alarmingly, one of the cells had four inmates in a cell that was designed, at best, to be double celled. There was room only for them to lay down arranged carefully to not touch each other. Another inmate reported that during his time on Module 1 he was housed in the same cell with seven inmates. Most of the other cells were double celled with several cells being single celled. The four safety cells had concrete bunks.

The physical plant (i.e., the cells) was extremely problematic and likely not remediable. None of the cell doors had a food port, which meant that the cell door needed to be opened for medication administration purposes as well as for food tray purposes. They are "dry cells" so water must be passed the same way and inmates told us they will drink from the toilet due to the lack of water. Warden Schell reported that he has received funding for modifying the cell doors to include a food port. The housing unit had office space for interviewing purposes and a dayroom-like space for programming purposes as well as an outdoor recreational area.

We attempted to interview 18 inmates in a community meeting-like setting during the morning of June 18, 2025. Due to the acuity of most of the inmates on this unit, we were unable to gather basic information from them during the group interview. There were several inmates who were overtly psychotic.

Staff reported that generally 8 to 10 inmates participate in the structured therapeutic activities when offered and a similar number participated in unstructured out of cell therapeutic activities. During the morning of June 19, 2025, we observed a group therapy on this unit that included eight inmates. The therapy appeared to be a cognitive behaviorally based treatment. The inmates attending this group had difficulties participating due to their symptoms. An activity therapy group would have been more appropriate for the participants.

The mental health nurse estimated that about 10% of the inmates on this unit were medication non-adherent.

Related to custody vacancies, special assignment (SA) correctional officer positions were not filled.

Psychiatric coverage is provided by two psychiatric residents and an attending (i.e., supervising) psychiatrist on a three day (4 to 6 hours/day) per week basis. The psychiatrists also cover two other units during the same coverage days. The psychiatric residents change every month. A weekly team meeting occurs although the psychiatrists only attend the beginning of the meeting.

We also observed the two psychiatric residents and an attending psychiatrist during their medication clinic on this unit. They indicated that they do meet with other clinicians to discuss

their caseload during the treatment team meeting. They reported difficulties in obtaining past menta health records from other facilities despite sending signed release of information forms. The interviews took place in a private room with the door open, where officers could overhear the conversations.

Staff provided conflicting reports regarding the number of the current 12 inmates on suicide watch who were not suicidal based on mental health reasons but remained on suicide watch due to custodial safety issues. The staff did not appear to be aware of how these safety issues were being addressed by custody staff.

We observed a suicide risk assessment being conducted by a psychologist at the cell front. The inmate being assessed also had a cellie in the cell during this suicide risk assessment.

Information was obtained from Dr. Kam regarding the suicide risk assessment process. If Dr. Kam was familiar with the inmate needing a suicide risk assessment it was very common for it to occur at the cell front. He stated that such assessments would occur in a confidential setting when he was not familiar with the inmate in question. This practice appeared to be, in part, related to custody staff shortages.

Assessment: Module 1 houses many acutely mentally ill inmates who require a higher level of mental health care than is available on this unit. Related to both custody and mental health staffing allocation and vacancy issues, such treatment cannot be provided on this unit. In addition, the decrepit physical plant, overcrowding and the restricted out of cell time exacerbates many of the inmates' mental illnesses.

Several inmates on recent suicide watch were reported to have been on suicide watch for many months due to apparent custody safety issues in contrast to being suicidal secondary to a mental illness.

Except when it is clinically contraindicated, suicide risk assessment should be done in a confidential setting and not at the cell front. A cellmate present in the cell during such an assessment would surely affect the information gathered by the clinician.

A multidiscipline treatment team process, which consists of a psychiatrist, psychologist, human services professionals, nursing staff and custody staff (including a correctional case manager) should be developed and implemented on this housing unit. It is not acceptable to house inmates on a safety watch for long periods of time when the underlying problem is a safety housing issue that needs to be appropriately addressed by correctional staff.

We discussed with Warden Schell, Bruce Kam, PsyD. and Chad Kahule (Residency Section Administrator) issues related to the management of inmates placed on suicide watch due to safety concerns. The usual correctional policy and procedure regarding such management is often bypassed by inmates and/or ACO's for various reasons, which results in the inmate declaring that he is suicidal that leads to direct admission to Module 1. Circular arguments were

voiced by both custody and mental health staff when we attempted to either propose a solution or elicit a solution to this problem. This issue needs to be jointly resolved by custody and mental health staff leadership and appropriate training and supervision be provided to line correctional and mental health staff re: this issue.

There were clearly inmates on this unit who required an inpatient psychiatric level of care. Many correctional systems have negotiated a memorandum of agreement between the correctional system and the state hospital system to provide inpatient psychiatric care for such persons. It is strongly recommended that this option be explored in Hawaii by leadership staff. It would be difficult, if not impossible, to adequately manage this level of acuity at OCCC related to both the physical plant limitations and staffing allocation/vacancy issues.

Module 11

This mental health housing unit is considered a step-down program from Module 1. The count during June 18, 2025 was 51 inmates. We met with 48 inmates in a community meeting - like setting. Many of these inmates had previously been housed in Module 1. They reported that their stay in Module 1 was characterized by very little out of cell time and harsh conditions of confinement, especially if they were placed on suicide watch. Several of the inmates reported difficulties with the work line inmates when they were housed in Module 1. Several other inmates also complained of problems with the ACO's on that unit and had experienced either being sprayed with pepper gas or observing others being pepper sprayed.

These inmates reported they were generally offered about 4.5 hours per weekday of out of cell time and about six hours of out of cell time during weekend days. Thirty-minute group therapies were offered on a twice per weekday basis. Some of the groups were described as being too repetitive. Five to fifteen inmates generally attended a group activity.

Medication continuity was not an issue although the inmates reported that the clinical contacts with a psychiatrist were not confidential. Individual counseling was reported to not be available.

Inmates indicated that hot water had not been available for showers for a long time. They also complained of the presence of black mold in the housing unit.

Assessment: This unit clearly provided a protective environment as compared to a general population unit based on information obtained from these inmates. It was encouraging that two groups per weekday were provided although the duration of these groups were short and described by several inmates as often being repetitive and/or not helpful.

Corrective action needs to occur regarding the psychiatric clinical contacts occurring in a non-confidential manner.

Mental Health Treatment Team

A multidisciplinary treatment team, which includes the disciplines of psychology, psychiatry, nursing, human services professionals and para medical assistants, occurs every Tuesday to review/discuss inmates residing in Modules 1 & 11. We were not on-site at the time of this meeting so we could not observe the process. Correctional staff were not part of this treatment team. We were told that the correctional case managers used to be part of the mental health treatment team but years ago were removed by mental health staff due to reported HIPPA concerns.

Outpatient Level of Mental Health Care

During the afternoon of June 19, 2025, we interviewed 10 inmates, who were all diagnosed with a SPMI, in four different group settings. All but one of these inmates were prescribed psychotropic medications. They were all seen on a regular and timely basis by a psychiatrist with most of the psychiatric sessions occurring in a confidential setting except for patients in one of the housing units. Continuity of medication was not an issue. None of these patients were receiving individual counseling.

Assessment: All of the patients interviewed were appropriate for an outpatient level of mental health care. They were receiving appropriate and timely follow-up by the psychiatrist. Staff need to be reminded that clinical sessions should occur in a confidential setting unless clinically contraindicated.

The Medical Infirmary

We briefly toured the medical infirmary, which did not include twenty-four hour beds for mental health purposes. We also spoke with nursing staff about the medication administration process. Staff reported that the criteria for psychotropic medication for non-adherence was for an inmate to miss three consecutive days of all medications. Under such circumstances, the psychiatrist would be notified.

The evening pill call line is dependent on number of different custody factors but generally occurs prior to 6:30 p.m. Medication continuity problems did not appear to be common.

The Holding Unit

We observed the mental health rounding process performed by a HSP in the Holding Unit, which is a restricted housing unit. Although the HSP was apparently familiar with inmates in this unit, he did not talk with or make eye contact with every inmate in the unit. He did interview a recently admitted inmate for screening purposes and talked to several other inmates.

The physical plant of the Holding Unit was dismal. Most of the inmates were single celled. Staff indicated that inmates with a SPMI were generally diverted from this unit based on the mental health screening that occurs shortly after admission.

Assessment: The physical plant of the Holding Unit was dirty and decrepit. The relevant policies and procedures do not specifically exclude inmates with a SPMI although staff reported that such exclusions occur by practice. Reference should be made to a later section in this report entitled "Administrative Segregation and Disciplinary Segregation" for specific recommendations regarding this issue.

Additional Information

In contrast to HCF, diagnoses are made by psychiatrists and psychologists at this facility.

A formal quality improvement program was not present at OCCC although data was provided via spreadsheets regarding treatment hours provided in the Mental Health Module, mental health appointments, discharge planning and diagnoses of mental health caseload inmates.

Prior External Reviews

American Correctional Association

An April 9, 2024 American Correctional Association (ACA) needs assessment report was reviewed. Observations and/or recommendations included the following:

1. Concerns with the contract services vendor were noted. Specifically, lack of timely medication delivery to the population
2. Many of the same concerns were identified in our assessment OCCC that have been observed in several facilities. (However, these concerns were not summarized).

Hawaii Correctional System Oversight Commission

A March 7, 23 report was reviewed which included, but not limited to, the following observations and/or recommendations:

1. Five of the thirty-six cells in the admissions module were in need of repair and could not be occupied, which forced serious crowding in the remaining cells.
2. The infirmary was seriously overcrowded, which at times resulted in patients having to sleep on mattresses on the floor.
3. The electronic medical record (EMR) has been down since June 2022.
4. The infirmary bathrooms were not ADA compliant.
5. Suicide watch cells appeared to be extremely punitive. It was recommended that cells which hold individuals on suicide watch should be painted and reconfigured for more therapeutic environment for those who are in crisis.
6. There was persistent overcrowding along with the need to keep inmate separated, which caused OCCC management to resort to intolerable actions.
7. Housing unit windows, which are covered by wood, should be replaced with frosted windows to allow natural light.

8. Contact visit should be restored.

National Commission on Correctional Health Care

A health services accreditation focused survey (February 9, 2024) was reviewed, which included, but was not limited to, the following observations and/or recommendations.

1. Standard J-B-05 (suicide prevention and intervention) was in partial compliance. CQI studies were needed in the context of demonstrating compliance with the acute suicide monitoring and non-acute suicide monitoring.
2. Medication administration training was in partial compliance.
3. Pharmaceutical operation was in partial compliance.
4. Medication services were in partial compliance.
5. Emergency services and response plan were in partial compliance.
6. Receiving screening was in partial compliance.
7. Nursing assessment protocols and procedures were in partial compliance.
8. Continuity, coordination, quality of care during incarceration were in partial compliance.
9. Emergency psychotropic medication was in partial compliance

Summary

The mental health system at OCCC is very problematic for the following reasons:

1. Central office mental health leadership positions have been vacant.
2. Significant mental health staffing vacancies at OCCC with a focus on vacant psychologists' positions.
3. Significant line staff ACO vacancies exist.
4. Significant physical plant limitations.
5. Lack of an adequate quality improvement process.
6. Lack of an adequate multidisciplinary treatment team in Modules 1 & 11.
7. Inmates remaining on suicide watch for prolonged periods of time due to self-identified safety concerns in contrast to being clinically suicidal.
8. Suicide risk assessments are often occurring at the cell front in contrast to a confidential setting.
9. The use of pepper spray was excessively deployed within Module 1.

Positive aspects of the mental health system included the following:

1. Nursing staff ensured that continuity of medications was present.
2. Psychiatrists' evaluations and follow-up were timely.
3. The mental health treatment modules provided inmates with serious mental illnesses a protective environment as compared to general population housing units.

Our scope of work covered the following areas:

1. *Review all policies pertaining to Mental Health inmates including but not limited to assessments, diagnosis, treatment plans, referral criteria, follow up care, HSH referrals, housing and re-entry.*

    a. *Outline appropriate treatment plans for SPMI inmates, for inmates with dual diagnosis and those with frequent suicide attempts but no SPMI diagnosis.*

    b. *Recommendation for a preferred screening tool for qualified mental health staff and intake services to trigger referral to licensed staff.*

Response: During June 20, 2025, we met with Romey Glidewell, N.P. to provide her verbally with our comments and suggested revisions regarding the policies and procedures relevant to the mental health care system. In general, these policies and procedures, if implemented, will provide a very useful infrastructure and guidelines for the health care clinicians involved in the mental health care system. Many of our recommendations were substantive in nature.

Our suggested revisions to these policies and procedures will require many hours from the perspective of revising the current policies and procedures. Successful implementation will not be possible until the staffing vacancies have significantly been reduced and the psychiatrists' allocations increased.

Regarding the health care screening process, at OCCC that referral rate to mental health services was >80%, which means there was a very high false positive rate. Once a quality improvement process is in place, this issue should be further assessed and either the screening instrument revised or training provided to nursing staff re: referral criteria.

Written recommendations regarding the following two policies will be provided in a later portion of this report:

1. Policy #COR.10.1G.05 (Suicide Prevention and Intervention), and
2. Policy # COR.11.01 (Administrative Segregation and Disciplinary Segregation).

2. *List of training criteria and content for security staff.*

    a. *Content for new cadets training.*
    b. *Content and requirements for retraining seasoned staff.*
    c. *Identify special requirements for those requesting MH posts.*

Response: We interviewed Catherine Krueger, R.N., who provides the basic mental health training and suicide training to all newly hired correctional officers and health care staffs. The initial training consists of basic mental health training (four hours) and suicide prevention training (four hours). Refresher courses (two hours for basic mental health training and two hours for suicide prevention training) is required every two years.

Lindsay Hayes, who is the author of a training curriculum entitled "Suicide Detection and Prevention in Jail and Prison Facilities" has given permission for the Hawaii DRC to use all of or portions of this training. Attachment 4 and 5 are copies of his PowerPoint slides and instructor's manual. Attachment 6, which is a chapter in press, can serve as a resource document for the suicide prevention training as well as provide ideas for revision of the suicide prevention policy.

Under usual circumstances, we would recommend specialized and enhanced mental health training for ACO's assigned to Modules 1 & 11 at OCCC. However, since the bid process occurs every twelve weeks such training would not be very practical. It is our recommendation that the bid post for these two modules be at least six months although we realize that this is an issue that needs to be negotiated with the pertinent union. If these posts were for at least six months, we would recommend specialized mental health training for the ACOs working in these units. Another option would be to make these posts "Warden Select" posts and require the specialized mental health training for the ACO's.

3. List of training criteria and content for mental health and medical staff.

a. Identify appropriate staff to sufficiently diagnose and treat mentally ill population given the current climate of staffing options.

b. Recommend acceptable alternative practices when staffing is insufficient.

Response: It is not appropriate for unlicensed mental health clinicians to be making mental health diagnoses. It is not appropriate for unlicensed clinicians to be treating mentally ill inmates without appropriate clinical supervision from a licensed mental health clinician. The current significant vacancies of psychologists does not change the above assessment.

When clinical staffing is insufficient, clinical leadership staff needs to prioritize inmates' access to assessment and treatment with priority based on clinical acuity and safety issues (e.g., danger to self and to others). This appears to already have occurred at both HCF and OCCC, which essentially means the current staff is doing the best they can do under very unfavorable circumstances. However, such a "triage plan" does not mean that the current mental health system is providing adequate treatment to all inmates in need of such treatment.

c. Identify appropriate staffing ratios for SPMI census.

Response: The following indented section summarizes recommendations from the publication entitled "Psychiatric Services in Correctional Facilities, A Work Group Report of the American Psychiatric Association", Third Edition. American Psychiatric Association, 2016.

> Adequate numbers of appropriately trained mental health professionals, performing duties for which they are trained and authorized, must be present in every correctional facility. Staffing must be adequate to ensure that every inmate with serious mental illness or in psychiatric or emotional crisis has timely access to evaluation by a competent mental health professional… .

Psychiatrists are a critical and necessary component of any correctional mental health delivery system. Diagnostic evaluation and prescription of psychotropic medications are frequently the most significant mental health treatment interventions for inmates with serious mental illness… .

Psychiatry staffing levels are complicated algorithms that vary based on clinical acuity and patient needs, system organization, physical plants, acuity of care delivery, resource availability, and population characteristics. The factors that impact psychiatric staffing in correctional settings are facility specific. These factors include: type of facility (jail, intake facility, prison), size of facility (e.g., average daily population (ADP) less than 50; ADP greater than 1000), inmate turnover rate, location of facility, program space availability, security level of facility (higher security demands restrict movement and may significantly reduce clinician productivity), and care delivery model (e.g., team vs. individual practitioner). Specifically, a few of the many factors that may reduce psychiatric productivity through reduced access to patients include the need to individually cuff, shackle, and escort some inmates by custody personnel; have limited numbers of inmates in any waiting area; wait for count and other locked-down time periods; and wait for multiple doors along the path from cell to examination room to be unlocked by central control staff. Higher security facilities and high-risk patient populations pose additional safety-related challenges in staff recruitment, retention, and productivity. Small, medium-security prisons with stable populations allow for greater productivity.

There are no prevailing national standards for psychiatric staffing in correctional or other settings. Nevertheless, courts and regulatory agencies, court monitors, and health consultants, frequently seek to establish staffing ratios in correctional settings in order to comply with constitutionally mandated minimally acceptable medical care. Governmental agencies with oversight of correctional settings often seek such ratios to assess their budgetary needs. Correctional facilities have historically not had enough psychiatrists to adequately provide the services described in the sections above.

In practice, a facility-specific staffing needs analysis is a fundamental step in determining the actual psychiatric staffing required in any given facility to meet the standards of care.

Correctional facilities need guidance about adequate psychiatric staffing. Needs vary based on facility characteristics, but all relevant and necessary psychiatric functions must be met. Based on 15 years of experience in the field since the publication of the 2nd edition of Psychiatric Services in Jails and Prisons, the following are recommended basic guidelines about psychiatric staffing requirements:

Jails

For general population needs: 1 full-time equivalent (FTE) psychiatrist for every 75 to 100 SMI patients on psychotropic medication prescribed for a mental health diagnosis.

Note: We recommend 1.0 FTE psychiatrist for every 100 to 150 SMI patients on psychotropic medication prescribed for a mental health diagnosis.

For residential treatment units or the equivalent (where a mental health diagnosis is a requirement for admission): 1 FTE psychiatrist for every 50 patients.

Note: We recommend 0.5 FTE psychiatrist for every 50 patients and 3.0 to 5.0 FTE other mental health clinicians (e.g., psychologists, HSPs, recreational therapists).

Prisons

For general population needs: 1 FTE psychiatrist for every 150 to 200 SMI inmates on psychotropic medication.

Note: We recommend 1.0 FTE psychiatrist for every 200 to 250 SMI patients on psychotropic medication prescribed for a mental health diagnosis.

For residential treatment units or the equivalent (where a mental health diagnosis is a requirement for admission): 1 FTE psychiatrist for every 50 patients.

Note: We recommend 0.5 FTE psychiatrist for every 50 patients and 3.0 to 5.0 FTE other mental health clinicians (e.g., psychologists, HSPs, recreational therapists).

Re: an infirmary level of mental health care: We recommend 1.0 FTE psychiatrist and at least 1.0 FTE mental health clinician for every fifteen patients housed in an infirmary setting for mental health reasons.

We are aware it is very difficult to recruit psychiatrists and psychologists to a correctional setting related to a variety of factors including the conditions of employment (i.e., poor physical plant---not a Kaiser plan-like setting, significant staffing vacancies, etc.). However, the ability to provide needed treatment to a very underserved population, provide treatment to a very interesting population and provide supervision to unlicensed clinicians eager to learn can be an attraction to many public interest oriented psychiatrists.

The long-standing contract with the Queens Medical Center appears to be very successful at OCCC. Efforts to expand his contract to include more psychiatrists and psychologists is recommended. Similar efforts should be made with the Department of Psychiatry at the University Hawaii School of Medicine.

d. Recommend training criteria for medical staff including nursing and LPN's.
e. Recommend training for unlicensed mental health providers i.e. social workers and human services professionals.

Response: We recommend that the basic mental health curriculum for health care staff be significantly modified to provide training relevant to the mental health services' policies and procedures once they have been developed and are ready for implementation. Emphasis should be placed on the Mental Health Services policy and procedure, treatment plans, suicide prevention policy and procedure, medication nonadherence, confidentiality, discharge planning and quality improvement. The training should also include information relevant to implementation of a multidisciplinary treatment team in the context of relevant recommendations made in this report.

A policy regarding medication non-adherence should be revised or developed that defines psychotropic medication non-adherence to include either 3 consecutive days of non-adherence or 50% non-adherence over a one week period of time.

See our previous comments regarding suicide prevention training for correctional officers.

f. Recommend housing policies for those with active suicidal ideation, including assessment and reassessment criteria.

Response: Policy #COR.10.1G.05 (Suicide Prevention and Intervention) was reviewed as was the Suicide Risk Evaluation (SRE) form. In general, this policy was adequate as was the SRE form although we made specific suggestions to leadership staff during our site visit. We also recommend that clinical leadership staff obtain from CDCR their Suicide Risk Assessment and Self-Harm Evaluation (SRASHE) form, which would provide DRC with some useful suggestions/revisions regarding the SRE form currently in use. Attachment 6 should also serve as a guide re: housing policies for inmates with suicidal ideation. Note that the current housing practices for inmates with suicidal ideation is more punitive than therapeutic.

The policy should be revised to include a suicide prevention committee at both HCF and OCCC that includes a psychiatrist, psychologist, HSP, nursing staff, and custody staff leadership. We recommend obtaining the CDCR suicide prevention policy that will provide a template for the functions of such a committee. Attachment 6 also provides relevant information re: such a committee.

As previously summarized in this report, the psychologists' vacancies and sparse psychiatrists' allocations are major barriers to successfully implementing the suicide prevention and intervention policy and procedures.

g. Identify critical areas of delinquency in current housing and supervision of suicide and safety watch cells.

Response: Refer to the body of the report that specifically discusses the inappropriate housing of inmates reporting suicidal ideation in order to attempt to address safety concerns in contrast to being clinically suicidal. It is our recommendation that a multidisciplinary treatment team, consisting of a psychiatrist, psychologist and HSP be formed that provides assessment and treatment for inmates at HCF on B Ward of the infirmary and at OCCC for inmates placed on suicide watch. This team should have a correctional case manager who works at HCF and a correctional case manager who works at OCCC in order to facilitate resolution of inmates in these units who are identified as having safety concerns in contrast to being clinically suicidal. Nursing staff at each institution should also be available for consultation to this team.

Attachment 6 should also serve as a guide re: housing policies for inmates with suicidal ideation. While we are aware that there are plans to build a new jail facility with more beds, implementation of these recommendations cannot be deferred, in part, related to the very uncertain timetable that the jail will be constructed as well as the underlying reasons for these recommendations.

Death reviews-suicides

Policy #COR. 10A.09 (Procedure in the Event of an Inmate Death) was reviewed. This policy requires a clinical mortality review (i.e., a multidisciplinary administrative review) within thirty days of the death as a component of the Health care Division Quality Assurance Program. The purpose of the administrative review is to answer, at a minimum, the following three questions:

1. Could the medical response at the time of death be improved?
2. Was an earlier intervention possible?
3. Independent of the cause of death, is there any way to improve patient care?

As a component of the Health Care Division Quality Assurance Program, a "psychological autopsy shall be performed on all deaths by suicide within thirty days by the Mental Health Branch Administrator or a designated psychologist. Corrective actions, if any, identified through the review process of the Quality Assurance Committee shall be implemented and monitored through the continuous quality improvement program for systemic issues and through the patient safety program for staff-related issues.

This policy is very problematic for the following reasons:

1. The three questions to be answered by the administrative review are too vague and ambiguous. For example, it appears that question #1 is trying to address the appropriateness of the emergency medical response. However, the policy and/or the form used for the administrative review does not provide enough structure to determine the appropriateness of the emergency medical response. For example, there are no timelines summarized such as the exact time that the inmate was discovered, who discovered the inmate, when was the emergency response initiated, when was 911 called, what time was CPR initiated, if the inmate was hanging what time was he cut down, etc.

2. Regarding question #2, what type of earlier intervention is being referenced. Is it a emergency medical intervention, mental health intervention, custody intervention or some other type of intervention?

   It appears that this administrative review is attempting to assess both the emergency medical response and other interventions (in the case of a suicide) that should be assessed via the psychological autopsy process.

3. Question #3 should be restricted to the emergency medical response since completion of a psychological autopsy process is required to answer the broader question that it appears to be asking.

Other basic information such as in which correctional facility did the suicide occur, the manner of suicide, the type of housing unit where it occurred, the age and race of the deceased inmate, date of admission to the correctional facility, etc. are absent in the administrative review form. This lack of basic demographic information prevents the Health Care Division Quality Assurance Program from forming an adequate analysis of relevant demographic information specific to suicide systemwide.

The policy is also vague regarding the specific components of the required psychological autopsy.

We reviewed three multidisciplinary administrative death reviews related to two suicides and one homicide that occurred during November 20, 2024, February 5, 2025 and May 17, 2025. There were no psychological autopsies performed regarding the two suicides, which was likely related to the Mental Health Branch Administrator's vacancy and the significant psychologists' vacancies. We have chosen not to provide comments regarding the administrative reviews that were documented for reasons previously summarized regarding the problems associated with the policy requiring such reviews. In addition, we discussed our concerns regarding the policy in detail with Ms. Glidewell.

It is also our understanding that there currently is not a functional Health Care Division Quality Assurance Program within the Hawaii Department of Corrections and Rehabilitation.

It is our recommendation that clinical leadership staff contact the Director of Mental Health, Amar Mehta, M.D. at the California Department of Corrections and Rehabilitation (CDCR) in order to obtain their suicide prevention policy and procedures, mortality and morbidity review policy and procedures and several redacted samples of their death review reports involving inmates who have suicide that include a psychological autopsy.

h. Review current limitations to diagnosis and recommendations for oversight.
i. Review and recommend appropriate discharge planning criteria.

Response: The current limitations re: diagnosis and recommendations for oversight have already been addressed.
Discharge planning needs to be addressed by a policy and procedure-either via a separate policy and procedure or within the Mental Health Services policy and procedures. The following paragraph summarizes recommendations from the publication entitled "Psychiatric Services in Correctional Facilities, A Work Group Report of the American Psychiatric Association", Third Edition. American Psychiatric Association, 2016.

> There is increased recognition of the risk for reincarceration of individuals with serious mental illness (Baillargeon et al. 2008). Timely and effective discharge planning is essential to continuity of care and an integral part of adequate mental health treatment. This is true whether the patient is released into the community or transferred to another correctional facility. Because discharges (e.g., from jails) or transfers (e.g., between prisons) may occur on short notice, discharge planning needs to begin as part of the initial treatment plan. Discharge planning is provided for all inmates with serious mental health needs as well as other mental health caseload inmates whose release is imminent although the nature of the discharge planning process will vary based on the inmate's needs. For planned discharges health care or other designated staff should arrange for a sufficient supply of current psychotropic medications to last until the patient can be seen by a community health care provider. Patients with critical medical and/or mental health needs must have appointments scheduled with community providers, including arrangements for psychiatric hospitalization as needed (NCCHC 2008, 2014a, 2014b). Confidentiality concerns should be addressed to facilitate sharing of information among providers in different settings.

j. Recommendation for a preferred suicide risk assessment with certification program for licensed mental health staff.

Response: See previous response regarding the Suicide Prevention and Intervention policy and procedure. It is recommended that an internal credentialing process be established for psychologists, certified mental health nurses, psychiatric nurse practitioners and interested non-psychiatric physicians to perform suicide risk evaluations. Psychiatrists need to familiarize themselves with the suicide risk evaluation form in order to perform suicide risk assessments.

4. Review and assist in outlining criteria for administrative segregation hearings to include mental health staff to ensure that behavior associated with a known diagnosis does not incur criminal charges, to decriminalize mental health disorders within the facility.

Response: Policy # COR.11.01 (Administrative Segregation and Disciplinary Segregation) was reviewed. This policy requires mental health staff to conduct a mental health review within twenty-four hours of an inmate's placement in administrative segregation in order to identify inmates "with known or suspected mental health issues or inmate[s] who exhibit behaviors that

impact their ability to be safely placed in administrative segregation." This policy requires a similar process for all inmates placed in disciplinary segregation.

The above policy also requires "mental health professional shall tour the segregation housing unit(s) not less than five times per week." Policy states that "inmates in segregation shall receive privileges consistent with a facilities available resources and security consideration." Inmates were reported to be offered one hour of out of cell time per weekday.

This policy also requires that "any disciplinary segregation sanction shall consider an inmate's medical and mental health needs, the gravity of the facts, and the severity of the serious misconduct violation." However, the policy is silent regarding how the information regarding an inmate's mental health needs are conveyed to the hearing officer and the nature of the mitigation of the sentence that is possible.

Assessment: This policy does not exclude inmates with a serious and persistent mental illness (SPMI) from being housed in a restrictive housing unit (RHU) that is characterized by being locked down 23 – 24 hours per day for prolonged periods of time. Such an omission is not consistent with the current standard of correctional mental health care. The standard of mental health care is that inmates with a SPMI should be excluded from housing in such a RHU with very few narrowly defined exceptions unless the conditions of confinement within the RHU are changed (e.g., offering such inmates ten hours per week of out of cell unstructured activities (i.e. recreational yard) and up to ten hours per week of structured therapeutic activities depending on their level of mental health care. Reference should be made to Attachments 7, 8, 9, which are consistent with this standard of care.

The policy should require a mental health evaluation for any inmate with a SPMI or a suspected SPMI who is charged with a major disciplinary infraction for purposes of recommending a mitigated sentence if the inmate's mental disorder contributed to his behavior and he is found guilty. Such an examination should be performed by a licensed mental health professional, who is not the inmate's treating clinician, and is done for purposes of mitigation in contrast to purposes of determining responsibility or non-responsibility in the context of the alleged infraction.

Overcrowding and inadequate physical plants at both facilities assessed very problematic. We strongly support development and implementation of a diversion program that would reduce the growing inmate population at OCCC and likely reduce the population numbers at HCV over time. However, such a program involves multiple agencies and was outside the scope of our work.

It is unclear to us our role, if any, in the next step of the Settlement Agreement process. Please let us know to facilitate the coordination of our schedules.

Please contact us if you have further questions.

Sincerely,

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