OVERVIEW

Audit of the Adult Mental Health Program

Report No. 01-13, July 2001

Summary

The Adult Mental Health Division of the Department of Health is responsible for coordinating and administering a comprehensive integrated mental health system for individuals 18 years of age and older. Significant state and federal resources are dedicated to provide an array of mental health services at the Hawaii State Hospital, state operated community mental health centers, and private provider sites. These resources increased from approximately $50 million during FY1998-99 to nearly $70 million during FY2000-01.

We assessed whether the division adequately planned for the treatment of patients in the least restrictive and most therapeutic environment. We concluded that the division disregarded long-range planning and instead sought "quick fixes" to resolve outstanding federal court orders stemming from a 1991 settlement agreement that sought to remedy alleged deficiencies in confinement, care, and treatment of patients at the Hawaii State Hospital.

Furthermore, the division requested and spent millions of dollars to transition the state hospital to a psychosocial rehabilitation center through expanded community-based services without first formally identifying needs and developing the necessary infrastructure to support those needs. Consequently, key leadership positions were not formally established, and new positions that were to facilitate the transition remained unfilled. As of November 2000, 66 positions equal to approximately $4 million in salary costs remained unfilled.

Our review of hospital operations found that further improvements are needed to ensure patients are adequately protected from harm and provided with sufficient treatment. We reviewed the performance appraisals of 83 direct care staff and found that 70 percent were completed anywhere from one day to nine months prematurely. We also reviewed the training records of 74 direct care staff and found that approximately 20 percent of these staff did not complete mandated training in specific areas including patient safety and treatment planning. This is cause for concern because the federal court has targeted training in these areas as needing improvement.

We found patient safety is compromised by staff's failure to follow hospital procedures when secluding and restraining patients. We reviewed 20 episodes of seclusion and/or restraint and found that staff failed to follow hospital procedures in 15 percent of these cases. The hospital also needs to direct its attention toward improving the treatment planning of patients. Seven of 12 initial treatment plans we reviewed were incomplete, and in one case failed to identify a patient's safety risk for suicide and violence toward others. Furthermore, we found that half of the patients in our sample were not meaningfully engaged in the formulation of their treatment goals and preferences, although the hospital recognizes that patient

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involvement facilitates the likelihood for successful treatment. We also found that treatment teams did not routinely identify treatment alternatives for patients who failed to make progress toward their treatment goals.

Our review of the hospital operations also indicates that management controls for overtime, leave, and inventories continue to need improvement in order to protect state resources from misuse and waste. We found inaccurate overtime payments made to 17 percent of the staff in our sample. Of further concern, a former hospital administrator circumvented the civil service system when he allowed staff serving in the newly created unit manager positions to seek overtime to increase their base salaries. Two unit managers were paid a combined total of approximately $30,000 in overtime during FY1999-2000 without any assurance that they actually worked the overtime they reported. In fact, one unit manager acknowledged that he submitted inaccurate overtime claims upon the request of hospital management.

We also found that inadequate oversight of sick and vacation leave allow staff to misuse leave. Patterns of potential sick leave abuse are not investigated, and staff are allowed to use sick leave for unallowable purposes. Furthermore, employees on unauthorized leave are not charged leave without pay as required by the Hawaii Administrative Rules and as permitted by collective bargaining provisions.

The hospital can further improve its oversight of resources by standardizing inventory controls, and developing controls to discourage the use of gasoline credit cards for personal use.

Recommendations and Response

We recommended that the director of health adequately plan for the provision of adult mental health services. We also recommended that the Adult Mental Health Division chief ensure that patients confined at the Hawaii State Hospital be adequately and reasonably protected from harm and provided with sufficient treatment. Specifically, we recommended that the division chief ensure that treatment planning for patients confined at the Hawaii State Hospital be improved. We also recommended that the hospital administrator improve controls at the hospital to prevent the abuse of overtime and leave, and the loss of inventory.

The department disagrees that it failed to engage in long-range planning and that it failed to identify patient needs prior to requesting and receiving millions in funding. The department reports that it has already addressed some of our audit recommendations and that it is concerned about the impression of the lack of appropriate management controls at the hospital. The department responded that it has made many changes in policy and procedures that address the issues identified in our audit.

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