2008 Innovations Awards Program
APPLICATION

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ID # (assigned by CSG): 08-W-09HI

Please provide the following information, adding space as necessary:

State: __Hawaii____________________

Assign Program Category (applicant): Human Services________ (Use list at end of application)

1. Program Name
2. Administering Agency
3. Contact Person (Name and Title)
4. Address
5. Telephone Number
6. FAX Number
7. E-mail Address
8. Web site Address
9. Please provide a two-sentence description of the program.
10. How long has this program been operational (month and year)? Note: the program must be between 9 months and 5 years old on March 1, 2008 to be considered.
11. Why was the program created? What problem[s] or issue[s] was it designed to address?
12. Describe the specific activities and operations of the program in chronological order.
13. Why is the program a new and creative approach or method?
14. What were the program's start-up costs? (Provide details about specific purchases for this program, staffing needs and other financial expenditures, as well as existing materials, technology and staff already in place.)
15. What are the program's annual operational costs?
16. How is the program funded?
17. Did this program require the passage of legislation, executive order or regulations? If YES, please indicate the citation number.
18. What equipment, technology and software are used to operate and administer this program?
19. To the best of your knowledge, did this program originate in your state? If YES, please indicate the innovator's name, present address, telephone number and e-mail address.
20. Are you aware of similar programs in other states? If YES, which ones and how does this program differ?
21. Has the program been fully implemented? If NO, what actions remain to be taken?
22. Briefly evaluate (pro and con) the program's effectiveness in addressing the defined problem[s] or issue[s]. Provide tangible examples.
23. How has the program grown and/or changed since its inception?
24. What limitations or obstacles might other states expect to encounter if they attempt to adopt this program?

2008 Innovation Award: Hale Imua

1. Program name: Hale Imua (pronounced "HAH-lay ee-Moo-ah")

2. Administering Agency: Primarily the State of Hawaii's Adult Mental Health Division, with partnership from various private agencies outlined below

3. Contact person (Name and Title): Neil Gowensmith, Ph.D., Forensic Services Chief

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5. Telephone number: 808-832-1852 / 808-306-8096

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8. Web address: www.amhd.org (Department of Health's Adult Mental Health Division)
http://amhd.org/About/ClinicalOperations/Forensics/HaleImua.asp (Hale Imua)

9. Please provide a two-sentence description of the program.

Hale Imua is a successful 24-hour group home designed exclusively for severely and persistently mentally ill individuals who have continuing legal encumbrances. Participants, who would otherwise needlessly remain in locked hospital units, benefit from community housing and treatment as a result of several inter-agency collaborations that take the participant to the necessary community-based services.

10. How long has this program been operational (month and year)? Note: the program must be between 9 months and 5 years old on March 1, 2008 to be considered.

Hale Imua began its planning in Summer 2005 and admitted its first participant March, 2006.

11. Why was the program created? What problem[s] or issue[s] was it designed to address?

The state of Hawaii is faced with the challenge of providing high quality hospital-level services to a large population. The census at Hawaii State Hospital (HSH) is more than 90% forensic, meaning that the vast majority of admissions and discharges are controlled by the criminal court. However, community housing and treatment options have traditionally been limited for the forensic population in Hawaii. As a result, some patients have remained in HSH even after reaching maximum benefit of the hospitalization, simply because housing and treatment options were in short supply.

Hale Imua was created in response to this problem. Hale Imua is a 24-hour group home exclusively for a forensic population. In effect, Hale Imua fills a housing gap for a very specific forensic population that was otherwise "stuck" in the hospital. The population of Hale Imua is comprised of people on a post-acquittal conditional release. Most consumers have non-violent charges, drug and/or alcohol histories, and poor support systems. Some have violent charges, some are sex offenders, and some are characterologically disordered. In all cases, participants have little to no options for community placement other than Hale Imua.

12. Describe the specific activities and operations of the program in chronological order.

Information about the program and referral packets are sent to HSH and a hospital with AMHD-contracted beds. Treatment teams review caseloads and make initial referrals to Hale Imua. The packet is reviewed at a larger Hale Imua staff meeting, and follow-up information is gathered as needed (interviews, record reviews, etc.). Visits for the patient to Hale Imua can be conducted to let the patient see the program and housing first-hand. If the person is tentatively accepted into the program, a court hearing is conducted to determine whether or not a conditional release will be granted (a requirement for Hale Imua). If granted, a gradual transition is begun in which the participant visits Hale Imua more and more often over the course of a few weeks (as necessary). Once fully integrated into Hale Imua, the consumer is a full-time participant in all Hale Imua activities.

Typical days for Hale Imua participants include meals, group or individual therapy appointments, medication dispensation, clubhouse participation, vocational training, and other outings as approved. There is no chronological order for these program elements, however. The combination of elements is individually tailored to each participant.

Specifics regarding the process of referral, treatment, and discharge include:

- A description of the program is provided to a patient that meets the eligibility requirements for the program.
- Based on the patient's interest, a referral is made by the respective hospital (Hawaii State Hospital or Kahi Mohala).
- The program team reviews the referral packet and, if the patient is considered an appropriate referral, an interview is scheduled. When received, inappropriate referrals are communicated to the referring hospital by the Hale Imua team.
- Based on the interview, the patient is either approved, denied or deferred acceptance into the program. The referring agency communicates the decision to the patient.
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- If acceptance is deferred, the Hale Imua treatment team would recommend monitoring the candidate's engagement in community activities (e.g. Clubhouse participation, treatment group participation) before making a final decision.
- If the candidate is accepted, the transition begins:
    - Assign a Hale Imua case manager and psychiatrist
    - If candidate has an existing case manger in the community, communication between Hale Imua case manager occurs to maintain "continuity of care"
    - Hale Imua case manager attends candidate's monthly hospital Recovery Planning Review up until discharge from the hospital
    - Hale Imua case manager and hospital SW coordinate transition into the community (i.e., benefits, CRF funds, appropriate paperwork, etc.)
    - Hale Imua case manger provides candidate with orientation to Hale Imua (behavioral contracts reviewed, at times a tour of the house, assessing motivators for contingency management component of Hale Imua, etc.)
    - The patient ~~may~~ begins attending Clubhouse and other Hale Imua programming prior to his/her court date.
- By the time the court hearing requesting a conditional release occurs, the patient may have already had a fair amount of experience participating in the Clubhouse and/or Hale Imua programming.
- When the court grants the patient a conditional release, he/she is discharged from HSH.
- Upon discharge from hospital, Hale Imua case manager coordinates and assists move into Hale Imua housing (Steadfast 24 hour group home):
    - Moving in belongings

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- Introducing to housing staff
- Taking candidate to DHS appointment for benefits
- If needed, assisting in initial purchase of food, toiletries, etc.
- Scheduling appointment with MD within 7 days of discharge from hospital

- Hale Imua Consumer engages in Programming Components:
  - Treatment groups (wide variety of groups including IMSR, anger management, understanding the legal system, and many others)
  - medication monitoring (weekly is the initial interval, reassessed periodically to encourage independence in managing their own medications)
  - Individual therapy (if appropriate)
  - Steadfast Housing activities (chores etc.)
  - Clubhouse participation
- Participation is monitored through a contingency management program
  - Consumers earn rewards based on the level of participation in their individualized program
  - Consumers may determine the type of reward (i.e. gift cards, lunch, etc.)
  - Rewards are distributed weekly
- Medication evaluation
  - Attending MD provides monthly med evals or prn
  - Hale Imua RN assists in monitoring and continued education weekly
- Clinical Rounds
  - Treatment team (WOCMHC, Steadfast, Clubhouse) meets weekly initially
  - After one month, consumers are discussed bi-weekly
- Discharge Planning
  - Initiated during intake process
  - Continuous process throughout duration of treatment
  - Presented at clinical rounds
  - Transition planning and activities from Hale Imua to new living and treatment arrangements

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13. Why is the program a new and creative approach or method?

There are two main reasons. First, this is a program exclusively for difficult-to-place forensically encumbered individuals. All participants are on a post-acquittal Conditional Release (CR), meaning that they committed a crime, were found not guilty by reason of insanity, acquitted, and committed to HSH. After some period of time, the participants were determined to no longer need hospital level care. However, for several years no appropriate community services existed to manage these types of individuals. CR consumers were at times released to the community under various circumstances, but those discharges often resulted in poor outcomes (rehospitalization, recidivism, psychiatric decompensation, etc.). With the advent of Hale Imua, these individuals have a dedicated housing and treatment program that addresses their unique needs and provides an avenue out of the hospital. In short, instead of waiting for placement options to be created in the community, we created our own program to fill the gap.

Secondly, Hale Imua operates in a unique fashion. Assertive Community Treatment (ACT) services have been shown to be effective with many populations, including CR populations. Hale Imua is not an ACT service, but it utilizes the ACT principles in its operation. That is, several agencies are involved with Hale Imua. Case management, psychiatry, psychotherapy, and forensic oversight are provided by a state-operated community mental health center, psychosocial rehabilitation is provided by a nearby clubhouse, housing is provided by a private housing provider, and MI/SA services are provided by a local dual diagnosis rehab center. This model, incorporating

interagency agreements and functions, as well as both state-operated and private providers, is a first for Hawaii. The traditional ACT model brings services to the client. However, Hale Imua is not a licensed facility and so therefore cannot provide services on site. Therefore, instead of bringing services to the consumer, Hale Imua takes consumers to their services. We believe the intent of the ACT model is alive and well in Hale Imua, even if it doesn't fit the traditional definition of ACT.

In this way, we have responded to an issue related to a particularly difficult subsection of hospitalized consumers and, using a new paradigm for Hawaii, created a brand new program that is tailored to their unique needs and provides a mechanism for recovery and reentry into the community.

14. What were the program's start-up costs? (Provide details about specific purchases for this program, staffing needs and other financial expenditures, as well as existing materials, technology and staff already in place.)

Hale Imua was started without any additional dedicated funding or staff positions. It was created as an interagency agreement between state-operated and private providers. Case management, psychiatry, forensic oversight and psychotherapy all occur through the community mental health center (Windward CMHC). Windward CMHC is the primary hub for Hale Imua and oversees the mental health treatment and oversight over the program and its participants. Hale Imua participants are active consumers at Windward CMHC and therefore do not require any additional funding or staffing.

Psychosocial rehabilitation occurs at the nearby Ko'olau Clubhouse, which again requires no new staffing or materials.

Steadfast Housing is a private housing provider that contracts statewide housing options with the state of Hawaii. They manage, staff, and oversee the cottages at Hale Imua. Participants pay monthly rent for their rooms, with additional subsidies from state general funds and federal Medicaid reimbursement as well as Department of Health payment.

Hina Mauka provides the dual diagnosis treatment, and just as it does with other Department of Health consumers, has services subsidized by from state general funds and federal Medicaid reimbursement as well as Department of Health payment.

Materials and technology transfer were needed at start up to get the program off the ground. An advisory board was created and treating staff selected. Selected case managers, psychiatrists, therapists, housing staff, clubhouse staff, and MI/SA staff were trained to understand the unique issues and requirements of the CR consumer. Treatment services (therapeutic modules, groups, etc.) were created and copied. In short, very little was required in the way of funding, but instead the focus was on utilizing current resources and providing in-depth training to the staff that was detailed to the program.

Specific costs include:

- Preparing the homes for occupancy and furnishing them through state resources and donation cost approximately $12,000 per house.
- Labor for the preparation and furnishing of homes was provided by HSH workers (no outside contractors).
- While the housing is State-owned property, consumers have rights of tenancy and the homes are managed by a private non-profit (Steadfast Housing Corporation).
- Steadfast Housing Corporation needed to project spending $200,000 for staffing 6 people to staff the houses and one resident manager for each 2 houses. Rent paid by residents offsets some of the staffing costs.
- Existing WCMHC staff were re-assigned to initiate Hale Imua program.
- Additional expenses included contingency management funds ($1,500 per month) and UA kits (approximately $2,000).

15. What are the program's annual operational costs?

- Staff have since been added to the program (Coordinator position is $60,000, 3 Case Management Specialist positions at $43,000 each, 1 Peer Specialist at $28,000 plus fringe benefits (38%).
- Office supplies (unknown)

16. How is the program funded?

State general funds and Federal Medicaid funds.

17. Did this program require the passage of legislation, executive order or regulations? If YES, please indicate the citation number.

No. However, the program was recognized as a standout program in Hawaii by the taskforce convened under Hawaii Senate Concurrent Resolution 117, 2007.

18. What equipment, technology and software are used to operate and administer this program?

Very little. A basic spreadsheet program is used to track and monitor progress of the individual participants, as well as collect and analyze program outcome data.

19. To the best of your knowledge, did this program originate in your state? If YES, please indicate the innovator's name, present address, telephone number and e-mail address.

Yes. Two people are primarily responsible for the development of Hale Imua:

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20. Are you aware of similar programs in other states? If YES, which ones and how does this program differ?

Not aware of similar programs in other states.

21. Has the program been fully implemented? If NO, what actions remain to be taken?

Hale Imua is fully implemented and is nearing its two-year anniversary. All of the 24 beds are currently filled.

22. Briefly evaluate (pro and con) the program's effectiveness in addressing the defined problem[s] or issue[s]. Provide tangible examples.

Hale Imua admitted its first participant in March of 2006. The first six months of Hale Imua showed an above-average amount of rehospitalizations and elopements. A root cause analysis was conducted, with the following findings:

• Inappropriate referrals to Hale Imua (essentially anyone granted CR from HSH was granted eligibility into Hale Imua)
• Not enough focus on MI/SA issues
• Participants at Hale Imua had low insight and motivation, but the majority of treatment services required high levels of insight and motivation
• No transition plan for the move from hospitalization to community placement
• Not enough medication management

Essentially, in the beginning, Hale Imua was simply "too much, too fast" for many participants.

After this root cause analysis, several aspects of the program were altered. Changes included:
• a more sophisticated referral and screening process (focusing on participants with appropriate levels of insight and motivation)
• improved focus on MI/SA issues, including increased partnership with Hina Mauka substance abuse rehabilitation facility
• implementation of a contingency management program to appropriately address participants with lower levels of insight or motivation
• an option for gradually transitioning potential participants from the HSH into Hale Imua
• increased nursing coverage.

Since that time, Hale Imua has shown a marked change in its effectiveness. All outcome measures show significant progress. Several indicators point to the success of Hale Imua at its two-year anniversary:
• Elopements are down more than 85% from the first 6 months
• Successful discharges (graduations and transitions to other community placements) are up approximately 90% from the first 6 months
• Long-term rehospitalizations are down from 2 in the first year to zero in the past six months
• Arrest rates for Hale Imua participants are 10-20% lower than the arrest rates for other consumers on conditional release
• Financial savings to the state surpassed more than $4 million during the past two years

23. <u>How has the program grown and/or changed since its inception</u>

Hale Imua's primary role has always been to serve as an outlet for difficult-to-place forensic hospital patients. However, at times Hale Imua has not operated at capacity and therefore has been able to offer a smaller 4-bed cottage to serve as a crisis stabilization program for consumers at risk of losing their CR in the community. The 4-bed cottage offers increased stability, structure, and supervision for those individuals that are violating the terms and conditions of their CRs and who are likely to be returned to the HSH if not stabilized. Hale Imua integrates these consumers into much of the regular Hale Imua program, and offers contact and support from other residents. Approximately 10 consumers have been involved with this special program at Hale Imua. Most of these individuals were successfully diverted from hospitalization, though a few did require transfer to HSH. As hospital referrals have again increased, however, the 4-bed cottage has returned to the primary function of offering longer-term housing to current HSH patients.

24. <u>What limitations or obstacles might other states expect to encounter if they attempt to adopt this program?</u>

Other states should be mindful of the lessons learned from our early experience with Hale Imua, as illustrated above. In retrospect, Hale Imua was implemented more quickly than it was ready for, and some of the referral and eligibility criteria were ill-formed at the inception of the program. Nursing coverage and presence has also been important in order to stem medication non-compliance. Personal visits and knowledge of the program by court personnel, court examiners, and hospital staff

has been instrumental in obtaining referrals. Finally, great care was taken to make Hale Imua a pleasant, clean, and safe place for consumers. It is truly a remarkable place to live, and the biggest problem now is handling too many referrals for too few beds.

Subsequently, overall states should expect to encounter great success with the program and buy-in from hospitals, courts, and consumers alike.