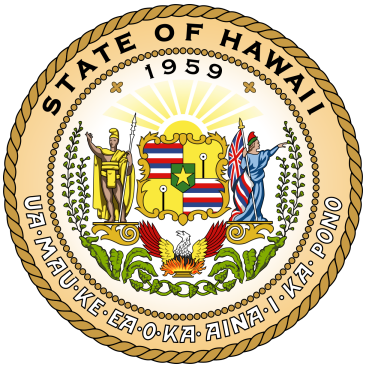


Report to the Legislature on

Act 90 (SLH 2019)/ H.B. 1013 Relating to Involuntary Hospitalization

and

Act 263 (SLH 2019)/ S.B. 1494 Relating to Health

PREPARED BY:
STATE OF HAWAIʻI DEPARTMENT OF HEALTH

Deputy Director of the Behavioral Health Administration, Edward Mersereau
Chairperson

December, 2019

Report to the Legislature on Act 90 (SLH 2019)/ H.B. 1013 Relating to Involuntary Hospitalization and Act 263 (SLH 2019)/ S.B. 1494 Relating to Health

December, 2019

TABLE OF CONTENTS

Executive Summary

A MANDATE BY THE 2019 LEGISLATURE TO EVALUATE THE CURRENT BEHAVIORAL HEALTH CARE SYSTEM AND MAKE RECOMMENDATIONS FOR IMPROVEMENT

The 2019 Legislature passed two distinct measures which tasked the Department of Health to gather various stakeholders in the community into a task force and working group for the purpose of evaluating the current behavioral health care system and making recommendations for improvement. Both measures, H.B. 1013 and S.B. 1494, were signed into law by Governor David Ige and became Act 90 (SLH 2019) and Act 263 (SLH 2019), respectively. In general, both Acts called for a comprehensive review of the current behavioral system of care, including the involuntary hospitalization system, existing resources, systemic gaps, and identification of action steps that could be taken to improve the overall system of care.

The approach taken to fulfill the mandates of the task force and working group in an effective and efficient manner drew upon successes of the Hawai'i Opioid Initiative which implemented a coordinated policy framework approach. This approach developed specific subject matter working groups within the broader framework in order to more effectively focus on the various components of the system. Additionally, the two entities were merged into one task force in order to avoid duplication of efforts, broaden the reach and scope of each entity, and to better respond to their mandated tasks. This was accomplished by a unanimous vote by both entities.

There were five workgroups developed to focus on: 1) Data, 2) MH-1, 3) Post Stabilization Community Support and Inventory of Resources, and Capacity, 4) Criteria for Involuntary Treatment, and 5) Funding and Eligibility. The groups worked between task force meetings and brought information and recommendations to the combined task force to review and, where necessary, take action through formal vote. This allowed the task force to use the time it met to address the broad system and coordinate the various findings and recommendations coming from the workgroups.

Generally, the combined task force findings and recommendations can be summarized into several themes:

- Current processes and systemic components remain relatively fragmented and siloed – highlighting the need to coordinate various efforts within the behavioral healthcare system into a more comprehensive and connected continuum of care. The need to develop coordinated entry systems that effectively "link and sync" crisis, post-crisis, and crisis prevention efforts such as Law Enforcement Assisted Diversion, Intensive Case Management and supportive housing is a vital and necessary component of an effective system.

- The current approach to dealing with individuals who are in mental health crisis imposes a significant burden on law enforcement and emergency medical response systems – highlighting the need to expand and enhance coordinated mental health crisis response protocols that allow for diversion, where appropriate, to specialized crisis centers targeted specifically for behavioral health crisis. These services should include short-term stabilization centers and Intensive Case Management.

- Effectuating the above two themes will most certainly result in more effective and efficient use of resources that exist and more clearly illustrate and identify the areas where resources are lacking. It is vital that assertive efforts and investments be made up front to realize a truly coordinated system of behavioral health services in order to reduce duplication of effort and maximize the impact of resources invested.

While much was accomplished by the combined task force, there remains a significant amount of work to be done. The findings and recommendations outlined in this report illustrate the need to continue efforts within the coordinated policy framework to assure momentum and direction is maintained. Many of the recommendations identified in the report validate initiatives and efforts currently underway at various stages; all of which have promising value and impact by themselves. However, one of the most important outcomes of the taskforce has been its effectiveness of bringing a wide range of stakeholders together in a way that promotes coordination. While the Department of Health may have been identified as the Lead Agency of the task force, the input and cooperation of these stakeholders represent the beginnings of a collaborative effort that should be continued in order to realize the achievement of the recommended actions.

Introduction

BACKGROUND

House Bill 1013 (H.B. 1013) was signed into law as Act 90 (Session Laws of Hawai'i (SLH) 2019), on June 7th, 2019 by Governor David Ige, formally creating the Involuntary Hospitalization Task Force and assigning primary responsibility for convening its members to the Hawai'i State Department of Health. The task force directive was to examine sections of Chapter 334, Hawai'i Revised Statutes, and make recommendations to the legislature to address ambiguities and inconsistencies in the statute, as expressed by stakeholders in the community, that contribute to concerns about behavioral health access, resources, and capacity, and which may impact the continuity of care and public safety. It put forth a primary goal to diminish unnecessary emergency department admissions and improve overall access for behavioral health patients to the most appropriate level of care.

Senate Bill 1494 (S.B. 1494) was also signed into law during the Thirtieth Legislative session as Act 263 (SLH 2019). Act 263 designated responsibility to the Department of Health to formally establish a working group to evaluate current behavioral health care and related systems and identify steps to be taken to promote effective integration to more effectively respond to and coordinate care for persons experiencing substance abuse, mental health conditions, and homelessness. Several of the tasks asked of this working group were parallel to the Involuntary Hospitalization Task Force mandates.

In an effort to consolidate and effectively carry out the tasks of both Acts, a motion to merge the Act 90 Task Force and the Act 263 working group was introduced during two separate meetings to both committees. The motion was unanimously carried and the Task Force and the working group merged with the purpose of improving efficiency and effectiveness and with the agreement to abide by the Sunshine Law requirements of Act 90. Act 263 working group members and the bill’s respective objectives were absorbed into the Act 90 Task Force focus workgroups.

OVERVIEW OF INVOLUNTARY HOSPITALIZATION, CURRENT BEHAVIORAL HEALTHCARE AND RELATED SYSTEMS

In 2015, behavioral health disorders represented the leading cause of disease burden in the U.S., surpassing cancer and cardiovascular disease.[1] Approximately one in five adults in the U.S. experience mental illness in a given year.[2] An increase in psychiatric boarding challenges, escalating healthcare costs, public safety concerns around behavioral health and higher rates of incarceration for individuals experiencing behavioral health issues has solidified a desire to change how we address acute behavioral health needs within our communities. Although rates of homelessness have declined almost 10 percent since 2017, per capita, Hawai'i is tied for the highest rate of homelessness in the nation.[3] The overlapping issues of homelessness, substance use, and behavioral health disorders present complex problems within our communities.

These ongoing issues and challenges highlight the imperative need to assess the relationship between homelessness, addiction, and behavioral disorders in order to understand the complexities of behavioral health issues in the community. These problems are often co-occurring, and commonly, one exacerbates the other. For example, the end result of homelessness is often substance use, and substance use often contributes to homelessness. The National Coalition for the Homeless has found that 38 percent of homeless individuals are alcohol dependent, and 26 percent are dependent on other harmful chemicals. The difficult conditions of living on the street, having to find food, struggling with ill-health, and being separated from loved ones creates a highly stressful state of being. Substance use is the common coping mechanism many turn to. Hawai'i community members who experience homelessness and chronic homelessness are especially at risk for substance dependence issues. Aside from alcohol, methamphetamine remains Hawai'i's most prevalent drug use among adults.[4] Hawai'i also has one of the highest rates of incarceration due to

[1] Rabah Kamal et al. Journal of the American Medical Association. Costs and Outcomes of Mental Health and Substance Use Disorders in the U.S. 2017; 318 (5):415
[2] NAMI. Mental Health by the Numbers.https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers.
[3] Henry, Meghan, Anna Mahathey, Tyler Morrill, Anna Robertson, Azim Shivji, and Rian Watt. "The 2018 Annual Homeless Assessment Report (AHAR) to Congress." https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf. The U.S. Department of Housing and Urban Development Office Of Community Planning And Development, 2018.
[4] Alcohol and Drug Abuse Division. Report to the Twenty-Ninth Legislature, State of Hawai'i. Kapolei, HI: Department of Health December 2016

methamphetamine related convictions.[5] Furthermore, individuals suffering from homelessness may also develop psychiatric conditions, and many individuals suffering from mental illness have co-occurring substance use disorders (SUD). This cause and effect relationship of SUDs and homelessness, homelessness and psychiatric illnesses represent a “trifecta” of interwoven social problems facing our community. Reports suggest that nationally, 33 percent of individuals who are homeless battle mental illness and that mental illness is a major cause of homelessness, which can often lead to substance use. In Hawai'i, the 2019 Oahu Homeless Point In Time Count for Oahu reported 36.4 percent of single adults suffer from some type of mental illness, closely reflecting the national average.[6]

Unfortunately, many of those suffering from substance use or other psychiatric disorders do not recognize the need for treatment. The way that many of these individuals land in our behavioral health and criminal justice systems are through interactions with law enforcement personnel because of crisis situations. When a law enforcement officer responds to a person in crisis whom they believe may be suffering from a behavioral illness, they call on the help of a Mental Health Emergency Worker (MHEW) which is a qualified mental health professional designated by the Department of Health. The MHEW can determine if the individual is suffering from a behavioral illness and is imminently dangerous to themselves or others, and can authorize involuntary transportation to a licensed psychiatric facility for further evaluation, a process known as “MH-1”.[7]

The current process for MH-1 patients has been to transport individuals experiencing a mental health emergency to a designated psychiatric facility where they receive a psychiatric evaluation and may require involuntary hospitalization. Psychiatric hospitalization is the treatment option of last resort for individuals with acute or chronic serious mental illness who need intensive care. The process to authorize an MH-1 for a person in crisis requires a considerable amount of time and resources. In order to deliver a consumer to a designated psychiatric facility, 911 systems are engaged, followed by an encounter with a law enforcement officer. A law enforcement officer, in the possible instance of a behavioral health related crisis, contacts a MHEW who approves involuntary transportation by ambulance or other appropriate means. Most

---

[5] U.S. Sentencing Commission, 2015 Datafile, USSCFY15. Retrieved from https://www.ussc.gov/sites/default/files/.pdf/research-and-publication/federal-sentencing-statistis/state-district-circuit/2015/hi15.pdf

[6] Partners in Care “Point In Time Count, Oahu” 2019. Retrieved from https://www.partnersincareoahu.org/sites/default/files/PIC%202019%20Oahu%20PIT%20Count%20Report%20-%20FINAL_0.pdf

[7] Hawai'i Revised Statutes §§334-59 - 334-62

often, the law enforcement personnel is required to accompany the person in crisis to the designated emergency facility, taking them off the street and away from their duties for several hours.

Authorized transports of MH-1 patients are currently taken to emergency departments that lack the physical infrastructure within their facilities, including secure rooms and dedicated security personnel, which are critical to safely caring for MH-1 patients needing psychiatric care. Additionally, many lack the kind of specialized staffing and programming necessary to adequately and safely assess patients in psychiatric crisis. These facilities regularly have trouble placing such patients in need of admission to licensed psychiatric beds. There is a significant strain on emergency departments that are within designated licensed psychiatric facilities given that these facilities receive the bulk of MH-1 patients.

A 3rd quarter 2018 MHEW report revealed that the Queen's Health System in Honolulu and Adventist Health Castle Medical Center in Kaneohe receive over 95 percent of the MH-1 emergency department visits on Oahu. Queens admits approximately 30 percent of their cases while Castle admits approximately 50 percent.[8] Although the data is not as readily available on the prevalence of MH-1 cases. Anecdotally, the safety concerns and impacts on emergency departments receiving MH-1 patients are very similar. The neighbor islands have greater gaps in care and a lack of needed resources than Oahu. Kauai and Hawai'i counties, for example, are lacking adequate resources such as MHEWs and designated psychiatric facilities to appropriately triage and treat individuals who are experiencing a behavioral health crisis. Kauai has only one hospital with inpatient psychiatric beds, but it has a very small emergency department and no general medical services. On Hawai'i Island, there are only two hospitals with psychiatric services with much greater geographical distances to cover. Patients who are brought to hospitals without psychiatric services often wait days in the emergency department before being transferred to another facility that has adequate psychiatric services. Maui, although the county has begun MHEW implementation, has only one designated psychiatric facility to which mental health emergency workers, through Aloha House, can authorize involuntary transportation. Emergency facilities throughout the entire state have simultaneously experienced a substantial increase in psychiatric emergency admissions which has resulted in overcrowding and unsafe environments for MH-1 patients, medical staff and other patients.

[8] AMHD. "AMHD and MH1 Program Update May 2018" 2018.

Emergency department overcrowding factors are complex, and it is clear that substance use and behavioral health patients play a significant role in this. “Emergency Room (ER) Boarding” is a term used for the extended stay that psychiatric patients experience in the ER. Behavioral health patients experience more than twice as long wait times than other patients while arrangements are made for their psychiatric services elsewhere. According to an American Psychiatric Association study, 81 percent of the 340 survey respondents stated the increase in patients holding for an inpatient psychiatric bed negatively affects the care of other patients, reduces the availability of emergency department staff for other patients, and contributes to longer wait times for all patients often causing patient frustration.[9]

One significant contributing factor to emergency department overcrowding, specifically for behavioral health patients, is the declining psychiatric bed capacity in the nation. The decrease of psychiatric inpatient beds in hospitals and the increase in the number of psychiatric patients has become a major national issue which has had detrimental economic, community behavioral health, and recidivism effects. Today, there are fewer psychiatric beds per capita in the United States than there were in 1850. An analysis of the broader system of both inpatient and other 24-hour residential-treatment beds revealed a stark 77.4 percent decrease from 1970 to 2014.[10] Hospital beds, in general, have plummeted from their historic peak in 1955 by 97 percent in 2016. A Treatment Advocacy Center report on psychiatric bed shortages disclosed that even when private hospitals are included, the number of psychiatric beds per 100,000 people in the United States ranks the nation 29th among the 34 countries in the Organization for Economic Cooperation and Development.[11] Without access to psychiatric beds, acutely ill individuals are forced to wait for appropriate level of psychiatric care, while families watch helplessly as their loved ones deteriorate in the absence of appropriate care. With nowhere else to turn, those in need end up in other systems, a process known as transinstitutionalization. These systems include emergency rooms without psychiatric beds, homeless shelters and, too often, jails and prisons.

Delays in treatment reduce patient satisfaction and increase the risk of patients leaving without treatment. Extended stays can often cause the patient’s condition to deteriorate without the adequate level of care for their clinical needs. Delays in receiving crisis stabilization services significantly increase the risk of physical injury to the patient and to

[9] Mulligan K. ER docs report large increase in psychiatric patients. Psychiatr News, 2004.
[10] Snook, John, and E. Fuller Torrey. “America Badly Needs More Psychiatric Treatment Beds.” Treatment Advocacy Center. National Review, 2018.
[11] Treatment Advocacy Center. “Psychiatric Bed Shortages.” Treatment Advocacy Center, 2018. https://www.treatmentadvocacycenter.org/key-issues/bed-shortages.

others around them.[12] In the state of Hawai'i, one testimony from a local hospital reported it had experienced a disproportionately high increase in the number of MH-1 patients brought into its facility, despite the expansion of designated psychiatric receiving facilities in 2012. In 2018, a reported 60 percent of the MH-1 patients transported to the facility's emergency department did not require psychiatric hospitalization and could have been transported to another psychiatric facility with a more appropriate level of care. While many of these initial visits to the emergency department are necessary, having other psychiatric facilities that could assist in triaging MH-1 individuals would lessen the overall burden on emergency departments. Because emergency departments serve individuals with acute needs, they often are not the appropriate setting for meeting post-stabilization, or long-term needs of patients with serious behavioral health needs. There is currently no available data regarding the MH-1 population to assess the viable and effective alternatives that may need to be developed to address this population.

Poor access to care, including long waiting times as a result of inadequate psychiatric resources, can lead to higher rates of attendance at emergency departments. Inevitably, this results in profound economic and population health consequences. The Oahu Coordinated Entry System Homeless data from August to October 2017 revealed that the average cost per emergency department visit including ambulance transportation is $3,633 while the average cost of Hospital stay per day including the initial visit is $6,952. On average, the length of inpatient stay for MH-1 emergency department admissions is 3 days.[13]

In addition to costly emergency department visits, those who do not receive appropriate post acute or preventive care are not afforded crucial diversion opportunities which can also cause the criminal justice system to become a de facto behavioral health system. Over 2 million people with serious mental illnesses are booked into jail each year.[14] One study showed that by 2014, ten times the number of people with serious behavioral health illness were in prisons and jails as in state mental hospitals, nationally.[15] Evidence shows that the prevalence of mental illness in jails is 3-4 times higher than the general population. Furthermore, people with mental illness in jail are more likely to be homeless post release. Given the multiple behavioral health and social risk factors, this population is especially at risk of "recycling" through both the criminal justice and

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3627782/
[13] Oahu Coordinated Entry System. "High Utilizer/ Super Utilizer - ER Visits/ Hospital Stays Data from August to October 2017." 2017.
[14] NAMI. "Jailing People With Mental Illness." NAMI, 2019. Retrieved from https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness
[15] Snook, John, and E. Fuller Torrey. "America Badly Needs More Psychiatric Treatment Beds." Treatment Advocacy Center. National Review, 2018. .

healthcare systems. A “Revolving Hospital Door” study which measured the rate of hospital readmissions among homeless individuals revealed that half (50.8 percent) of all hospitalizations resulted in a 30-day hospital inpatient readmission and 70.3 percent resulted in either an inpatient readmission, observation status stay, or emergency department visit within 30 days of hospital discharge.[16] The lack of adequate behavioral health settings to serve this population, along with siloed services, creates a considerable cyclical systemic burden.

Comprehensive crisis response and stabilization services are crucial elements of the continuum of care. Reducing unnecessary transportation to emergency departments and appropriately placing clients in more suitable levels of care will improve outcomes for consumers, reduce inpatient hospital stays and costs, and facilitate access to other necessary behavioral health services and community supports.

[16] Doran, Kelly M., Kyle T. Ragins, Andrea L. Iacomacci, Alison Cunningham, Karen J. Jubanyik, and Grace Y. Jenq. "The revolving hospital door: hospital readmissions among patients who are homeless." *Medical care* 51, no. 9 (2013): 767-773.

PURPOSE

The purpose of this combined task force was to fulfill the mandate of the Legislature to engage a multidisciplinary team of stakeholders to form a collaborative body to examine the existing laws and systems surrounding involuntary transportation and hospitalization of individuals who are at risk of harm to themselves or others due to behavioral health needs. Five working groups established within the task force examined sections of Chapter 334, Hawai'i Revised Statutes, developed recommendations on how to reduce unnecessary emergency department admissions, and explored ways to improve access for involuntarily hospitalized (MH-1) patients to the most appropriate level of care.

Through this task force, the Legislature sought to identify action steps that the State can adopt in order to improve and construct a more comprehensive system of care and flow of patients through the continuum of care. Furthermore, the task force is committed to reviewing the progress that has been made thus far so as to ensure that previous work on this issue is organized and considered in a cohesive manner. This approach assured that the task force was able to identify gaps and operationalize policies more effectively for the overall enhancement of the behavioral healthcare system.

The central goal is to improve efficiencies within the system and increase efficacy and maximization of current resources by reducing unnecessary emergency department admissions and improving standardized access for MH-1 patients. Recommended systematic improvements include a balanced utilization of behavioral and psychiatric facilities, which not only creates safer healthcare environments but supports placement at appropriate levels of care, decreases emergency department admissions, and promotes significant economic savings through jail diversion efforts and effective client transition through the continuum of care.

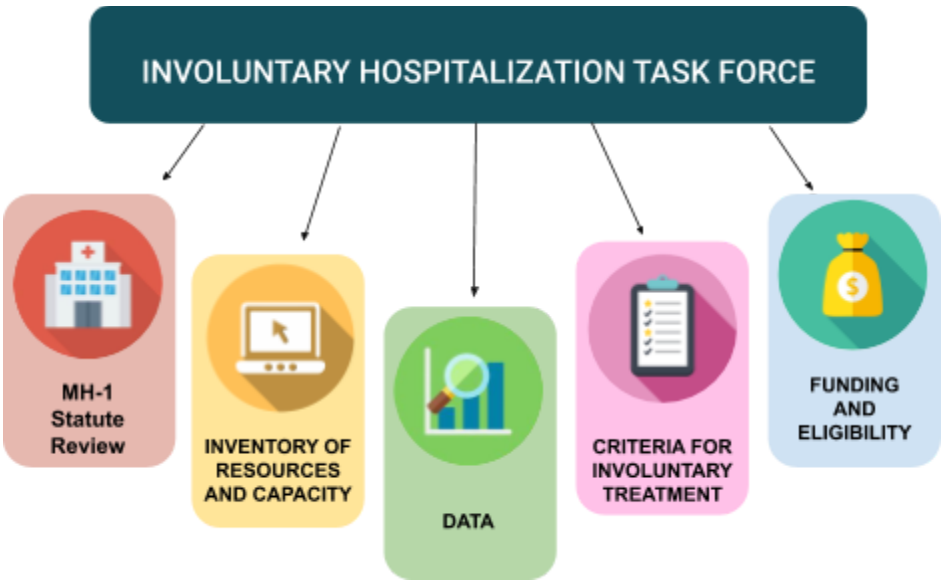
The task force envisions a behavioral healthcare system that is more reflective of how we intervene in primary healthcare crises, in which those in need are able to access the appropriate level of care, on-demand, and with no barriers to vital crisis interventions. The recommendations contained in this report were developed in part by evaluating and addressing gaps within our own system and looking to other states who have exceptional behavioral healthcare standards and programs.

Focused Workgroups

WORKGROUPS AND OBJECTIVES

The issues surrounding involuntary hospitalization and the gaps in the continuum of care have been a longstanding topic among stakeholders. Incremental improvements have been made for decades in an effort to restructure behavioral health treatment within the state. While acknowledging the abundance of information and previous work that has been accomplished within the community, the mobilization and coordination of these key stakeholders was essential to constructing a collaborative framework to address these challenges.

By examining the success of previous task force planning strategies such as the Hawai'i Opioid Initiative, it was apparent that utilizing this collaborative framework provided a structured approach to coordinating efforts across various state and community systems. Additionally, it provided an opportunity to place key stakeholders into subcommittees that were synonymous with their areas of expertise. Within each of these working groups, specific sets of action items were assigned which included: reviewing existing laws and policies, standardizing criteria for designated facilities, assessing gaps in current law enforcement and healthcare facilities, examining funding and reimbursement, and developing recommendations for a more robust coordinated system of care throughout the State.



MH-1 Statute Review Objective
To review the statute and protocols from the point of contact through triage to emergency departments or other community support. This focus workgroup assessed gaps and shortcomings in the MH-1 system. Specifically, the workgroup examined patient experiences, the hand-off which occurs when a patient is reintegrated into the community, the rights and responsibilities of emergency medical services, current availability of alternate receiving sites, facility challenges when addressing MH-1 cases, security and safety concerns of intaking facilities, and patient wait times.
Post Stabilization Community Support and Inventory of Resources and Capacity Objective
To identify community resources available by island and their capacity. This focus workgroup examined existing behavioral health resources within the state and geographically inventoried outpatient and residential substance use treatment and mental health providers for each county.
Data Collection Objective
To quantify the needs and outcomes. This focus workgroup examined existing data collection and sharing strategies between the Department of Health's Behavioral Health Administration and other human service entities throughout the State. The workgroup assessed the need for data sharing strategies in order to make reliable data-driven decisions throughout the entire behavioral healthcare system.
Criteria for Involuntary Treatment Objective
To review MH-4, MH-6, and ACT and identify criteria for involuntary treatment. This focus workgroup examined gaps and barriers in the MH-1 process, as well as the Hawai'i Revised Statute, Chapter 334-59, to determine a complete and accurate interpretation of the law. The workgroup also assessed the required time of commitment, the extent to which facilities can accommodate involuntary commitment cases based upon their existing capabilities and barriers to broader implementation of ACT orders where appropriate.
Funding and Eligibility Objective
To determine the funding necessary to support the solution. This focus workgroup evaluated current funding sources and reviewed eligibility criteria that either promotes or hinders access to care. It assessed all eligibility sets and criteria for services to identify similarities and differences and if conflicting differences are causing barriers to care.

Findings & Recommendations of the Task Force

The following recommendations are structured around corresponding findings of the task force's focused workgroups on Data, MH-1, Post-stabilization Community Support and Inventory of Resources and Capacity, Criteria for Involuntary Treatment, and Funding and Eligibility.

1. Telepsych Evaluation and Treatment Options
2. Develop a Reliable Distribution and Transport Process for Patients
3. Contract Consolidation Across Divisions

FINDING A: The State of Hawai'i has unique geographical obstacles which has resulted in a disparity of resources, services and qualified staff to meet the community's behavioral health needs. Access to behavioral healthcare is especially challenging on the neighbor islands and rural areas of Oahu where there are significant shortages of behavioral health and specialty care services. Additionally, transportation is a major issue for those who need to obtain care, especially in the instance of a crisis situation. Aside from geographical challenges, service access barriers exist for those who are underinsured, and those who have complex needs. Federally designated underserved populations and geographical areas make up the entirety of the neighboring islands and the rural parts of Oahu which has resulted in recurring disproportionate access to behavioral healthcare across the state. The following recommendations aim to address access to behavioral healthcare especially for residents in rural areas.

RECOMMENDATION 1A : Utilize readily available resources to employ a statewide telepsych option for consumers for evaluation and treatment to ensure equal access to care across each county.

The purpose of telepsych is to deliver behavioral health services using technology in order to improve access to quality behavioral healthcare in rural and urban areas across the state. The use of telepsych technology would allow patient access to psychiatric and specialist services they might not otherwise have within the comfort of their local community. Additionally, the use of telepsych can help minimize healthcare costs while reducing patient travel time. It is recommended that Telepsych be a sustainable service modality to reduce provider shortages, long waitlists, geographic barriers, and improve access to behavioral health care. It was found that Hawai'i State Hospital in-house psychiatrists who are on-call may be able to provide telepsych services to the community. The Task Force recommends that these underutilized assets be employed for statewide telepsych availability.

RECOMMENDATION 2A: Develop a reliable crisis triage, diversion, and transportation process for MH-1 individuals.

In psychological or behavioral crisis situations it is important that an individual be transported, voluntarily or involuntarily, in a timely manner to a behavioral health treatment facility which has appropriate resources and staffing to immediately mitigate the crisis. In needing to structure the behavioral health crisis system to reflect to the primary healthcare trauma system, it is important to recognize that an individual experiencing a primary healthcare crisis normally starts receiving treatment as soon as they are in the ambulance. It is typically ensured that in a primary healthcare trauma situation, the individual will be transported to an emergency department which has the suitable resources and staffing to care for that patient immediately. Section 334-59, Hawai'i Revised Statutes, specifies that after a Mental Health Emergency Worker (MHEW) has examined a person and has reason to believe the person 1) is mentally ill or suffering from substance abuse; 2) imminently dangerous to self or others; and 3) in need of care or treatment, they may “direct transportation by ambulance or other suitable means, to a licensed psychiatric facility for further evaluation and possible emergency hospitalization.”[17] This language limits the implementation of diversion resources. The task force has found through examples of other states such as Arizona and Florida, it is imperative to implement alternative reliable crisis triage, diversion, or

[17] Hawai'i Revised Statutes §334-59

transportation processes that ensure individuals in behavioral health crisis situations receive care, appropriate to their clinical need, in a timely manner.

Mental Health Emergency Worker services face capacity constraints in being able to screen individuals in crisis and triage them to alternative receiving sites and services. Ideally, MHEWs would be able to screen and triage patients by their level of need to the appropriate facility or service and reduce displacement out of their community. The work group recommends that law enforcement and MHEWs develop a criteria that would standardize the assessment process. The criteria would provide law enforcement and MHEWs the ability to assess the needs of the individual prior to transport.

The Task Force also recommends that existing community sites and services are provided additional resources to serve as alternative receiving sites for delivering the appropriate level of care for patients who may have some needs but do not rise to the level of an MH-1. Such sites and services would include: crisis services, residential treatment facilities, subacute care residential facilities, intensive case management, assisted community treatment, community paramedics, peer specialist, detox facilities and/or services, outreach centers. This would allow for individuals in need to have access to services in a less invasive manner. The ability to deliver care to people without transportation to an ED, would mean that they would be able to remain in their community and law enforcement officers would not be taken off the road or experience lost time for patrol.

RECOMMENDATION 3A : Consolidate behavioral health contracts and collaborate with entities who can readily, or through timely phasing, provide the infrastructure for statewide behavioral health services.

In an effort to “link and sync” behavioral health services across the state, it is recommended that contracts issued by the Behavioral Health Administration with community service providers be consolidated and coordinated where appropriate for the purpose of increasing access to all levels of services for providers and patients. This approach also allows for more coordinated networking of providers and resources in the community.

Current Initiatives Relating to Finding A

- Community Paramedicine - Community paramedicine is a relatively new and evolving healthcare model. It allows paramedics and emergency medical technicians (EMTs) to operate in expanded roles by assisting with public health and primary healthcare and preventive services to underserved populations in the community. The goal is to improve access to care and avoid duplicating existing services.
- Hawai'i Coordinated Access Resource Entry System (CARES) - A centralized behavioral health referral center that authorizes individuals into the continuum of care and manages a patient's transition through substance use treatment and behavioral health services.
- Subacute Stabilization Residential Services (SSRS) - A Behavioral Health Administration contract (in progress) which will establish a facility, or multiple facilities, that will provide post-stabilization treatment for the state of Hawai'i.
- Treat Alternative Transport - An Emergency Medical Services (EMS) initiative that assists in transporting and triaging individuals who do not meet MH-1 criteria but require behavioral health care to appropriate services within the community.

1. HIPAA and 42CFR Trainings
2. Centralized Directory of Providers and Available Resources
3. Standardized Time of Admission Protocols for Involuntary Hospitalization Forms
4. Centralized Data Sharing Repository
5. Standardized Use of ACT and PAD

FINDING B: Current inconsistencies and fragmentation of behavioral health services limit continuity of care and patient outcomes. This often results in inefficient use of resources and funds to address mental health, homelessness and substance use disorders. Consequences of a fragmented behavioral health system include, but are not limited to, difficulty in standardizing or setting quality outcome metrics, over-utilization of some services and under-utilization of others without accurate assessment of their efficacy, and more importantly, decreased capacity and client flow through a treatment continuum (if all clients are kept for the maximum length of stay regardless of their progress, treatment beds are prevented from being maximized). The following recommendations are related to standardizing and centralizing behavioral health resources. In doing so, behavioral health services throughout the state can more effectively and efficiently utilize resources, and reach a more consistent continuum of care to improve patient outcomes.

RECOMMENDATION 1B: Develop and implement consistent trainings, delivered by the Department of Health, to ensure standardized use of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Code of Federal Regulations Title 42, Part 2 (42CFR).

The Health Insurance Portability and Accountability Act of 1996 is a Federal law that restricts access to individuals' private medical information.[18] Furthermore, 42 CFR, Part 2 (commonly referred to as "Part 2") are the federal regulations governing the

[18] Dhcs.ca.gov. (2016). *What is HIPAA*. Retrieved from: http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/1.00WhatisHIPAA.aspx

confidentiality of drug and alcohol abuse treatment and prevention records.[19] The implementation and adherence to HIPAA and 42CFR, Part 2 regulations are not currently standardized throughout facilities/providers. Although there are clear guidelines in both HIPAA and 42CFR, Part 2, the way these regulations are currently adhered to is on an institution-by-institution basis. While these regulations are important in any system of care to ensure patient privacy and ethical best-practices, they can cause barriers when facilities are unaware of how to appropriately share data and information between entities. Clearly understanding how to effectively share information from provider to provider while still abiding by these regulations is essential for ensuring a patient's treatment plan is not disrupted.

RECOMMENDATION 2B: Construct a comprehensive database of all providers and services that will be maintained and updated in real-time, available on-line 24/7, and would be easily accessible to all appropriate statewide organizations and agencies.

The Post Stabilization Community Support and Inventory of Resources and Capacity workgroup identified 19 separate databases, each of which varied in depth of information and services provided. There is currently no single reliable or regularly updated database of providers and behavioral health services in the State that is easily accessible to organizations, agencies, and consumers. Having access to a comprehensive and centralized database would allow all behavioral health systems to be visible in real time which would allow for uncomplicated client placement based on their clinical need and level of care. This would significantly improve the care continuum by ensuring a seamless entry into the continuum of care as well as transitions between levels of care.

RECOMMENDATION 3B: Standardize the time of admission guidelines for all involuntary hospitalization processes and protocols.

Current involuntary hospitalization forms do not give guidance to the status of the patient while in an emergency department or other treatment site, awaiting management by a qualified psychiatric facility. While it is understood that the MH-4 form is completed when the patient is involuntarily admitted, the interval between the patient's arrival under terms of either the MH-1 or MH-2 has no defined boundaries. It is advised that: 1)

[19] Milken Institute School of Public Health. "Health Information and the Law: 42 CFR Part 2." Health Information and The Law Project. 2019. Retrieved from http://www.healthinfolaw.org/federal-law/42-cfr-part-2

such boundaries be established (e.g., “reevaluation of patient’s safety and need for hospitalization at 12 hour intervals, not to exceed 72 hours without engagement of the Family Court”); 2) the Department of Health is to assess the current emergency department or outpatient department length of stay for adults and for children who are pending psychiatric hospitalization, by island; 3) the Department of Health is to publish relevant guidelines on its website; and 4) the Department of Health is to provide training on this topic across all affected emergency departments and law enforcement sites. It is recommended that language be synchronized to clarify the definition of Time of Admission across all involuntary hospitalization forms.

RECOMMENDATION 4B: Develop a centralized data sharing repository which abides by HIPAA and 42CFR regulations and can be accessed by all State behavioral health providers and related entities.

There is currently no centralized data sharing repository that is accessible by all State behavioral health providers and related entities. The lack of a data sharing repository limits providers from being able to access vital consumer protected health information which, if accessible, could effectively assist in treatment planning, establishing a high utilizer database, jail diversion, and more proactive intervention efforts. The absence of information sharing between health systems on MH-1 individuals has resulted in gaps in treatment with no warm hand-offs or coordinated efforts to connect patients with the needed substance abuse and mental health services available. The sharing of information, such as number of emergency room visits, location, conditions, etc. would assist in managing this population and stakeholder’s ability to deliver the appropriate level of care. We recommend that additional resources are either allocated to existing systems or develop a community health record accessible to providers, law enforcement, MHEWs, and case managers.

It is recommended that providers agree to participate in sharing real-time data with the Hawai'i Health Information Exchange (HHIE) and the Department of Health, and that HHIE agree to share identifiable data to providers of that person to assist in care coordination. It is also recommended that there be mandated data sharing with other related entities through a secure data portal that abides by HIPAA and 42CFR regulations. Furthermore, a consideration was made to link the Department of Health’s Utilization Management with Hawai'i CARES and that the Department of Health’s epidemiologists or other designated staff will be responsible for reviewing data monthly, cleaning data from combined data sets with HHIE, and drafting an annual report to the legislature. The annual report will include MH-1 numbers, trends over time and patterns

by socio-demographic, geographic, and other pertinent variables. A subsection will be included to provide insight on high utilizers. Additionally, the report will include conclusions, accomplishments, and future recommendations and will be shared with providers and other stakeholders included in the behavioral health system. It is expected that these reports will also assist with grant applications and in determining and acquiring additional funds. An advisory committee will participate in the report while the Department of Health's Governance board will oversee any request for data for research and will only release de-identified data that has been approved by the Data Governance and IRB committees.

RECOMMENDATION 5B: Ensure standardized use of non-admission treatment options such as ACT and PAD by developing consistent protocols and trainings through the Department of Health and identify a pilot cohort of 40 patients to assure refinement of both services.

Assisted Community Treatment (ACT) refers to a civil court procedure wherein a judge orders an individual diagnosed with a severe mental disorder who is experiencing a psychiatric crisis that requires intervention to adhere to an outpatient treatment plan designed to prevent further deterioration that is harmful to themselves or others. This form of involuntary treatment is distinct from involuntary commitment in that the individual under the court order continues to live in their home community rather than being detained in a hospital or incarcerated.[20]

A psychiatric advance directive (PAD), also known as an advance mental health care directive, is a written document that describes what a person wants to happen if at some time in the future they are judged to be suffering from a mental disorder in such a way that they are deemed unable to decide for themselves or to communicate effectively.[21]

These two services have been effectively implemented in various communities throughout the nation and is a vital component to a comprehensive care continuum. The use of these tools have been inconsistent across the behavioral health services in the state of Hawai'i. Input from the Judiciary, Hawai'i Civil Rights Commission, Civil Liberties Union, and other related stakeholders, has been and will continue to be necessary to develop broadly accepted protocols to effectively and consistently implement these services within our community. To ensure these tools are being uniformly utilized, it is recommended that the Department of Health develop trainings on

[20] Hawai'i Revised Statute Chapter 334 §121-134
[21] Hawai'i Revised Statute Chapter 327G

how to utilize ACT and PAD within our system. It is also recommended that during phase one of implementation, that a pilot cohort of 40 patients is identified to assure refinement of both services.

Current Initiatives Relating to Finding B

- Hawai'i CARES - A centralized behavioral health referral center that authorizes individuals into the continuum of care and manages a patient's transition through substance use treatment and behavioral health services.
- Assisted Community Treatment (ACT) - A civil court procedure wherein a judge orders an individual diagnosed with a severe mental disorder who is experiencing a psychiatric crisis that requires intervention to adhere to an outpatient treatment plan designed to prevent further deterioration that is harmful to themselves or others.
- Psychiatric Advanced Directive (PAD) - A written document that describes what a person wants to happen if at some time in the future they are judged to be suffering from a mental disorder in such a way that they are deemed unable to decide for themselves or to communicate effectively.

1. Coordinated Access Resource Entry System (CARES)
2. Post-Stabilization Community Resources
3. Support H4 Centers and the Hawaii HOME Project
4. Leahi Pilot Program for Co-Occurring Disorders
5. Re-Evaluate Existing Funding Sources

FINDING C: Expanding on "linking and syncing" efforts within the state, it is integral that we encourage collaboration and coordination both within behavioral health systems and between behavioral health, public safety, and other related systems. A successful and effective care continuum depends solely on the commitment of stakeholders throughout the community. Such cross-system collaboration is essential for successful jail diversion efforts, transitions from the justice system to the community behavioral healthcare system, and for patient recovery and community reintegration. In addition to the need for a more robust continuum of care, it was found that vital resources were lacking or entirely absent from our present care continuum. Some of these critical resources that are insufficient within our system include, but are not limited to, psychiatric beds, holistic programs for individuals with co-occurring disorders, adequate psychiatric resources within designated receiving facilities, and post-stabilization residential facilities. The ramifications of inadequate or missing resources within a care continuum means that individuals entering the behavioral health or criminal justice systems with incomplete resources are at a higher risk of relapse, recidivism, and emergency department readmissions. Ultimately, gaps in the continuum of care perpetuate a "revolving door" which puts individuals at risk for worsening behavioral health conditions, chronic homelessness, and a slew of other risk factors. Beyond patients, there is a significant negative impact on emergency departments, law enforcement and other public safety entities, and it substantially increases healthcare costs. The following recommendations are related to creating a more robust continuum of care and ensuring access to

treatment that is appropriate for every level of care by addressing gaps in the current care continuum.

RECOMMENDATION 1C: Develop and implement a centralized behavioral health managing entity which will assist consumers in entering the continuum of care, and progress through the continuum of care based on clinical need and level of care that encourage a coordinated and collaborative network of care that ensures best practices and improved patient outcomes.

On October 1st, 2019, the Hawai Coordinated Access Resource Entry System (Hawai'i CARES) was launched. This centralized behavioral health managing system assists clients with entering into the continuum of care. Historically, SUD treatment programs in Hawai'i have operated independently of each other, offering limited or little coordination of services without ensuring that client care shifts freely between levels of care as clinically appropriate. The goal of Hawai'i CARES is to implement a synchronized system of care rather than an assortment of independent programs and treatment modalities. There is currently a disparity of intake and access processes among behavioral health systems including intake and assessment packets which can range from 10-60 pages long depending on the contracted provider. Patients who are unsuccessful in one program or who do not complete treatment as a direct result of insufficient resources or capacity, are often forced to restart in another program which requires them to complete new, lengthy intake and assessment packets. Also, providers across all behavioral health systems are unable to effectively track patients through their episode of care. Also, decentralized waitlists and bed inventories perpetuate cherry picking, ER boarding and patient holding. Hawai'i CARES operates as a centralized behavioral health managing entity which will effectively universalize screening and assessment processes, thus reducing barriers to treatment and recovery support services in the continuum of care. Hawai'i CARES will ensure treatment is available on demand to those who need it, when they need it, and where they need it. Currently Hawai'i CARES is working on linking all substance use treatment services. Later, through phasing and provider collaboration, Hawai'i CARES will be connecting all behavioral health services within the State.

RECOMMENDATION 2C: Identify either single or multiple providers, as well as a facility that can readily, or through a timely phasing process, provide the infrastructure to implement statewide post stabilization (subacute) residential services.

An increase in psychiatric boarding challenges, escalating healthcare costs, public safety concerns around behavioral health and higher rates of incarceration for individuals experiencing behavioral health issues have solidified a desire to change how we address acute behavioral health needs within our communities. Data collected in the state of Hawai'i estimates that a significant portion of individuals experiencing a crisis (54 percent) have needs that align better with services delivered within a subacute level of care facility. Subacute Residential Stabilization Services (SSRS) have been a missing component of our State's comprehensive continuum of care, which in having, would bridge the gap between acute hospitalization and lower level residential and community resources. Individuals with behavioral or substance abuse disorders experiencing a crisis enter the health care delivery system most often through emergency departments. The acute phase may last only hours if it is primarily due to substance abuse, or significantly longer if it is due to chronic severe mental illness requiring days of treatment. Undiagnosed mental illness can be exacerbated in the hospital. The period after the acute phase is often referred to as the "post-stabilization" phase of services, meaning that the acute crisis is resolved or controlled to the degree that inpatient treatment is no longer indicated. This does not mean that all treatment goals have been accomplished and the patient is cured.

Within Hawai'i, especially on the neighboring islands, there are no available services that provide subacute behavioral health stabilization services for consumers who meet the post-stabilization criteria for two generally accepted Level of Care frameworks for behavioral health care: Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) – Level 5A Intensive -Short Term Residential Services, and American Society of Addiction Medicine Patient Placement Criteria 3rd Edition (ASAM) – Levels 3.5 and 3.7, Residential Services.

A LOCUS Level 5 residential treatment facility has capacity to treat persons who are stepping down from acute inpatient care or people who are in crisis but who do not require the security of a locked facility. These services are capable of providing intense treatment programming (as described for all Level 5 services) and they are sometimes referred to as subacute or respite care. Length of stay usually would not exceed 7-10 days.

Furthermore, the ASAM Level 3.5 – Clinically Managed High Intensity Residential services are designed to serve individuals, who, because of specific functional limitations, need safe and stable living environments in order to develop and/or demonstrate sufficient recovery skills so that they do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive

level of care. Level 3.5 assists individuals whose addiction is currently so out of control that they need a 24-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress. Their multidimensional needs are of such severity that they cannot safely be treated in less intensive levels of care.

ASAM Level 3.7 require Medically Monitored Intensive Inpatient Services to provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. They feature permanent facilities, including inpatient beds, and function under a defined set of policies, procedures, and clinical protocols. They are appropriate for patients whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program.

Both ASAM levels are characterized by their focus on individuals who need secure safe environments where targeted treatment can focus on stabilizing their level of functioning so that they may be successfully treated in less intensive levels of care, but whose acuity does not meet acute hospitalization levels of care.

The post-stabilization phase can be as simple and direct as a discharge home with a follow-up appointment to a health care provider. But often it is not that easy, especially if the patient is experiencing homelessness. While the acute crisis may be resolved, further specialized treatment is often needed on a timely basis to prepare an individual to benefit from longer term rehabilitation. This could be an addiction treatment program, or therapeutic behavioral health program, or even ACT. The community health care settings where the various levels of treatment are available are limited (very limited on neighboring islands) especially if a residential component is needed. Those that do exist often have to address complex patient management and programming issues, making admission decisions complex in order to serve the needs of the entire community.

Emergency departments are the most accessible and easiest/quickest part of the system and if the condition is severe enough a hospital bed will be provided for the patient. But after that, if a patient cannot go home, the options are extremely limited, particularly on the neighbor islands. Without treatment options, the patient will not progress towards recovery but regress and cycle back to the emergency department or languish on the streets in our community. This tragic cycle occurs because we have failed to stand up enough stabilization options that are accessible in the community. There needs to be options so that a “warm handoff” to a community setting can be

made after initial stabilization to facilitate continued treatment/healing and reduce the risk of recurrence of crisis acute admissions.

For hospitalized patients, it currently takes significant time for a referral to occur from the point of initial contact through assessment and referral to an agency for assistance. During this time, the patient may no longer have an acute inpatient treatment need and therefore will be discharged. In order to provide timely case management and referrals for transitions out of the hospital, we recommend that health plan care coordinators and community providers be contacted and involved early during the hospitalization.

Least restrictive level of care is often not available, especially on neighboring islands, because we only have high levels of care that are easily accessible and very little options that provide lower levels of care such that the people with high acuity and multiple chronic conditions are often placed into higher levels of care for a longer period of time than is necessary or more likely, they are discharged from expensive, emergent care in a very short time and released back to the community to a much lower level of care that is not adequate for them, because the right level of care does not exist in our system, or is unavailable. Without enough step-down treatment and differing acuity options for this population, such patients become frequent utilizers of short doses of easily accessible high level, expensive care and never truly reach long term recovery and normalcy.

It is recommended that a system be designed for the few people with very complex problems involving substance use disorder (SUD) and co-occurring (COD) mental health disorders as well as comorbid physical chronic medical conditions. In such a system, patients would move according to their needs, accessing the “least restrictive” levels of care at the appropriate intensity. They would access services from any point on the continuum and move to the least restrictive level of care according to need, even skipping steps if appropriate. Different pathways will be developed for different populations and needs, such as those who are homeless and will need varying levels of housing support. This can be done by collaborating with the Coordinated Entry System (CES) in each county whose function is to match housing needs with housing resources.

The Task Force recommends identification and removal of barriers to improve access to community programs that currently exist, and increased funding to more robustly fund current options and develop additional community treatment options. In addition, resources would be needed as well as new, creative uses of funding (housing, etc.) could be used to establish step down services as a means to improve recovery rates for complex patients. The committee also recommends investment in Certified Peer

Specialists and Peer Navigators to help patients navigate the continuum of care and transitions between steps.

RECOMMENDATION 3C: Continue to support and encourage collaboration with H4, Joint Outreach Centers, and Hawai'i HOME and increase promoting strategies to maximize community attendance.

Hawai'i Homeless Healthcare Hui (H4) is a comprehensive homeless service facility serving Oahu's chronically homeless population. The center provides four levels of services including 1) Hygiene, 2) Non-emergency healthcare, 3) Medical Respite, and 4) Transitional Housing. The H4 center currently serves 1,200-1,400 chronically homeless individuals, saving Hawai'i taxpayers $30-$40M per year by curbing the tide of healthcare demand. Services are available on a walk-in basis on Monday, Wednesday, and Friday each week, from 8:00 a.m. to 12:00 p.m. at the Institute for Human Services (IHS) site and from 1:00 p.m. to 8:00 p.m. at the Joint Outreach Center in Chinatown.[22]

The Hawai'i Homeless Outreach and Medical Education (Hawai'i HOME) project was established in 2006 and offers free clinic services to homeless individuals. To date, the project has had over 10,500 patient visits and has serviced over 5,200 individuals. The Hawai'i HOME project currently operates out of 10 sites in various locations on Oahu and offers acute and chronic medical services, social resources, vision screenings and eyeglass prescriptions.

These services are readily available and easily accessible for individuals experiencing homelessness within the community. Promoting these services ensures an opportunity for entry into the system of care. Continued support and collaboration with these services will increase the number of individuals experiencing homelessness being linked to medical care, case management, and other necessary services.

RECOMMENDATION 4C: Implement a Recovery House pilot program to more appropriately care for individuals with co-occurring behavioral health disorders and that would insure a seamless consumer transitioning process.

[22] "Hawai'i Homeless Healthcare Hui." Retrieved from http://www.h4Hawai'i.org/

Co-occurring behavioral health conditions affect nearly 8.2 million Americans each year. About 60 percent of state and federal prisoners have a substance use disorder.[23] In the Hawai'i State Hospital, the average number of patients that have a substance use disorder (causing frequent re-hospitalization) is 85 percent; 75 percent of which have a co-occurring disorder. Unfortunately, 36 percent of patients reenter the Hawai'i State Hospital within 6 months after being released, most of which have co-occurring disorders. Studies have consistently shown that all best practice programs for co-occurring disorders require a safe and supportive space for recovery. Currently, consumers struggling with co-occurring disorders in Hawai'i often relapse due to gaps in services and a lack of housing that is dedicated to their unique needs. There is a need for such housing that will support the wellness and recovery of these patients. In a recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA), "Best Practices for Recovery Housing," recovery housing programs for co-occurring disorders decreased drug related deaths and hospitalizations by 60 percent. It is recommended that a pilot program be implemented that would specifically target the co-occurring population and would utilize an unused wing of the Leahi House Pilot. Leahi House Pilot program is a 5-6 months long, 24 hour residential recovery program for consumers with co-occurring disorders. It is intended to assist consumers in avoiding hospitalizations, re-hospitalizations, and incarceration. The recovery house pilot program would expand on current contracts for 24 hour housing, ICM+, Supported Employment, Representative Payee, Outpatient Treatment, and Community Based Case Management. This would allow for proof of concept without the necessity of adding additional contracts. The pilot program will enroll 6-8 patients with co-occurring disorders. A Transitional Living Program (TLP) is also recommended to be added in the future which would allow the possibility of an additional 32 patients into the program.

RECOMMENDATION 5C: Coordinate and maximize existing funding to address capacity shortages within the States behavioral health care continuum and then identify funding needs, if any, to support the envisioned comprehensive continuum of care.

In order for licenced psychiatric facilities to take MH-1s, they need to have adequate resources that will ensure a safe environment and the clinical expertise needed to provide a psychiatric assessment. We are recommending that additional resources and supports are provided to facilities.

[23] SAMHSA. "Behavioral Health Barometer". 2015. Retrived from https://www.samhsa.gov/data/sites/default/files/2015_Hawai'i_BHBarometer.pdf

A comprehensive inventory of resources is needed to address capacity issues for available beds and/or various services in order to effectively treat, prevent and/or avoid unnecessary transport or hospitalization. Furthermore, additional funding sources need to be identified or reallocated to ensure licensed psychiatric facilities are adequately equipped and staffed to receive MH-1 and acute behavioral health patients. This funding is needed to ensure sufficient reimbursements for creating or enhancing services with qualified staff to meet chronic behavioral health needs. Existing resources need to be utilized and appropriately reallocated, where possible, to fund an effective and cost-efficient coordinated framework, leverage funding from the Hawai'i Opioid Initiative and access other available grant sources. Also, short term plans and long term visions for funding need to be developed across the behavioral health system in order to ensure sustainable expenditure.

Current Initiatives Relating to Finding C

- Hawai'i CARES - A centralized behavioral health referral center that authorizes individuals into the continuum of care and manages a patient's transition through substance use treatment and behavioral health services.
- Subacute Stabilization Residential Services (SSRS) - A current Behavioral Health Administration contract which will establish a facility, or multiple facilities, that will provide post-stabilization treatment for the state of Hawai'i.
- Hawai'i Homeless Healthcare Hui (H4) Center - A comprehensive homeless service facility serving Oahu's chronically homeless population by providing hygiene services, non-emergency medical services, medical respite, and transitional housing.
- Hawai'i Homeless Outreach and Medical Education (HOME) project - Offers free clinical services to Oahu's homeless population and currently serves out of 10 locations throughout the City and County of Honolulu.
- Leahi Pilot Program - A recovery house which provides clinical and holistic care for individuals who have co-occurring behavioral health disorders.

FINDING D: Since the 19th century, the United States has turned to jails and prisons to manage individuals suffering with behavioral health conditions. Today, individuals experiencing a behavioral health crisis are more likely to encounter police than get medical help. As a result, 2 million people with mental illness are booked into jails each year.[24] The vast majority of those individuals have not committed a violent crime and most who are currently in jail have not yet gone to trial, so they are not yet convicted of a crime. The rest are serving short sentences for minor crimes.

At least 83 percent of jail inmates with a mental illness did not have access to needed treatment.[25] Criminalizing people with mental illness creates an unnecessary burden on law enforcement, corrections, and state and local budgets. It does not protect public safety and people who would greatly benefit from community behavioral health resources are being ignored.

Studies have shown that diversion efforts are successful at interrupting the traditional criminal justice process for individuals with behavioral health illnesses by increasing access to community treatment, housing, and adjunctive services, avoiding or shortening criminal justice confinement, and, by linkage into treatment, will reduce substance use, psychiatric symptoms, and criminal justice recidivism.[26] While there

[24] NAMI. “Jailing People With Mental Illness.” NAMI, 2019. Retrieved from https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness

[25] NAMI. “Jailing People With Mental Illness.” NAMI, 2019. Retrieved from https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness

[26] Broner, Nahama, Pamela K. Lattimore, Alexander J. Cowell, and William E. Schlenger. "Effects of diversion on adults with co-occurring mental illness and substance use: Outcomes from a national multi-site study." *Behavioral Sciences & the Law* 22, no. 4 (2004): 519-541.

have been various efforts within the state to effectively divert behavioral health patients from the justice system, the following recommendations address the need to create a more robust coordinated and reliable system to effectively divert individuals with mental illness from jails, and to ensure recovery oriented treatment within all State institutions that engage with these patients.

RECOMMENDATION 1D: Locate an existing facility or facilities within the state that have suitable infrastructure (or with minimal effort can be made suitable) to support central receiving facilities for jail diversion and behavioral health crises and allocate resources to appropriately staff these facilities as alternatives to ER's and jails.

One exemplary location which has successfully implemented a designated central receiving facility into their care continuum is Arizona. The implementation of a new care model effectively addressed the influx of mental health patients in their emergency departments. This goal of the care model is to move behavioral health patients from the emergency department to a safe, secure, and appropriate care setting in a timely manner. An emergency psychiatric center called the Banner Psychiatric Center was opened in September 2010 and is staffed 24/7 by a psychiatrist or behavioral health nurse practitioner along with other behavioral health support staff. Additionally, a transfer process was developed using a regional transfer center at Banner Health known as the Regional Patient Placement Office; a call center that is staffed 24/7 by registered nurses who match requests for patient transfers to available resources. The office assists an average of 2,000 transfers per month, including more than 400 behavioral health patients transferred from emergency departments. Behavioral health services were put under this centralized model, which enables the Regional Patient Placement Office to facilitate the transfers from the emergency departments to the Banner Psychiatric Center in a timely manner and allows access to real-time updated lists of psychiatric bed availability within Banner Health and the community.

As a result, the Banner Psychiatric Center has treated more than 6,000 patients. Hold times in the hospital Emergency Departments decreased by more than 40 percent. Less than 50 percent of the patients who are brought to the Banner Psychiatric Center are later admitted to an inpatient unit. Before implementation of the center, that rate was 75 percent. This has freed up acute inpatient beds in local hospitals to be able to accept higher acuity patients who require that level of care.[27]

[27] Pat Little-Upah, MA; Chris Carson, MD; Robert Williamson, MD; Tom Williams, MC; Michael Cimino, MBA; Neena Mehta, MSN; Jeff Buehrle, MBA; Steve Kisiel. "The Banner Psychiatric Center: A Model for

RECOMMENDATION 2D: Implement a statewide response system to address behavioral health crisis situations which enables an effective collaboration between each county's law enforcement personnel and Mental Health Emergency Workers.

The Mental Health Emergency Worker (MHEW) program, implemented in 2006 on the Island of Oahu, consists of designated qualified mental health professionals who are contracted to provide consultation to law enforcement officers to assist in intervening in psychiatric crisis situations and diverting individuals with mental illnesses from the criminal justice system. The role of MHEWs are to assess the crisis situation via telephone to determine if the individual is suffering from a behavioral health illness and if they are a danger to themselves or others, in which case they authorize involuntary transport to a designated licensed psychiatric receiving facility (MH-1). The contract was recently expanded to provide these services statewide. In addition to law enforcement consultation, the MHEW program will assist in collaborating with law enforcement officers receiving Crisis Intervention Trainings (CIT) to include a basic understanding of mental illness and possible signs and symptoms a person may exhibit as a result of their illness in order to effectively determine when to call an MHEW. It is recommended, in addition to the continued support of the statewide MHEW program implementation, that an increased number of law enforcement personnel receive CIT to assist in handling behavioral health crisis situations. In 2018, Oahu's MHEWs received 3,657 calls in which 2,899 resulted in MH-1. The expansion of the services to cover the neighboring islands is expected to assist law enforcement personnel in effectively intervening in behavioral health crisis situations while being sensitive to each county's specific geographical and cultural needs. Support and collaboration from the justice system, EMS, public safety personnel, behavioral health system, and other related systems are needed to effectively implement the service statewide.

RECOMMENDATION 3D: Continued support for the Law Enforcement Assisted Diversion (LEAD), other Jail Diversion efforts and the Help Honolulu program.

The Law Enforcement Assisted Diversion Honolulu (LEAD HNL) program, overseen by Hawai'i Health and Harm Reduction Center in assistance with the University of Hawai'i at Manoa, is a community-based diversion program for people whose criminal activity is due to behavioral health issues. The goal of LEAD HNL is to reduce recidivism for minor

---

Providing Psychiatric Crisis Care to the Community while Easing Behavioral Health Holds in Emergency Departments" The Permanente Journal. 2013. Retrieved from **https://doi.org/10.7812/TPP/12-016**

offenses by referred clients in an effort to reduce the burden on the criminal justice system and improve clients' health and wellness. The program engages clients in social services aimed at addressing housing, substance use, behavioral health, and health issues. After one year of implementation, the program saw 55 percent fewer cited encounters with law enforcement after referral to the program, a decrease in time spent unsheltered by 38 percent, and a decrease of 18 percent of methamphetamine use for those who self-reported use.[28]

Another program aimed at jail diversion is the Health, Efficiency, and Long-term Partnerships (H.E.L.P. Honolulu) program. This is a new unit within the Honolulu Police Department that teaches plainclothes officers how to interact with individuals who are homeless so they are more apt to accept help. Basic information about interactions with the individuals can be accessed by officers in order to assist them if they come into contact with that individual in the future.

Continued support for these programs are necessary to prevent individuals with behavioral health illnesses from entering the justice system. Additionally, jail diversion programs support a recovery based model in which individuals with behavioral health illnesses, including substance use disorders, are able to receive necessary treatment and successfully transition back into the community.

RECOMMENDATION 4D: Consider re-working the Hawai'i State Hospital master plan to include continued utilization of the Guensberg facility and repurposed use of the Bishop building.

The current Hawai'i State Hospital (HSH) master plan includes the closure of the Guensberg facility which currently houses 90 psychiatric beds. Instead, a new facility with 144 psychiatric beds is being constructed which will yield a total of 54 additional psychiatric beds. The task force recommends considering re-working the HSH master plan in order to continue utilizing the 90 beds in the Guensberg facility to yield, in total, 144 new beds. It is also suggested that the use of the Bishop building on the HSH campus be reconsidered in order expand transitional beds for individuals leaving high acuity care at the HSH who are transitioning into the community. Additional funding may be required to repair and update older facilities on the Campus.

[28] "Law Enforcement Assisted Diversion Honolulu 1 -Year Program Evaluation Report". 2019. Retrieved from https://homelessness.Hawai'i.gov/wp-content/uploads/2019/10/191030-LEAD-Honolulu-Evaluation-FINAL-USE-THIS-ONE-2.pdf

Current Initiatives Relating to Finding D

- Mental Health Emergency Worker (MHEW) program - Designated qualified mental health professionals who provide consultation services to law enforcement and public safety personnel which assist in intervening in behavioral health crisis situations as well as authorizing MH-1 and involuntary transport to a designated licensed psychiatric facility.
- Crisis Intervention Training (CIT) - A training that assists law enforcement in recognizing and appropriately managing a mental health problem. The training is available to a variety of jail diversion programs, re-entry programs, and provides education and support to individuals and families at risk of involvement with the justice system.
- Law Enforcement Assisted Diversion Honolulu program (LEAD HNL) - A community-based diversion program for people whose criminal activity is due to behavioral health issues.
- H.E.L.P Honolulu - Health, Efficiency, and Long-term Partnerships (H.E.L.P. Honolulu) is a new unit within HPD that teaches plainclothes officers how to interact with individuals who are homeless so they are more apt to accepting help. Information about the individuals can be accessed by officers in order to assist them if they come into contact with that individual in the future.

Next Steps

The combined task force has reviewed several behavioral health systems, policies, and other related systems in order to compile a set of findings and recommendations for the Legislature. These recommendations will effectively address gaps within our State's care continuum as well as maximize the utilization of existing systems and current initiatives.

The task force is deeply committed to building a system of care which is rooted and grounded in the recovery model and is responsive to the needs of the community. While there are critical gaps within our continuum of care, various components of the continuum exist within our State already. In order to operationalize the most comprehensive continuum of care, it is essential that we encourage and continue collaboration and coordination both within behavioral health systems and between behavioral health, public safety, judiciary, and other related systems.

Several initiatives are currently in place or in the process of implementation that will address many of the gaps found within the continuum. Moreover, existing contracts that have proven effective on the island of Oahu are being extended to provide services on the neighboring islands. It is necessary that we continue to coalesce the presently fragmented behavioral health services so that we can more effectively rehabilitate those in the community with behavioral healthcare needs.

Going forward, it will be important to maintain the momentum of these current efforts through documentation of progress and effectiveness as well as through adjusting objectives as needed. We ask for continued support for our current initiatives and existing systems, as well as a commitment of ongoing evaluation of our behavioral healthcare and related systems so that we can continue to build a continuum that is more accessible along a cohesive and coordinated system of care. It is recommended that the combined task force continue its efforts into 2020 to continue evaluating the current laws, systems, and policies relating to involuntary hospitalization and health systems.

References

1. Rabah Kamal et al. Journal of the American Medical Association. Costs and Outcomes of Mental Health and Substance Use Disorders in the U.S. 2017; 318 (5):415
2. NAMI. “Mental Health by the Numbers.” Retrieved from https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
3. Henry, Meghan, Anna Mahathey, Tyler Morrill, Anna Robertson, Azim Shivji, and Rian Watt. “The 2018 Annual Homeless Assessment Report (AHAR) to Congress.” The U.S. Department of Housing and Urban Development Office Of Community Planning And Development. 2018. Retrieved from https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf.
4. Alcohol and Drug Abuse Division. Report to the Twenty-Ninth Legislature, State of Hawai'i. Kapolei, HI: Department of Health. 2016
5. U.S. Sentencing Commission, 2015 Datafile, USSCFY15. Retrieved from https://www.ussc.gov/sites/default/files/.pdf/research-and-publication/federal-sentencing-statistis/state-distric-circuit/2015/hi15.pdf
6. Partners in Care “Point In Time Count, Oahu” 2019. Retrieved from https://www.partnersincareoahu.org/sites/default/files/PIC%202019%20Oahu%20PIT%20Count%20Report%20-%20FINAL_0.pdf
7. Hawai'i Revised Statutes §§334-59 - 334-62
8. AMHD. “AMHD and MH1 Program Update May 2018” 2018.
9. Mulligan K. ER docs report large increase in psychiatric patients. Psychiatr News, 2004.
10. Snook, John, and E. Fuller Torrey. “America Badly Needs More Psychiatric Treatment Beds.” Treatment Advocacy Center. National Review, 2018.
11. Treatment Advocacy Center. “Psychiatric Bed Shortages.” Treatment Advocacy Center, 2018. Retrieved from https://www.treatmentadvocacycenter.org/key-issues/bed-shortages
12. Pat Little-Upah, MA; Chris Carson, MD; Robert Williamson, MD; Tom Williams, MC; Michael Cimino, MBA; Neena Mehta, MSN; Jeff Buehrle, MBA; Steve Kisiel. “The Banner Psychiatric Center: A Model for Providing Psychiatric Crisis Care to the Community while Easing Behavioral Health Holds in Emergency Departments” The Permanente Journal. 2013. Retrieved from **https://doi.org/10.7812/TPP/12-016**
13. Oahu Coordinated Entry System. “High Utilizer/ Super Utilizer - ER Visits/ Hospital Stays Data from August to October 2017.” 2017.
14. NAMI. “Jailing People With Mental Illness.” NAMI, 2019. Retrieved from https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness
15. Snook, John, and E. Fuller Torrey. “America Badly Needs More Psychiatric Treatment Beds.” Treatment Advocacy Center. National Review, 2018.
16. Doran, Kelly M., Kyle T. Ragins, Andrea L. Iacomacci, Alison Cunningham, Karen J. Jubanyik, and Grace Y. Jenq. "The revolving hospital door: hospital readmissions among patients who are homeless." *Medical care* 51, no. 9 (2013): 767-773.
17. Hawai'i Revised Statutes §§334-59
18. Dhcs.ca.gov. (2016). *What is HIPAA*. Retrieved from: http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/1.00WhatisHIPAA.aspx
19. Milken Institute School of Public Health. “Health Information and the Law: 42 CFR Part 2.” Health Information and The Law Project. 2019. Retrieved from http://www.healthinfolaw.org/federal-law/42-cfr-part-2
20. Hawai'i Revised Statute Chapter 334 §§121-134
21. Hawai'i Revised Statute Chapter 327G
22. American Association of Community Psychiatrists. levels of Care Utilization System for Psychiatric and Addiction Services Adult Version 2010”, 2009. Retrieved from https://cchealth.org/mentalhealth/pdf/LOCUS.pdf
23. “Hawai'i Homeless Healthcare Hui.” Retrieved from http://www.h4Hawai'i.org/

24. Kampman, Kyle, and Margaret Jarvis. "American Society of Addiction Medicine (ASAM) national practice guideline for the use of medications in the treatment of addiction involving opioid use." *Journal of addiction medicine* 9, no. 5 (2015): 358.
25. SAMHSA. “Behavioral Health Barometer”. 2015. Retrived from https://www.samhsa.gov/data/sites/default/files/2015_Hawai'i_BHBarometer.pdf
26. NAMI. “Jailing People With Mental Illness.” NAMI, 2019. Retrieved from https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness
27. NAMI. “Jailing People With Mental Illness.” NAMI, 2019. Retrieved from https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness
28. Broner, Nahama, Pamela K. Lattimore, Alexander J. Cowell, and William E. Schlenger. "Effects of diversion on adults with co-occurring mental illness and substance use: Outcomes from a national multi-site study." *Behavioral Sciences & the Law* 22, no. 4 (2004): 519-541
29. Pat Little-Upah, MA; Chris Carson, MD; Robert Williamson, MD; Tom Williams, MC; Michael Cimino, MBA; Neena Mehta, MSN; Jeff Buehrle, MBA; Steve Kisiel. “The Banner Psychiatric Center: A Model for Providing Psychiatric Crisis Care to the Community while Easing Behavioral Health Holds in Emergency Departments” The Permanente Journal. 2013. Retrieved from **https://doi.org/10.7812/TPP/12-016**
30. “Law Enforcement Assisted Diversion Honolulu 1 -Year Program Evaluation Report”. 2019. Retrieved from https://homelessness.Hawai'i.gov/wp-content/uploads/2019/10/191030-LEAD-Honolulu-Evaluation-FINAL-USE-THIS-ONE-2.pdf

APPENDIX A:

DESIGNATED TASK FORCE MEMBERS PURSUANT TO ACT 90 & ACT 263

- Arcena, Paula – AlohaCare
- Baker, Rosalyn (Senator) - Hawai'i Opioid Initiative, Executive Steering Committee
- Bazin, Patti - Hawai'i Medical Service Association
- Chang, Jason - Queen's Health System
- Cunningham, Brian - Wahiawa General Hospital
- Esslinger, Laura - AlohaCare
- Ferreira, Paul (Chief) - Hawai'i Island Police Department
- Friend, Renee - Maui Health Systems
- Fujiwara, David, MD - Kaiser Permanente
- Garcia, Lyndsey – Hawai'i Medical Service Association
- Gonce, Randy - Hawai'i Interagency Council on Homelessness
- Green, Rod (Captain) - Kauai Police Department
- Haning, William, MD - University of Hawai'i, JABSOM
- Hayashida, Colin - Department of Commerce and Consumer Affairs, Insurance Division
- Hughey, Nicholas - Waianae Coast Comprehensive Center
- Johnson, Alan - Hawai'i Substance Abuse Coalition
- Kajimura, Tricia - Mental Health America of Hawai'i
- Lambert, Mike (Lieutenant) - Honolulu Police Department
- Lusk, Heather - Hawai'i Health and Harm Reduction Center
- Medeiros, Dyan (Judge) - Judiciary
- Mersereau, Edward, Chairperson - Deputy Director, Behavioral Health Administration (DOH)
- Mitchell, Constance - Institute for Human Services
- Mizuno, John (Representative) – Hawai'i Opioid Initiative, Executive Steering Committee
- Mohr-Peterson, Judy - Department of Human Services
- Pontanilla, Jan (Sergeant) – Maui Police Department
- Prince, Merry - Maui Police Department
- Raethel, Kathy - Adventist Health Castle
- Raethel, Hilton - Healthcare Association of Hawai'i
- Robinson, Michael - Hawai'i Pacific Health
- Rosen, Linda, MD - Hawai'i Health Systems Corporation
- Segawa, Lance - Hawai'i Health Systems Corporation – Kauai Region
- Sivik, Scott - Ohana Health Plan
- Sonobe-Hong, Renee - Department of Public Safety
- Yoo, Kristine (Judge) - Judiciary

APPENDIX B:
OTHER TASK FORCE PARTICIPANTS

1. Anderson, Erik – Adventist Health Castle
2. Apter, George – Kaiser Permanente
3. Armitage, Andrea – Department of the Attorney General
4. Ashlock, Ryan – Adventist Health Castle
5. Champion, Michael, MD – Department of Health
6. Ching, Jonathan – Kaiser Permanente
7. Clemente, Mark – Senator Gil Riviere's Office
8. Cravalho, Andreas – AlohaCare
9. Cunningham, Brian – Wahiawa General Hospital
10. Curtis, Amy – Department of Health
11. Erteschik, Louis – Hawai'i Disability Rights Center
12. Espinda, Malia – Hawai'i Health Systems Corporation
13. Esslinger, Laura – AlohaCare
14. Faige, Jessie – Senator Karl Rhoads Office
15. Garrett, Colleen – Healthcare Association of Hawai'i
16. Gass, Mestisa – Mental Health American Hawai'i
17. Gonzales, Violeta – Leahi Hospital
18. Grambs, Marya – Partners in Care
19. Green, Josh (Lt. Governor) – Office of the Lieutenant Governor
20. Hardie, Lydia – Hawai'i Disability Rights Center
21. Hiraoka, Debbie – SH Consulting LLC
22. Ige, Arlene – Department of Commerce and Consumer Affairs – Insurance Division
23. Ishikawa, Nandi – Hawai'i Health and Harm Reduction Center)
24. Kim, Duk Whan – Hawai'i Cedar Church
25. Kohrer, Tammy – Wahiawa General Hospital
26. Leiggi-Brandon, Sondra – The Queen's Health System
27. Luke, Kenneth – Ohana Health Plan
28. Manding, Allysen – Senator Rosalyn Baker's Office
29. Markeley, Maryellen
30. Masunaga, Colette – The Queen's Health System
31. Merriam, Kathleen – Department of Health
32. Mitchell, Mark – Institute on Violence, Abuse and Trauma
33. Ocsow, Margarete – Senator Gil Riviere's Office
34. Ogawa, Quin – Kahi Mohala
35. Rhoads, Karl (Senator) – Hawai'i State Legislature
36. Riviere, Gil (Senator) – Hawai'i State Legislature
37. Robertson, Ian – Department of Commerce and Consumer Affair – Insurance Division
38. Rodriguez, Alicia – Honolulu Police Department
39. Sanada, Sean – Hawai'i Health Systems Corporation
40. Schultz, Taylor – Department of Health
41. Tanigan, Courtney – Hawai'i Health and Harm Reduction Center
42. Torres, Juanito – Hawai'i Medical Services Association
43. Wilkinson, Rachel – Ohana Health Plan
44. Won, Tricia – Maluhia Hospital

APPENDIX C:
TASK FORCE MEMBERS BY FOCUSED WORKGROUPS

Criteria for Involuntary Hospitalization

1. **Dr. William Haning** – UH, JABSOM (Co-Chairperson)
2. **Lt. Governor Josh Green** – Office of the Lieutenant Governor (Co-Chairperson)
3. **Heather Lusk** – Hawai'i Health and Harm Reduction Center
4. **Dr. Linda Rosen** – Hawai'i Health Systems Corporation
5. **Malia Espinda** – Hawai'i Health Systems Corporation
6. **Cheryl Tennberg** – Hawai'i Health Systems Corporation
7. **Jonathan Ching** – Kaiser Permanente
8. **George Apter** - Kaiser Permanente
9. **Frank Richardson** – Kaiser Permanente
10. **Dr. Tina Melendrez-Chu** – Kaiser Permanente – Kauai Region
11. **Diane Lee** – Kaiser Permanente
12. **Dr. David Fujiwara** – Kaiser Permanente
13. **Dr. James Ford** – Kaiser Permanente
14. **Tricia Won** – Maluhia Hospital
15. **Renee Friend** – Maui Memorial Medical Center
16. **Jessie Faige** – Office of Senator Rhoads
17. **Marya Grambs** – Partners in Care
18. **Jennifer Wong** – Judiciary
19. **Kathleen Merriam** – Department of Health
20. **Louis Erteschik** – Hawai'i Disability Rights Center
21. **Andrea Armitage** – Department of the Attorney General
22. **Dr. Michael Champion** – Department of Health

Data Gathering

1. **Eddie Mersereau** – Department of Health (Chairperson)
2. **Dr. Amy Curtis** – Department of Health
3. **Dr. Linda Rosen** – Hawai'i Health Systems Corporation
4. **Malia Espinda** – Hawai'i Health Systems Corporation
5. **Connie Mitchell** – Institute for Human Services
6. **Jonathan Ching** – Kaiser Permanente
7. **Rowena Fuata** – Kaiser Permanente
8. **Andy Mounthongdy** – The Queen's Health Systems
9. **Francis Chan** – Hawai'i Health Information Exchange
10. **Mark Mitchell** – Institute on Violence, Abuse and Trauma
11. **Todd Morgan** – AlohaCare
12. **Ryan Ashlock** – Adventist Castle
13. **Dr. James Lin** – Hawai'i Pacific Health
14. **Thaddeus Pham** – DOH / Hawai'i Opioid

Post-Stabilization Community Support

1. **Hilton Raethel** – Healthcare Association of Hawai'i (Chairperson)
2. **Steven Balcom** – AlohaCare
3. **Janelle Saucedo** – Department of Health
4. **Colleen Garrett** – Healthcare Association of Hawai'i
5. **Paige Heckathorn Choy** – Healthcare Association of Hawai'i
6. **Heather Lusk** – Hawai'i Health and Harm Reduction Center
7. **Malia Espinda** – Hawai'i Health Systems Corporation
8. **Sean Sanada** – Hawai'i Health Systems Corporation
9. **Derek Akiyoshi** – Hawai'i Health Systems Corporation
10. **Lyndsey Garcia** – Hawai'i Medical Service Association
11. **Patti Bazin** – Hawai'i Medical Service Association
12. **Michael Robinson** – Hawai'i Pacific Health
13. **Alan Johnson** – Hawai'i Substance Abuse Coalition/ Hina Mauka)
14. **Connie Mitchell** – Institute for Human Services
15. **Jonathan Ching** – Kaiser Permanente
16. **Dr. Tina Melendrez-Chu** – Kaiser Permanente
17. **Diane Lee** – Kaiser Permanente
18. **Haley Hsieh** – Laulima Data Alliance
19. **Violeta Gonzales** – Leahi Hospital
20. **Renee Friend** – Maui Memorial Medical Center
21. **Trisha Kajimura** – Mental Health America of Hawai'i
22. **Dr. Scott Miscovich** – Physician
23. **Colette Masunaga** – Queens Health System
24. **Debbie Hiraoka** – SH Consulting
25. **Judy Suzuki** – Straub Medical Center
26. **Jean Roberts** – Straub Medical Center
27. **Dr. John Myhre** – Waianae Coast Comprehensive Center

Funding and Eligibility

1. **Alan Johnson** - Hawai'i Substance Abuse Coalition (Co-chairperson)
2. **Laura Esslinger** - AlohaCare (Co-chairperson)
3. **Cheryl Tennberg** – Hawai'i Health **Systems Corporation** – Kauai Region
4. **Malia Espinda** – Hawai'i Health Systems Corporation
5. **Michael Hamamoto** – Hawai'i Health Systems Corporation – Oahu Region
6. **Lyndsey Garcia** – Hawai'i Medical Service Association
7. **Patti Bazin** – Hawai'i Medical Service Association
8. **Jonathan Ching** – Kaiser Permanente
9. **Dr. Kelley Yim** – Kaiser Permanente
10. **George Apter** – Kaiser Permanente
11. **Frank Richardson** – Kaiser Permanente
12. **Renee Friend** – Maui Memorial Medical Center
13. **Kenneth Luke** – Ohana Health Plan
14. **Marya Grambs** – Partners in Care

MH-1 Statute Review

1. **Dr. Rick Bruno** – The Queen's Health Systems (Chairperson)
2. **Sondra Leiggi-Brandon** – The Queen's Health Systems (Co-chairperson)
3. **Ryan Ashlock** – Adventist Health Castle
4. **Erik Anderson** – Adventist Health Castle
5. **Steven Balcom** – AlohaCare
6. **Andrea Armitage** – Department of the Attorney General
7. **Dr. Michael Champion** – Department of Health
8. **Dr. Mary Eckert** – Department of Psychiatry, UH Manoa
9. **Dean Nakano** – Emergency Medical Services
10. **James Howe (Jim)** – Emergency Medical Services
11. **Korey Chock** – Emergency Medical Services
12. **Dr. Linda Rosen** – Hawai'i Health Systems Corporation
13. **Malia Espinda** – Hawai'i Health Systems Corporation
14. **Michael Robinson** – Hawai'i Pacific Health
15. **James O'Connor** – Hawai'i Police Department
16. **Alicia Rodriguez**, Psy.D. – Honolulu Police Department
17. **Dr. David Fujiwara** – Kaiser Permanente
18. **Dr. Kelley Yim** – Kaiser Permanente
19. **Sam Balukoff** – Kaiser Permanente
20. **Renee Friend** – Maui Memorial Medical Center**Jan Pontanilla** – Maui Police Department
21. **Merry Greer Prince** – Maui Police Department
22. **Jessie Faige** – Office of Senator Rhoads
23. **Dr. Nathan Angle** – Straub Medical Center
24. **Dr. Nate Arnone** – Straub Medical Center
25. **Brian Cunningham** – Wahiawa General hospital
26. **Tammy Kohrer** – Wahiawa General Hospital
27. **Nicholas Hughey** – Waianae Coast Comprehensive Health Center

APPENDIX D:
Additional Resources

Current Related Initiatives

Hawai'i CARES: https://health.Hawai'i.gov/amhd/files/2013/06/AMHCD-Short-Form1.pdf
Referral Line: (808) 832-3100 (Neighbor Island residents, call toll free 1-800-753-6879).

Hawai'i Homeless Healthcare Hui (H4) Center: http://www.h4Hawai'i.org/

Hawai'i Homeless Outreach and Medical Education (HOME) Program:
https://Hawai'ihomeproject.org/clinic-schedule/

Hawai'i Opioid Initiative

- Website: https://Hawai'iopioid.org/
- HOI Report:
  https://health.Hawai'i.gov/substance-abuse/files/2019/01/The-Hawai'i-Opioid-Initiative_2.pdf

Law Enforcement Assisted Diversion (LEAD) Report:
https://homelessness.Hawai'i.gov/wp-content/uploads/2019/10/191030-LEAD-Honolulu-Evaluation-FINAL-USE-THIS-ONE-2.pdf

Mental Health Statutes

Hawai'i Revised Statutes Chapter 334 (General):
https://www.capitol.Hawai'i.gov/hrscurrent/Vol06_Ch0321-0344/HRS0334/HRS_0334-.htm

Assisted Community Treatment Criteria (Hawai'i Revised Statutes Chapter 334, Part VIII):
https://www.capitol.Hawai'i.gov/hrscurrent/Vol06_Ch0321-0344/HRS0334/HRS_0334-0121.htm

Involuntary Hospitalization Criteria (Hawai'i Revised Statutes Chapter 334-59):
https://www.capitol.Hawai'i.gov/hrscurrent/Vol06_Ch0321-0344/HRS0334/HRS_0334-0059.htm

Psychiatric Advanced Directives (Hawai'i Revised Statutes Chapter 327G):
https://health.Hawai'i.gov/amhd/files/2013/06/AMHCD-Short-Form1.pdf
https://www.capitol.Hawai'i.gov/hrs/isysquery/186cded6-3c6e-46f8-a988-388ff118a9fe/1/doc/#hit1

Other Resources

Health Insurance Portability and Accountability Act of 1996
https://aspe.hhs.gov/report/health-insurance-portability-and-accountability-act-1996

42 Code of Federal Regulations Part 2 - CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS
https://www.law.cornell.edu/cfr/text/42/part-2