
Audit of the Adult Mental Health Program

A Report to the
Governor
and the
Legislature of
the State of
Hawaii

Report No. 01-13
July 2001



THE AUDITOR
STATE OF HAWAII

Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.
2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.
3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.
4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.
5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.
6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds are existing funds meet legislative criteria.
7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.
8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.
9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawaii's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.



THE AUDITOR STATE OF HAWAII

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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



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 FY 1999-2000 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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Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 01-13
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Foreword

This audit of the Department of Health's adult mental health program was conducted pursuant to House Concurrent Resolution No. 111, H.D. 1, S.D. 1, of the 2000 legislative session. Our audit focused on the Adult Mental Health Division's planning efforts and operations at the Hawaii State Hospital.

We wish to express our appreciation for the cooperation and assistance extended to us by the officials and staff of the Department of Health.

Marion M. Higa
State Auditor

Table of Contents

Chapter 1 Introduction

Background	1
Objectives of the Audit	8
Scope and Methodology	8

Chapter 2 The Adult Mental Health Division Needs To Improve Its Management of the Mental Health System

Summary of Findings	9
The Adult Mental Health Division Has Not Provided Sufficient Direction to Ensure the Provision of Adequate Mental Health Services	10
Further Improvements Are Needed to Ensure Patients Are Adequately Protected from Harm and Provided with Sufficient Treatment	18
The Hospital's Overtime, Leave, and Inventory Controls Still Need Improvement	28
Conclusion	34
Recommendations	34

Response of the Affected Agency	39
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List of Exhibits

Exhibit 1.1	Organizational Chart of the Adult Mental Health Division	3
Exhibit 1.2	Adult Mental Health Division \$23 Million Supplemental Funding Request for FY2000-01	7
Exhibit 2.1	Actual and Proposed Hawaii State Hospital Patient Census and Nurse Staff	22

Chapter 1

Introduction

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. The Legislature appropriates significant resources to enable the department to meet this purpose. However, the Legislature was concerned when it was asked to authorize millions of dollars in additional funding without any assurance that the department had adequately planned to address legal requirements stemming from a 1991 settlement agreement between the State and the U.S. Department of Justice. The settlement agreement and subsequent court orders mandated that deficiencies be corrected at the Hawaii State Hospital.

To address this concern, the Legislature requested the State Auditor to conduct a program and financial audit of the Adult Mental Health Division through House Concurrent Resolution No. 111, H.D. 1, S.D. 1, of the 2000 legislative session. The resolution specifies that the audit include a review of the state hospital's operations, the department's plans for complying with court orders applicable to the hospital, the availability of community-based services for the severely mentally ill, and legislative appropriations.

Background

The Adult Mental Health Division provides an array of services to adults with mental illnesses. State and federal resources that support both inpatient and outpatient services have increased from approximately \$50 million during FY1998-99 to nearly \$70 million during FY2000-01. In the past, the division dedicated approximately 60 percent of its funding for the operation of the Hawaii State Hospital. However, the division decreased the hospital's budget by an estimated \$3 million while increasing funding for outpatient services by approximately \$20 million for FY2000-01.

This shift in funding occurred as the division sought to downsize the hospital. Consequently, patients discharged from the hospital were expected to increase the demand for community-based services, which provide these patients with appropriate care.

The Adult Mental Health Division is responsible for administering a comprehensive mental health system

The Adult Mental Health Division provides comprehensive mental health services to individuals with serious mental disorders, persons suffering from acute or severe mental health crisis, and those experiencing distress and trauma from a declared disaster. Services include therapy, case management, drug treatment, biopsychosocial rehabilitation, job training, medication management, residential shelter, and emergency/crisis intervention.

The division is responsible for coordinating services provided by the Hawaii State Hospital, state operated community mental health centers, and private providers. Chapter 334, Hawaii Revised Statutes (HRS), requires case managers to coordinate cooperation among various elements of the mental health system.

The division also provides evaluation and consultation services to the state's court system.

Organizational structure

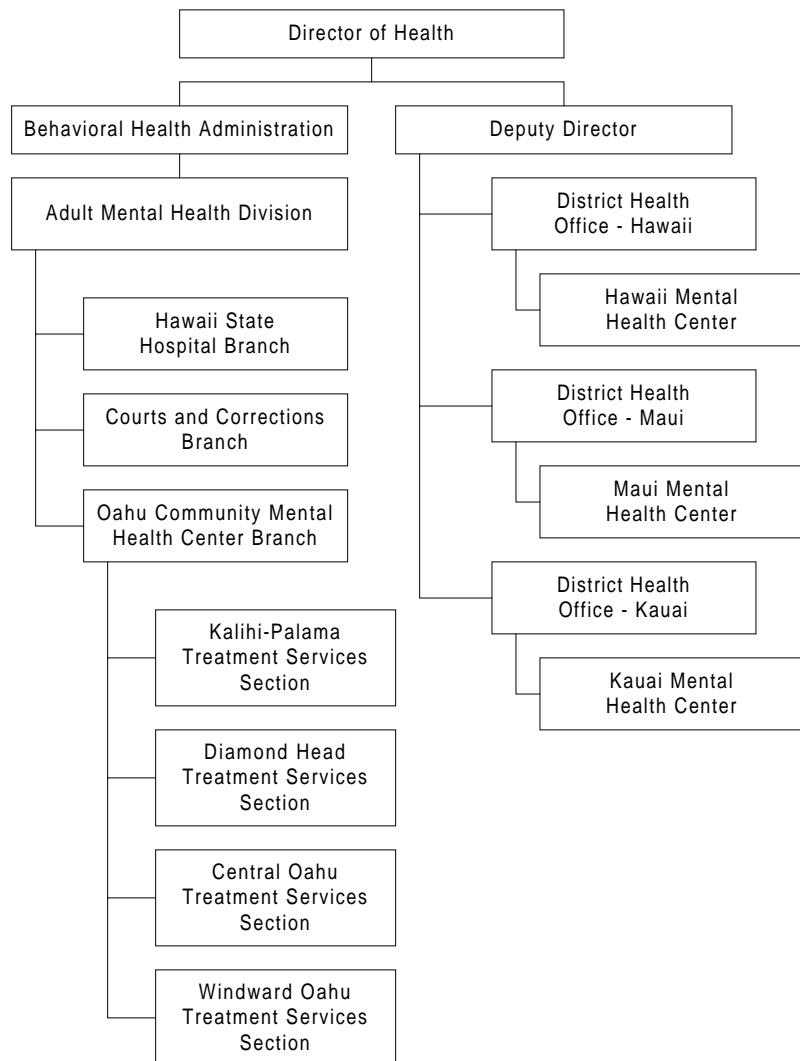
The Adult Mental Health Division is organized into the Hawaii State Hospital, Oahu Community Mental Health Center, and the Courts and Corrections branches. The division chief oversees the operations of each branch and reports to the department's behavioral health administrator. Each branch plays a role in providing a system of services to adults with mental illnesses.

The state hospital treats patients with serious mental illnesses who cannot be cared for in the community and pose a risk of harm to themselves or others. Patients suffer from severe and persistent mental illnesses including schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic, and other anxiety disorders.

Seven community mental health sites provide services to individuals in their respective areas of residency. The Kalihi-Palama, Diamond Head, Central Oahu, and Windward treatment service sections on Oahu all report to the Oahu Community Mental Health Center Branch. Mental health centers on the islands of Hawaii, Maui, and Kauai report to their respective district health offices. However, in practice, each neighbor island health center reports to the Adult Mental Health Division.

The Courts and Corrections Branch provides evaluation and consultation services to the state courts and corrections system. Consultations usually take the form of mental examinations pursuant to court orders to determine a person's fitness to proceed, sanity, and potential danger to self and others. Exhibit 1.1 shows the division's organizational structure.

Exhibit 1.1 Organizational Chart of the Adult Mental Health Division



Source: Department of Health

Although not attached to the department, the State Council on Mental Health and service area boards serve in an advisory role to the department. The council advises the department on the allocation of resources, statewide needs, and the state plan for mental health. The service area boards advise the department about service area needs.

Population served

The Hawaii State Hospital is licensed for 168 beds. Patients at the hospital include the forensic population (those committed by the courts through the criminal justice system), civil commitments, and patients who voluntarily agree to hospitalization.

During September 2000 approximately 150 patients were being cared for at the hospital. Nearly 80 percent were estimated to be forensic patients. Between January and September 2000 a total of 108 patients were admitted to the hospital. Approximately 74 percent of these patients were committed through the criminal justice system. The courts civilly committed another 12 percent, and the remaining 14 percent were voluntarily hospitalized.

The federal court scrutinizes hospital operations

The Hawaii State Hospital has operated under the close scrutiny of the federal court for approximately ten years. In 1991, the U.S. Department of Justice filed suit against the State of Hawaii for allegedly violating the constitutional rights of patients at the Hawaii State Hospital. The suit was filed pursuant to the federal Civil Rights of Institutionalized Persons Act.

As a result of this suit, the State entered into a settlement agreement with the Department of Justice to remedy alleged deficiencies in confinement, care, and treatment of patients at the hospital.

The settlement agreement establishes criteria for patient care

The settlement agreement established remedial measures to eliminate and avoid conditions posing a threat to life, health, and safety of patients at the state hospital. Conditions requiring immediate correction included monitoring and limiting the use of seclusion, restraint, and psychotropic drugs in patient treatment. The settlement agreement also established staffing requirements to ensure that patients were provided with a sufficient number of appropriately qualified psychiatrists, psychologists, social workers, rehabilitation therapists, nurses, and other direct care staff.

Non-compliance with the settlement agreement results in a court appointed monitor

Although the court found that the Department of Health did improve conditions at the hospital, the court continued to express discontent with the department's non-compliance with its orders. At a status conference on February 1, 1999, the court found that the State continued to be out of compliance with significant orders concerning patient care and treatment. Because non-compliance was long-standing, the court

ordered that a compliance committee, comprised of representatives from the state Department of Health and the U.S. Department of Justice, be formed to identify and implement solutions for all outstanding issues. The court warned that if the department failed to have programs in place to resolve all areas of non-compliance by December 1999, it would appoint a special master to assume control of the hospital and take necessary corrective action at the State's expense.

The Hawaii State Hospital submitted the *Hawaii State Hospital Clinical/Organizational Plan* on June 15, 1999 to address remaining deficiencies. However, the entire compliance committee did not endorse the plan. Committee members representing the Department of Justice believed the plan "lack[ed] specificity," and included "few new ideas about how to achieve compliance." The Department of Justice's psychiatric consultant also expressed concern that the department was prematurely and inappropriately discharging patients for administrative reasons, thereby overriding clinical judgment. As a result, the court appointed a special monitor on January 31, 2000 to oversee the development of the department's plan. The court-appointed monitor continues to function in this role.

The Hawaii State Hospital is transitioning from an acute care facility to a psychosocial rehabilitation facility

The Hawaii State Hospital has historically provided custodial care to the mentally ill with an emphasis on stabilizing and managing symptoms that led to hospitalization. At the time of our audit fieldwork, patients admitted to the hospital required an acute level of care and were referred to the Psychiatric Intensive Care Unit (PICU) for stabilization. Most patients remained at PICU for about a week before being sent to the Stabilization, Transition, Education Program (STEP) for further stabilization. Once stabilized, staff determined whether the patients should be discharged and reintegrated into community living, or receive further treatment in the hospital setting. Patients requiring hospitalization were transferred to one of four units on the hospital's lower campus. However, the court found the hospital remiss in providing adequate rehabilitative services to patients.

In recognition of the need to improve rehabilitative services, Act 119, Session Laws of Hawaii 1999 (SLH), authorized the department to transition the state hospital from an acute care facility to a secure psychiatric rehabilitation facility. The department responded by announcing that it would transition the state hospital to a psychosocial rehabilitation facility. Psychosocial rehabilitation helps individuals acquire the skills needed to live safely and productively in the community. This is consistent with state law, which requires that patients be treated in the least restrictive setting available.

The Legislature believed that the Hawaii State Hospital's functions needed to be reconfigured and supported with a comprehensive community-based program to avoid losing control of the hospital to a court appointed master. Therefore, Act 119 also allowed the department to privatize functions performed at the Hawaii State Hospital and to provide comprehensive community-based programs and services for individuals discharged from the hospital.

State law requires treatment in the least restrictive and most therapeutic environment

Chapter 334, HRS, requires the state's mental health system to be both coordinated and comprehensive in order to provide individuals with treatment in the least restrictive and most therapeutic environment possible. Moreover, state law requires that the mental health system allow individuals to move to the most appropriate, least restrictive level of care without having to pass through the entire system to reach the most appropriate level. Chapter 334 specifies legislative intent that a statewide system of residential treatment programs based on community treatment be established.

Funding was significantly increased to support the transition

The Hawaii State Hospital's recent focus on preparing patients for community reintegration has resulted in the need to increase the availability of community services. At the time of our audit fieldwork, the division planned to downsize the state hospital from 168 to 108 beds. This would free up resources to fund the expanded need for community-based services.

The department began to increase funding for private community providers during FY1999-2000, resulting in an additional \$14 million in emergency funding to avoid exhausting all available moneys prior to the close of the fiscal year. This \$14 million was in addition to a base budget of about \$51 million for adult mental health programs. During FY2000-01, the department also requested an additional \$20 million in supplemental funding for community services, for implementing psychosocial rehabilitation at the hospital, and to fund positions needed to monitor private community providers. An additional \$3 million in services would be funded from savings at the Hawaii State Hospital. Exhibit 1.2 displays the department's plans for the additional \$23 million.

Exhibit 1.2
Adult Mental Health Division \$23 Million Supplemental
Funding Request for FY2000-01

Category	Amount	Percentage
Contract Monitoring/Hospital Monitoring	\$2,846,282	12%
Case Management	\$7,554,534	32%
Group Home/Residential Care	\$6,970,142	30%
Psychosocial Rehabilitation	\$2,229,782	9%
Other Community Services	\$2,440,505	10%
Other	\$1,551,942	7%
Total	\$23,593,187	100%

Source: Department of Health

Previous audit reports

We conducted a management and financial audit of the Hawaii State Hospital during 1995 and found that past administrators had failed to properly manage hospital personnel and resources. Report No. 95-34, *Management and Fiscal Audit of the Hawaii State Hospital*, stated that personnel management had deteriorated to the point where employee absenteeism was rampant and discipline unenforceable. Chronic absenteeism had contributed to excessive overtime costs. We conducted a follow-up audit in 1997 and found that sick leave abuse and excessive overtime continued, preventing the hospital from meeting court ordered staffing requirements. We recommended that hospital units keep daily attendance records, require proper completion of sick leave forms, and consider centralizing the scheduling of overtime to improve problems with sick leave and overtime.

Our prior audits also reported that the hospital failed to ensure it employed competent staff. Specifically, staff were not given performance evaluations in a timely manner and competency requirements for each position were not enforced. We recommended the hospital ensure that supervisors evaluate staff in a timely manner and that all staff in direct care units who failed to meet competency requirements be placed on workplans, be directly supervised, and not be permitted to work overtime.

Our 1995 audit of the hospital also revealed inventory controls over consumable supplies at the automotive, housekeeping, and dietary units were weak. Although inventory controls had improved at the time of our follow-up work, we found that the application of these controls was inconsistent. We recommended that hospital wards keep inventories of

housekeeping and consumable items and be accountable for the distribution of these items.

Objectives of the Audit

1. Assess whether the Adult Mental Health Division has adequately planned for the treatment of patients in the least restrictive and most therapeutic environment.
 2. Assess whether the division has implemented sufficient management controls at the Hawaii State Hospital to ensure patient safety and adequate patient care.
 3. Assess whether the division has implemented adequate controls at the Hawaii State Hospital to reduce overtime, sick leave abuse, and inventory losses.
 4. Make recommendations as appropriate.
-

Scope and Methodology

This audit primarily focused on the division's plans to transition the state hospital to a secure psychosocial rehabilitation center, its progress towards meeting the requirements of the settlement agreement, and the department's action to address deficiencies in personnel management and inventory controls identified in our earlier audit reports. A subsequent audit will review community-based services and contract management.

Audit fieldwork included an assessment of the overall planning of the Adult Mental Health Division as well as the hospital's treatment planning for patients confined to the hospital. To determine whether patient treatment planning complied with hospital policy, we reviewed the medical records for a sample of patients admitted during September 2000. We also reviewed the adequacy of controls in place during FY1999-2000 and through September 2000, to assess their sufficiency in ensuring adequate patient care. Specifically, we assessed controls for ensuring adequate staffing; the proper use of seclusion, restraints, and psychotropic drugs; and the impartial investigation of alleged patient abuse reports. We also assessed whether the hospital's controls for protecting consumable goods from theft and loss are sufficient. Fieldwork included the review of applicable state and federal laws, national accrediting standards, the 1991 settlement agreement and subsequent court orders, patient medical records and treatment plans, consultant reports, inventory records, and interviews with division and hospital staff.

Our work was conducted from July 2000 through January 2001 in accordance with generally accepted government auditing standards.

Chapter 2

The Adult Mental Health Division Needs To Improve Its Management of the Mental Health System

The Adult Mental Health Division is responsible for providing an array of services to adults suffering from serious mental illnesses. Services must be provided in the least restrictive and most therapeutic environment possible; however, the division failed to adequately plan to ensure compliance with this legal mandate. Rather, the division engaged in varied approaches to resolve outstanding federal court requirements resulting from alleged unconstitutional conditions at the state hospital. At the time of our audit fieldwork, the division proposed that the Hawaii State Hospital be downsized and transitioned to a psychosocial rehabilitation facility. This decision was made without adequate plans to ensure success. The division requested and received millions in funding to support the development and expansion of community-based services as the hospital was downsized, even though it lacked the infrastructure necessary to manage expanded community services. Moreover, the division failed to sufficiently protect hospital resources it already manages from theft and waste.

Although the division has made progress in addressing specific court directives related to improving patient care, further efforts are required. Specifically, the state hospital must ensure that direct care staff are competent, staffing is adequate, patient treatment planning is sufficient, procedures for secluding and restraining patients are consistently followed, and allegations of patient abuse and neglect are investigated by an independent party.

Summary of Findings

1. The Adult Mental Health Division did not provide staff with sufficient direction to ensure that patients received the least restrictive and most therapeutic treatment. In its haste to comply with the federal court order and stipulation resulting from alleged unconstitutional conditions of confined patients at the Hawaii State Hospital, the division neglected to embrace the merits of long-range planning. Consequently, division priorities became moving targets impeding the division's ability to improve the delivery of adult mental health services.
2. The department has made progress in addressing the court's stipulation and orders; however, further improvements should be made to ensure patients are adequately protected from harm and provided with sufficient treatment.

3. The Hawaii State Hospital lacks adequate management controls to decrease the risk of fraudulent and inaccurate overtime claims, abuse of sick leave, inaccurate leave payments, and the theft of consumable goods. Although the hospital has made progress to strengthen controls in some areas, it has regressed in other areas.

The Adult Mental Health Division Has Not Provided Sufficient Direction to Ensure the Provision of Adequate Mental Health Services

The division's planning for mental health services was inadequate

The Adult Mental Health Division did not adequately plan to ensure that adults suffering from mental illnesses were treated in the least restrictive setting available. The division disregarded the importance of long range planning and instead sought “quick fixes” to resolve outstanding federal court orders. Furthermore, the division has not given adequate attention to the court-appointed consultant assisting the division in planning for the improvement of the adult mental health system. Consequently, the division lacks the infrastructure necessary to effectively transition the Hawaii State Hospital to a psychosocial rehabilitation facility.

Chapter 334, HRS, makes the Department of Health responsible for planning and developing a comprehensive mental health system in response to a needs assessment, program and facility evaluations, and community participation. However, we found that the department had not sufficiently planned for adult mental health services, resulting in an amorphous system.

The absence of a long-range plan and insufficient communication with both public and private community service providers resulted in rapidly shifting priorities. Furthermore, the division requested and spent millions of dollars in state funding without first adequately assessing patient needs and developing the infrastructure to support those needs. Consequently, taxpayers have no assurance that state resources were spent efficiently.

Long-range planning was lacking

The Department of Health is responsible for establishing and operating a community mental health system within the limits of available funding. To ensure that resources designated for mental health services are allocated in a rational manner, state law requires the department to develop a four-year plan. Planning for the immediate four-year future establishes continuity in an organization's direction and ensures that the organization is accountable for its results. The existence of a long-range plan is an essential element in an environment such as the state hospital, where changes in leadership have occurred frequently.

We reviewed the department's mental health plans for FY1999-2000 and FY2000-01 and found that they failed to establish long-range goals and objectives. Insufficient planning resulted in changing organizational priorities as the division sought a "quick fix" to address the concerns of the federal court. A division planner informed us that it was impractical to develop a long-range mental health plan since changes were occurring rapidly. We disagree. The purpose of long-range planning is to avoid constant shifts in priorities. In fact, long-range goals and objectives are changed only gradually and infrequently since they represent careful study. Moreover, both the federal court and State Legislature have expressed their desire that the Department of Health develop a clear plan for improving the state's adult mental health system. Subsequent to our audit fieldwork, the division prepared a four-year implementation plan for service development. Although the development of this plan is a step in the right direction, it does not adequately address the future of the state hospital.

Communication with community groups needs improvement

Chapter 334, HRS, requires that the department respond to community expressions of needed services and programs when developing the state mental health plan. Seven service area boards representing area residents, mental health consumers, and service providers create a venue for community participation and input. Each board is responsible for developing a service plan in accordance with Section 334-11, HRS. Hawaii Administrative Rules require that the statewide mental health plan incorporate each service area plan.

We found that inactive service area boards have seriously hampered community involvement in the development of the state mental health plan. For example, the Leeward-Central Service Area Board has been inactive for approximately five years. Consequently, Leeward and Central Oahu residents are not provided sufficient opportunity to identify mental health service needs. Community participation from Maui residents was also stifled since its service area board was inactive for approximately two years. The Maui Service Area Board was only reestablished in July 2000. Two other service area boards were unable to meet the quorum necessary for decision making. Therefore, these boards did not develop service area plans for inclusion in the state mental health plan.

The division is aware of service area boards' inactivity and the high turnover of board members, but has not taken sufficient steps to ensure that vacancies are filled in a timely manner. Although Section 334-11, HRS, makes the governor responsible for filling vacancies on each board, the division is responsible for facilitating the identification of prospective board members. The governor fills vacancies by appointing members from a list of names submitted by the area board. If the board

is unable to achieve a quorum, the service area chief (a department employee) and the service area board chairperson must hold a public hearing to select individuals to assist in the preparation of a list of possible board members. However, at the time of our fieldwork, the division had not held any public hearings for this purpose. Instead, the division advertised to recruit individuals interested in serving as board members during 1999 and 2000 and allowed interested individuals to contact the governor directly. The division should take an active role in facilitating the appointment of service area board members as specified in Chapter 334, HRS, and in soliciting community involvement in the development of the state mental health plan. The division did seek statewide community input when developing its implementation plan for service development; however, this process was separate and apart from the community input guaranteed to service area boards.

The department's plan to downsize the Hawaii State Hospital and close a community-based mental health center was not discussed with community members

The division's lack of community-based planning resulted in essential decisions being made without community involvement. For example, during April 1999 the department announced that it planned to close the Hawaii State Hospital and place approximately 170 patients in community treatment facilities. However, the department failed to discuss this plan with private providers who would need to accommodate patients discharged from the hospital. Several private providers informed us that they first learned of the department's plans to close the hospital from the local news or during legislative hearings. The department should have worked with these providers prior to deciding to terminate treatment at the Hawaii State Hospital.

Department officials later modified the plan to close the hospital and instead planned to treat at the hospital 80 patients committed by the courts. The department changed the plan once more by increasing the number of patients to be treated at the hospital to 108. The former clinical director of the state hospital informed us that she did not know how the department determined these numbers. The court-appointed monitor reported in February 2001 that the division is no longer pursuing its goal of downsizing the state hospital to 108 beds and that capacity will be determined by need. These frequent changes in plans have demoralized division employees who worry about the status of their state positions. In fact, the United Public Workers' union threatened to sue the State if the hospital was closed and adult mental health services became privatized.

State operated community mental health center staff were unclear about their role in this transition. In previous years, community mental health centers followed patients admitted to and discharged from the hospital.

However, this responsibility has now been delegated to privately operated Assertive Community Treatment (ACT) teams.

Poor communication between the division's administration and the community mental health centers was more recently criticized during August 2000 when the Diamond Head Mental Health Center staff learned that their center would be closed without sufficient prior discussion and notice. The division planned to continue servicing patients treated at the Diamond Head Mental Health Center at its Kalihi-Palama Center. Meetings should have been held with every client at the outset to explain the plans and to assure them that services would continue. However, staff at the Diamond Head Mental Health Center were unable to do this because they were unaware of the department's plans.

Services were not determined by patient needs assessments

The department's poor planning was further exacerbated by its failure to identify service needs in a timely manner. The department paid millions of dollars for mental health services without first completing a formal statewide needs assessment to determine and guide funding decisions. The division's request for \$14 million in emergency funding for FY1999-2000 and \$20 million in supplemental funding for FY2000-01 was made without the benefit of first completing a formal needs assessment. The division hired a consultant to determine the range of services needed to adequately serve individuals who have been or will be diverted, discharged, or transferred from the Hawaii State Hospital only *after* it received the requested funding. The Legislature funded the department's request in order to satisfy the federal court.

The consultant submitted a report in November 2000 that estimates \$122 million is needed annually to meet all clinical, residential, rehabilitation, and support needs of consumers currently in the system as well as those entering the system on a monthly basis. The consultant also estimated that \$27 million of this amount is needed annually to serve those covered by the federal court's definition of individuals currently served, transferred from, or diverted from the Hawaii State Hospital. The consultant recommended that the State identify available federal funds for meeting community service needs prior to committing additional state funds to these services. As noted in Chapter 1, the department already received nearly \$70 million during FY2000-01 for adult mental health services.

The consultant also recommended that any new state funding be spread out over a three- to four-year period, and that the division identify the infrastructure needed to support additional resources to the adult mental health system. Finally, the consultant recommended that the division

develop a plan for service delivery and allocation. On March 15, 2001, the division issued its four-year implementation plan for service development.

The division did not use its consultant services wisely

The issue of weak planning was identified in an earlier federal court order as well. On June 28, 1996, the federal court ordered the State to contract with the “independent expert,” Technical Assistance Collaborative, Inc. (TAC), to assist in developing and implementing a comprehensive plan to meet the requirements of the court orders. The court also ordered that TAC file quarterly reports evaluating the status of the State’s compliance and setting forth recommendations for correcting deficiencies.

The division paid TAC approximately \$360,000 for services provided between 1996 and 2000. Services included assisting the department with discharge and community placement of patients eligible for discharge, monitoring the adequacy and appropriateness of residential and other community supports provided to discharged patients, and preparing quarterly reports to the division chief and Department of Justice on the progress of the community placement plan implementation efforts. The department contracted with TAC for additional services to be provided between August 2000 and June 2001 for an amount not to exceed \$316,000. This contract requires TAC to assist the division in transitioning the hospital to a secure rehabilitation facility and in planning and implementing expanded community services. TAC is to provide technical support to determine the range of necessary services for persons who have been or will be discharged, transferred, or diverted from the hospital. TAC must also develop a budget and strategic implementation plan to meet the federal court’s requirements based on a needs assessment.

Our review of the division’s management of its contracts with TAC revealed that the division paid for services it did not receive. We also found that the division failed to implement the recommendations of this court-appointed expert in a timely manner.

The division paid for services it did not receive

We selected a sample of 19 services that the division paid TAC to provide and found that six of these contracted service requirements were not complete. For example, TAC should have evaluated the implementation of new housing resources secured during FY1997-98. However, the division was unable to provide us with a completed evaluation. Instead, it referred us to one of TAC’s quarterly reports, which fell short of evaluating the new housing resources. The report we were given only identified the number of beds available in each new program without evaluating shortage and housing types. TAC was also

required to evaluate the community mental health centers' ability to properly care for and manage patients being discharged from the hospital. As in the previous example, the quarterly reports did not address this requirement. Although the division met the federal court's requirement when it hired TAC as an independent expert, it failed to ensure that state moneys were well spent.

Implementation of the consultant's recommendations is untimely

TAC proposed specific recommendations to improve the division's ability to meet the court's requirements. Since the division paid TAC as an "independent expert," it was in the division's interest to carefully consider each recommendation and to quickly implement those that were feasible. However, we found the division did not implement some of TAC's key recommendations in a timely manner. For example, in April 1997, TAC recommended that the division create a housing resource coordinator position to expand expertise in federal, state, and local affordable housing programs. Over a year and a half later, TAC recommended that the division appoint a full-time housing coordinator to develop alliances with the City and County of Honolulu and the state's housing development agency to secure additional resources. The division only hired a full-time housing specialist during July 2000. The division was also untimely in developing and implementing a system to allow all mental health service providers the ability to track mental health consumers. Although the system is now operational, it is not accessible to all mental health service providers as was recommended approximately three years ago.

The division began to transition the Hawaii State Hospital to a psychosocial rehabilitation center without adequate infrastructure

The division began to transition the Hawaii State Hospital to a psychosocial rehabilitation facility without first ensuring that the infrastructure needed to support such a facility was in place. Specifically, the division failed to ensure it was appropriately staffed and that adequate community resources were available to support the transition. Essential leadership positions at the hospital and new staff positions that were requested to assist in the transition were not filled. Furthermore, the hospital did not provide adequate psychosocial rehabilitation training to staff. Moreover, community service providers and division administrators believed that community resources were insufficient to support the number of patients the hospital planned to discharge.

Key leadership positions have not been formally established

Administrative rules and directives require state agencies to describe job duties and responsibilities in formal position descriptions. These directives also require that a clear chain of command among all positions

within an organization be accurately identified in an organizational chart. Such directives help to ensure accountability and adequate supervisory control. However, in its haste to transition the state hospital to a psychosocial rehabilitation facility, the division reorganized and filled psychosocial rehabilitation leadership positions without first clearly defining their roles and responsibilities.

The division did not develop a formal job description for the director of psychosocial rehabilitation prior to filling the position. Furthermore, this position does not appear on the hospital's organizational charts. Consequently, supervisory control for this position is unclear. Also, the division had prepared a written duty assignment for unit managers at the time of our fieldwork indicating that they were responsible for daily supervision of all staff assigned to their units. However, the division did not formally establish these positions. The unit manager concept was developed as a means of providing a single point of accountability for each hospital unit. However, since these positions did not appear on the hospital's organizational chart, the unit managers' authority over the staff they supervised was weak.

The draft psychosocial rehabilitation manual and the description of the unit manager duty assignment indicate that the unit manager's authority is derived from the discipline chiefs. However, unit managers reported they did not have disciplinary authority. In fact, one unit manager informed us that not all discipline chiefs cooperated and supported their unit managers.

The unit manager system has since been abandoned, and each unit is now allowed to institute its own management arrangement.

New positions authorized by the Legislature have not been filled

The department requested and received approximately \$4.2 million to fund 69 new positions during FY1999-2000 and FY2000-01. The department justified its request for these positions on the premise that they were needed to transition the hospital to a psychosocial rehabilitation facility and to provide oversight for expanded community services as the number of patients discharged from the hospital was expected to increase. However, we found that the division did not fill many of the positions it requested. These positions included contract monitoring, management information system, utilization management, and psychosocial rehabilitation staff. As of November 2000, 66 positions equal to approximately \$4 million in salary costs remained unfilled.

Staff are not adequately trained

Staff training in the psychosocial rehabilitation approach is necessary to effectively implement this program. Although the hospital developed a training schedule for staff, the director of psychosocial rehabilitation informed us that the hospital has been unable to train staff as initially planned.

The hospital had planned to use a “float pool” of staff who would fill in for staff assigned to training. However, since the float pool was to be comprised of existing available personnel, its development was contingent upon decreasing the hospital’s population. When the hospital census did not decrease as estimated, the hospital did not have a float pool and was unable to relieve staff for training. As of October 2000, the director of psychosocial rehabilitation reported that staff had not completed one-third of the required training. Thus, the hospital’s ability to provide patients with quality psychosocial rehabilitative services is compromised.

Community resources to support discharged patients were inadequate

The division did not identify and build the community infrastructure needed to care for discharged patients prior to deciding to downsize the state hospital from 168 to 108 beds. Community groups and one department administrator informed us that community programs were inadequate to support the proposed downsizing of the Hawaii State Hospital. The development of an adequate community infrastructure requires time and careful planning. Prior to expanding contracted services, the division should assess the adequacy of current community services.

The Hawaii Disability Rights Center, a non-profit public interest organization, reports that some privately operated mental health facilities are not licensed or accredited. The center also found that not all staff hired by private community providers have proper credentials. The division should address these concerns when planning for the development and expansion of community based services.

Further Improvements Are Needed to Ensure Patients Are Adequately Protected from Harm and Provided with Sufficient Treatment

The mission of the hospital is to provide quality, integrated, active psychiatric treatment and rehabilitation to seriously mentally ill patients with community reintegration as the primary goal. Patient care in a safe and therapeutic environment is fundamental to the operation of the hospital. Concerns over the adequacy of patient care and safety at the Hawaii State Hospital date back to 1990 when the U.S. Attorney General alleged that the State violated the constitutional rights of patients. The resulting settlement agreement and subsequent court orders required the State to improve conditions without posing a threat to the health and safety of patients.

Specifically, the court ordered the State to improve patient care by ensuring staff competencies, establishing minimum staffing requirements, controlling the use of seclusion and bodily restraints, requiring that each patient receive an adequate and appropriate individualized interdisciplinary treatment plan, and establishing requirements for the investigation of alleged abuse and neglect. The hospital implemented management controls to address these concerns. However, the efficacy of these controls was weakened by their inconsistent application and by deficiencies in existing procedures and practices at the Hawaii State Hospital.

The division has not ensured the competency of direct care staff

Patients at the Hawaii State Hospital have a right to qualified, competent staff. Federal court orders, Hawaii Administrative Rules, and hospital policies and procedures guarantee this right. The hospital ensures that direct care staff are competent by evaluating their performance, requiring them to fulfill continuing education requirements, and reviewing the currency of professional staff's licenses. Although these management controls have been established, staff have yet to effectively implement them.

Deficiencies in staff performance evaluations were reported in our 1995 and 1997 audits of the hospital. Our current review of staff performance evaluations found that improvements are still needed. We also found a number of direct care staff have not completed continuing education requirements specifically related to patient care. Moreover, the hospital's personnel office has not ensured that staff with expired professional licenses refrain from treating patients.

Performance evaluations remain deficient

Hospital policy requires that employees be evaluated within six months of their employment and once a year thereafter. This is to ensure that staff who work at the hospital are qualified and competent. It is also consistent with the state's employee performance appraisal system that

requires employees to be evaluated at the end of their probationary period and once a year. In our 1997 audit, we reported the hospital had not ensured that staff were evaluated in a timely manner. While the hospital has made some progress in correcting this deficiency, we noted that some staff in our sample had evaluations completed *prior* to the end of the review period. This current practice is of concern because there is no assurance that staff met the expectations of their supervisor for the entire review period.

We reviewed the most recent performance appraisals for 83 out of a total of 330 direct care staff employed on October 3, 2000 and found that about 70 percent were completed prematurely. These evaluations were completed anywhere from one day to nine months before the end of the review period. Five evaluations were completed one month too early. These premature performance appraisals are unreliable because any change in employee productivity and behavior after the appraisals are completed would not be reflected in the employee's evaluation. This practice could also result in serious infractions that go undocumented in an employee's annual performance appraisal. This could also limit the hospital's ability to discipline staff who may have inappropriately received positive performance ratings.

The State's performance appraisal system also requires supervisors to meet with staff at the beginning, or shortly after the start of the rating period to discuss expectations and set goals. This practice ensures that supervisors clearly explain the duties and responsibilities of staff and provides staff with an opportunity to seek clarification if needed. However, in our review of 83 staff performance appraisals we found that supervisors discussed their expectations one or more months *after* the review period had begun in 25 percent of these appraisals. In one case, the supervisor failed to discuss expectations until the day the review period ended. Our 1997 audit also reported that initial discussions of expectations occurred over one month after the review period began. Failure to identify job responsibilities and expectations in a timely manner can have an adverse effect on patient care.

Not all staff met continuing education requirements

Continuing education provides staff with opportunities to develop, maintain, and enhance their professional competencies. It also ensures they remain current in technical and clinical advancements. The hospital requires clinical staff to complete training in specific areas including cardiopulmonary resuscitation (CPR); infection control; fire safety; conflict prevention, management and resolution (CPMR); patient rights; patient safety; treatment planning; and behavior management. The hospital requires that training in some areas be renewed periodically. Supervisors are responsible for scheduling required educational training

and for reporting whether employees comply with the requirements on the employees' annual performance appraisals.

We reviewed training records of 74 direct care staff and found that approximately 20 percent did not complete mandated training. Excluding CPR, these employees did not complete training in each of the required areas listed above.

Two areas in which we found the highest noncompliance with mandated training were patient safety and treatment planning. The hospital's executive committee required that training to protect patients from sexual exploitation and harassment be completed annually, beginning in 1999. However, 72 of the 74 staff in our sample did not meet this requirement. The high number of staff who did not receive annual patient safety/sexual harassment training is attributed to a former clinical director who verbally waived this requirement contrary to hospital policy and without proper authorization. In fact, the Adult Mental Health Division chief, who is a member of the hospital executive committee, was unaware of the clinical director's action until we brought it to her attention.

Moreover, training on patient treatment planning was required for all direct care staff during 1999, but 12 percent of the staff in our sample did not complete this training. Non-compliance with patient safety and treatment planning requirements is cause for concern because the federal Department of Justice and court orders have targeted these areas as needing improvement. Furthermore, effective treatment planning is the catalyst to helping patients reintegrate into their communities.

Tracking and enforcement of mandated staff training is inadequate

The hospital's ability to accurately identify staff with outstanding training is impaired by its lack of coordination between the staff development and training unit and hospital supervisors. Although the staff development and training unit tracks employee training and submits monthly reports to supervisors that identify staff who are deficient, the responsibility for resolving these deficiencies remains with individual supervisors. Deficient staff can provide their supervisors with evidence of completed mandated training, but this information may not be reported back to the staff development office. The staff development unit should be the official custodian of all staff training records and should be given authority to suspend staff with outstanding training requirements.

The hospital may not identify all staff with expired professional licenses

State law requires that certain professions and vocations be licensed to protect the health, safety, or welfare of the public. Psychiatrists, psychologists, nurses, physical therapists, pharmacists, the laboratory chief, technologists, and technicians working at the Hawaii State Hospital must be licensed. The hospital's personnel office tracks the currency of staff licenses, except psychiatrists, through status reports. The chief of psychiatry is responsible for ensuring that each psychiatrist's license is current.

We reviewed licensing records for all psychiatrists as well as a sample of 3 clinical psychologists and 45 nurses, to determine whether their professional licenses were current. The license of each employee sampled was current at the time of our review; however, we found that the personnel office's license renewal status report was incomplete. The status report failed to identify ten nurses in our sample. The reliability of this status report as an effective management tool is weak as it may fail to identify staff with expired professional licenses. This is of serious concern since practicing without a required professional license is illegal and poses a threat to patients' welfare.

The department continues to be non-compliant with staffing ratios ordered by the federal court

Minimum staffing ratios and requirements for various disciplines at the Hawaii State Hospital were established in the 1991 settlement agreement, a subsequent court order, and the 1998 corrective action plan of the state hospital. Almost a decade later, the hospital has yet to comply with several of these requirements. The department's ability to meet mandated staffing ratios has been thwarted by an increasing patient census combined with staff vacancies and a reduction in direct care positions. Failure to meet staffing ratios compromises both patient and employee safety.

Staff vacancies and abolished positions impede the department's ability to comply with prescribed staffing ratios

In 1995, the federal court ordered the hospital to fill nursing vacancies with permanent staff and to hire a sufficient number of permanent employees to ensure compliance with ratios for rehabilitation staff (occupational therapists). The hospital failed to follow the court's order and instead allowed these positions to remain vacant for extended periods. The court-appointed special monitor reported that the average length of time positions remained vacant between 1994 and 2000 was 7.7 months for registered nurses, 12.8 months for licensed practical nurses, and 16.7 months for paramedical assistants. The court monitor found these lengthy delays unacceptable.

Moreover, the Legislature recently abolished 56 vacant positions, as requested by the Department of Health, to downsize the Hawaii State Hospital. About 71 percent of these abolished positions provided direct care to patients, such as nurses and paramedical assistants. As a result, the hospital remains noncompliant with required staffing ratios.

The department’s plan to downsize the hospital was not realistic

The Department of Health’s plan to reduce the number of beds at the Hawaii State Hospital from 168 to 108 between 2000 and 2001 was unrealistic. Coincidentally, the proposed reduction was equal to the number of beds at the hospital’s aging Guensberg Building, which the hospital planned to close by October 31, 2001. The hospital has closed the building as of March 2001. A consultant to the Department of Health argued that the hospital’s plan to reduce bed space was a feasible goal *if* the State was successful in developing appropriate community-based services that would keep people stable and out of the hospital. However, community resources have not been adequate to sustain the discharged patients.

Additionally, the Department of Health has not been able to control admissions to the hospital. The majority of admissions continue to be patients committed by the courts. The department’s inability to resolve these issues of community services and court mandated admissions made its plans to reduce the hospital census unrealistic. In fact, at the time of our fieldwork the hospital’s census was increasing without sufficient staff to support it. Exhibit 2.1 compares the hospital’s actual patient census and nurse staffing against the proposed census and staffing.

**Exhibit 2.1
Actual and Proposed Hawaii State Hospital Patient
Census and Nurse Staff**

Month	Actual Patient Census	Proposed Patient Census	Actual Nurse Staffing	Proposed Nurse Staffing
July 2000	147	147	244.50	261
August 2000	152	144	235.50	261
September 2000	151	141	230.00	261
October 2000	147	138	225.75	261
November 2000	154	135	223.75	261
December 2000	160	132	225.25	257

Source:Hawaii State Hospital Transition Overview (June 9, 2000) and Hawaii State Hospital Nursing Office

Although controls for the use of seclusion and restraints have improved, further improvements are needed

The 1991 court order required that all patients secluded and physically restrained be adequately monitored by appropriate medical personnel in order to ensure them protection from harm. To protect patients from harming themselves or others, patients may be secluded and/or restrained when less restrictive interventions are ineffective. Hospital staff may physically restrain patients with any device or article of clothing, which restricts their freedom of movement, or chemically restrain them by administering psychotropic medication.

The court ordered that the use of psychotropic medications on a pro re nata (PRN) or “as needed basis” be limited to a 24 hour period. The hospital discontinued the administration of PRN medications and has since moved to using STAT (immediate) medication orders at one time dosages. Our review of approximately a third of the STAT psychotropic medication orders for the month of September 2000 revealed that ordering physicians considered less restrictive alternatives first and signed these medication orders as required.

In 1996, the court found that the hospital had made progress in reducing the use of seclusion and restraints. However, the court ordered the State to review all incidents of seclusion and/or restraint to determine whether patients suffered injury or abuse and whether corrective action was implemented as needed. The hospital has responded to the court’s orders by monitoring the restraint and seclusion of patients.

The hospital monitors the use of restraints and seclusion

The hospital’s quality improvement staff review seclusion and restraint incidents continuously and summarize the number of episodes experienced by patients each month. These reports identify staff compliance with documentation and other procedural requirements related to the use of seclusion and physical restraints. The continuum of care team reviews these reports and makes recommendations as needed. Quality improvement staff also receive copies of all psychotropic STAT medication orders and prepare reports identifying whether ordering physicians considered less restrictive measures as well as the desired effect of administering STAT medications. Staff also review whether the physician documented their patients’ progress within 12 hours of their written orders. The hospital’s clinical director receives a copy of all STAT psychotropic medication orders and is responsible for improving areas of noncompliance in the administration of these medications. Although the hospital has designated staff who monitor and address court concerns in these areas, we found that staff do not always follow hospital procedures when secluding and restraining patients.

Procedures for restraining and secluding patients are not followed

Standard procedures under which seclusion and physical restraints are administered include notifying the charge nurse or physician of a potentially harmful situation, using calming interventions, obtaining proper authorization, monitoring and documenting patient progress, and releasing the patient when release criteria determined by the ordering physician are met. We reviewed reports for 20 episodes of seclusion and restraint and found that procedures were not followed in approximately 15 percent of these episodes. In one case a patient was secluded 3.25 hours longer than authorized by the ordering physician. In another case, the clinical director was not contacted when a patient was restrained for over eight hours. Hospital policy requires either the attending or ordering physician to discuss the need for continued seclusion and restraint beyond eight hours with the clinical director.

A policy to guide the use of restraints for patients being transported between units is needed

In our review of restraint use, we found one patient was restrained while transported from a housing unit to the stabilization unit. There was no record of the length of time this patient was actually restrained. We found that the hospital does not have a policy for transporting patients under these circumstances. However, the hospital recently drafted a policy to ensure safe and appropriate use of restraints when transporting patients to “on” or “off-ground” appointments. This policy should be revised to include patients who are restrained while being transported at the hospital for purposes other than attending “appointments.”

The hospital needs to improve patient treatment planning

Treatment planning is an on-going interdisciplinary process, which begins upon hospital admission and continues as long as an individual receives services from the Adult Mental Health Division. Treatment planning at the hospital involves identification of problems that resulted in hospitalization and development of a plan of action to facilitate the discharge of the patient. Within 24 hours of hospitalization, each patient is assessed by a nurse who develops an initial treatment plan. This initial treatment plan directs the patient’s care until a treatment team develops a master treatment plan. Treatment team members include a clinician from psychiatry, psychology, social work, and nursing, and representatives of all disciplines delivering assessment or treatment services to the patient.

Although the 1991 settlement agreement requires the State to provide patients sufficient treatment, our review of the hospital’s treatment planning efforts identified areas where improvement is needed. Incomplete initial treatment plans, limited patient and treatment team

members' involvement in the planning process, and failure to consider treatment alternatives when goals are not met are all areas that need improvement. Without greater effort and attention, patients' rights to adequate psychiatric treatment and rehabilitation services are compromised.

Initial treatment plans are sometimes incomplete

Patients' initial care plans are documented on a form identifying each patient's strengths, weaknesses, anticipated discharge plan, psychiatric problems, safety risks, and any substance abuse or medical problems. However, in 7 of 12 initial treatment plan forms we reviewed, this information was incomplete. In one case, the plan failed to identify under the safety risk assessment section of the form, that a patient had attempted suicide and demonstrated violence towards others. Although the Initial Plan of Care form allows staff to identify safety observation levels for patients, this was not done. Another patient was assessed as a suicidal risk, yet the initial plan of care failed to identify that the patient required observation safety checks. Additionally, five of the 12 plans we reviewed did not identify anticipated discharge plans. Staff should exercise greater diligence in completing initial plans of care to ensure that patients are adequately supervised and appropriately treated.

Patient involvement in treatment planning should be more meaningful

Patient involvement in the treatment planning process facilitates the likelihood that the plan will result in achieving its stated goals. Hawaii Administrative Rules provide each patient with the right to participate in treatment planning. In addition, hospital policies encourage the involvement of each patient in their treatment. For example, the treatment coordinator meets with each patient to discuss and document the patient's goals and treatment preferences. Patients are also encouraged to attend master treatment plan meetings.

Our review of 14 patients' master treatment plans revealed that half were not meaningfully engaged in the formulation of their treatment goals and preferences. Goals and preferences were not documented for two patients. In both cases, the patient did not sign the goal and treatment preference form. Staff should document a patient's refusal to participate in discussing treatment goals. Documentation was not done in either case, and therefore, it is unclear whether staff made any attempt to discuss treatment goals and preferences with these patients. Five other patients indicated a desire to be either discharged or acquitted of their charges, but did not express goals and preferences for treatment. Staff should actively involve patients in the identification of their treatment goals and preferences to increase their likelihood for successful treatment.

Treatment team members should be accountable for failure to attend treatment plan reviews

Treatment plan review meetings are convened one month after the initial master treatment plan and at least every 30 days thereafter. The treatment team evaluates patient progress towards treatment goals and makes changes as needed to the master treatment plan during these meetings. All members of the treatment team are expected to attend treatment plan reviews, since participation of the entire treatment team is necessary for formulating, evaluating, and revising each treatment plan.

We found treatment team members do not always attend treatment plan reviews. A psychologist missed 2 of the 14 treatment review meetings we reviewed. Other relevant team members, including rehabilitation therapists, were frequently absent from the meetings. Treatment coordinators should be held responsible for providing notification of treatment plan review meetings to all treatment team members, who then should be held accountable for attending. Input of all staff is necessary to comply with federal court orders, which require that individual treatment plans of each patient be developed using an interdisciplinary team of professional staff.

Treatment alternatives should be considered and documented for patients not meeting treatment goals

We found that treatment teams did not routinely identify treatment alternatives for patients who were not making progress toward their treatment goals. The hospital's treatment planning training manual requires that treatment goals be revised or interventions modified when patients make minimal or no progress towards those goals. Lack of progress could reflect a failure of the intervention rather than failure by the patient. Treatment teams should consider alternative interventions to address treatment goals. Teams should document their rationale for not making changes when applicable.

Investigations of alleged patient abuse and neglect reports need improvement

In January 1995, the federal court found the State in contempt of the 1991 settlement agreement and ordered the State to take immediate steps to protect hospital patients from physical or emotional abuse and neglect. The court ordered the hospital to revise its policies, procedures, and practices for reporting and investigating allegations of abuse and neglect. A subsequent stipulation and order enumerated specific requirements for the revised procedures on abuse and neglect investigations. While the hospital has taken steps towards complying with these orders, additional improvements are needed. The hospital must ensure that investigations of abuse and neglect are impartial and that appropriate action is taken when abuse and neglect are substantiated.

Investigations are not always independent

The hospital's internal investigations of numerous abuse and neglect allegations defy court orders requiring that these investigations be conducted by a qualified individual who is independent of the Hawaii State Hospital. In addition to denying patients access to an independent investigation, patients are not afforded the full benefit of the protection and advocacy agency, the Hawaii Disability Rights Center. The sole mission of this non-profit agency is to protect and advocate for the rights of people with disabilities. A 1995 remedial plan required the hospital to provide copies of investigation reports to a protection and advocacy attorney immediately upon completion. However, risk management staff report that copies of completed internal investigations are not always provided to the attorney.

The hospital fails to take appropriate action when abuse or neglect is substantiated

Court orders require the hospital to initiate prompt and appropriate disciplinary action when abuse or neglect is substantiated. However, the court appointed special monitor, a former member of the hospital's patient protection committee, expressed serious concern about the hospital administration's unwillingness to aggressively pursue appropriate discipline in such cases. In one instance, a nursing supervisor who failed to report and investigate the alleged abuse of a patient was allowed to retire while undergoing a termination proceeding. The court monitor expressed concern that the "follow-up" in this case may have been inadequate because without a termination proceeding, this employee can regain employment with the State as a nurse.

In another case in our review of abuse and neglect reports, the hospital substantiated five complaints against the same employee over a nine-month period. This employee received a five-day suspension for falsifying a patient's records. Following her suspension, the employee continued to neglect patients in three separate cases. Although the hospital has recommended a total of 60 days suspension for these three open cases, it appears this employee may escape discipline since she will remain on vacation until voluntarily resigning. This employee may also be eligible for future employment with the State. These practices placed patients at risk for abuse by employees and permitted employees to continue such abuse without threat of serious disciplinary measures by management.

The Hospital's Overtime, Leave, and Inventory Controls Still Need Improvement

Our 1995 and 1997 audits of the Hawaii State Hospital found that management controls for overtime, leave, and inventories needed improvement to protect state resources from misuse and waste. While some conditions reported in our prior audits have improved, others have worsened. Overtime remains at high levels, with some staff receiving questionable and inaccurate payments. Sick leave also continues to be a major problem, with some staff being paid for unauthorized leave and the hospital failing to investigate possible sick leave abuse. Furthermore, in the absence of a sufficient inventory control system for all units at the hospital, goods are not adequately protected from loss or misuse.

Overtime is used to circumvent the civil service system for establishing positions

With the need to improve the accountability of staff working in patient units, the hospital created six unit manager positions in September 1999 whose responsibility would be the daily supervision of staff. These positions were created and filled by the hospital without following civil service rules and principles. Hawaii Administrative Rules require that positions be properly classified and compensated based on minimum qualification requirements and the level and nature of the position's duties. However, this was not the case when the hospital created the position of "unit manager."

The former hospital administrator selected staff from various disciplines including nursing, social work, and occupational therapy to accept the unit manager assignments. The assistant hospital administrator for administrative and support services informed us that the unit managers were simply "duty assignments" and not newly created positions. However, the unit managers informed us that they were no longer performing the job duties and responsibilities of their official positions. These unit managers appeared to be working out of their classification and in entirely new positions with significantly increased managerial authority. Since these positions were not reviewed and classified, the hospital administrator circumvented civil service and personnel rules by filling positions with staff who may not have had the requisite qualifications and experience for the positions.

A former hospital administrator also arbitrarily set the annual pay range for the unit managers at \$55,000 to \$60,000. He also encouraged unit managers whose base salaries were below \$55,000 to seek overtime compensation to bring their pay within this salary range. While the unit managers may have been needed by the hospital to function effectively, we question the means by which these positions were created, filled, and compensated.

Overtime paid to some unit managers is not adequately justified

The hospital paid two unit managers a combined total of approximately \$30,000 in overtime during FY1999-2000 without any assurance that these managers actually worked the overtime. Since unit managers were not required to keep daily attendance timesheets, overtime claims were approved on an informal honor system. While unit managers estimated they worked an average of 10 to 20 hours of overtime each week, some unit managers did not claim any overtime because their salaries were already within the pay range allowed by the hospital administrator.

Although the overtime paid to unit managers was intended to create equity among managers, our review of payroll records found one unit manager received over \$13,000 more than the pay range set for unit managers. In fact, this employee earned more than the hospital administrator did for two months in FY1999-2000. The employee informed us that he had an agreement with the hospital administrator which allowed him to work four ten-hour shifts each week. Our review of this employee's payroll records indicates that he would have had to work four 13-hour shifts per week for an entire year to justify the claimed overtime. This employee also informed us that he submitted inaccurate overtime claims upon request from hospital management to facilitate the processing of payroll. We find this disturbing since hospital personnel compensated this employee for overtime claims they knew were inaccurate. Hospital management should be cognizant of personnel rules and regulations that require payment of overtime only for legitimate claims.

Inaccurate overtime payments were made to hospital staff

We reviewed the payroll records of 25 hospital employees to determine the accuracy of overtime payments made to them over two one-month periods. We found eight discrepancies between the daily overtime reports submitted by staff and the semi-monthly pay reports prepared by the personnel office. These discrepancies resulted in 17 percent of the staff we sampled being incorrectly compensated.

In 1997, we reported that the lack of daily attendance records for nursing staff impaired the hospital's ability to verify the accuracy of semi-monthly attendance forms used to determine each employee's pay. Semi-monthly attendance forms identified the employees' work schedules but did not necessarily reflect their actual attendance. Although the nursing office now keeps daily attendance records, this information is not transmitted to the personnel office for verification of the accuracy of overtime claims. We found nine cases in which employees were paid overtime even though their overtime claims did not reconcile to their daily attendance records. Furthermore, overtime

claims filed by other hospital staff could not be reconciled to daily attendance logs because not all staff, including unit managers, were required to complete daily attendance time sheets.

Inadequate oversight of sick and vacation leave allows staff to misuse leave

The hospital's lax oversight of employees' use of leave creates opportunities for abuse. Specifically, staff who exhibited patterns of sick leave abuse were not always investigated and placed on follow up programs. Furthermore, staff used sick leave for absences unrelated to sickness and took leave without proper authorization.

Inappropriate use of sick leave coupled with unauthorized leaves make it difficult for the hospital to reduce its dependency on overtime as ordered by the federal court. Excessive overtime can have a harmful impact on patient care as it has been linked to patient abuse.

Patterns of potential sick leave abuse are not investigated

State law and administrative rules permit the department to investigate suspected sick leave abuse. Additionally, collective bargaining agreements for licensed practical nurses, paramedical assistants, and blue-collar non-supervisory employees establish specific provisions for the investigation of sick leave patterns. These agreements permit the hospital to investigate suspected sick leave abuse in cases where an employee establishes a pattern of absences.

Patterns could include absences due to sicknesses frequently occurring before or after holidays, weekends, days off, pay days or specific days of the week. An employee who is found to have an unacceptable pattern of sick leave absences may be required to undergo a medical evaluation to verify all subsequent absences. Progressive disciplinary action is allowed when employees refuse to participate in required medical evaluations or when a medical evaluation does not support an employee's claimed sickness. Although these controls were developed to discourage sick leave abuse, we found that the hospital's personnel staff are reluctant to investigate many apparent patterns of absences. Consequently, the hospital limits its enforcement of disciplinary action in cases where sick leave is abused.

Although the department claimed that sick leave abuse was completely under control in 1998, we found pronounced patterns of sick leave among a sample of 24 staff over a six-month period. Half of the employees in our sample frequently extended scheduled time off by claiming sick leave before or after days off, holidays, and vacation.

Supervisors allow staff to use sick leave for unallowable purposes

State law requires that paid sick leave be used only because of sickness. We found that supervisors approved sick leave for absences that were not attributed to employee sickness. For example, employees used sick leave when they cared for their sick children and when they did not have a babysitter. The state family leave law only allows parents to use sick leave to care for a child with a serious health condition. Section 398-1, HRS, defines a serious health condition as either a mental or physical condition that requires the employee's child to be cared for at a health facility or under the continuing supervision of a health care provider. When an employee uses sick leave to care for an ill child, the child's health care provider must certify the serious health condition. This was not done in the cases we reviewed. Unless approved as family leave, sick leave for absences other than the employee's sickness should be charged to vacation, compensatory time off, or leave without pay.

Employees on unauthorized leave are not charged leave without pay

The Adult Mental Health Division requires employees to schedule vacation in advance, except for emergencies, and to submit an application for sick leave within five days of returning to work. Supervisors review vacation and sick leave requests and document their approval or disapproval on the State's G-1 form to ensure that payments for leave are made only when appropriate. However, we found that 21 percent of the employees in our sample took sick and/or vacation leave without proper authorization. These employees were not placed on leave without pay as required by Hawaii Administrative Rules and as permitted by collective bargaining provisions.

Rather than follow established practices, the personnel office temporarily posts unauthorized leave to the employee's leave records. Personnel staff informed us that they remind staff with temporary leave postings to submit proper leave authorization forms by the end of each calendar year. Personnel staff reported that they then convert all unauthorized leaves to leave without pay at the end of the calendar year if staff have failed to submit proper forms. This practice does not ensure the timely withholding of pay for unauthorized leave. It also places an undue burden on personnel staff who must track unauthorized leaves over a prolonged period. Moreover, it increases the potential for errors to occur as personnel staff may overlook temporary postings of unauthorized leaves at the end of the calendar year.

Standard inventory controls are needed

The hospital maintains a large inventory of food, janitorial, and hygiene supplies used for patient care. During FY1999-2000, the hospital spent approximately \$750,000 for these consumable goods which are susceptible to theft and waste. The hospital also maintains a motor vehicle fleet and allows employees to refuel hospital vehicles at privately operated service stations.

In 1995, we reported that the hospital's stewardship over state property was weak and that inventory controls were inadequate. Although inventory controls had improved during our 1997 follow-up audit, we reported that further improvement was needed to adequately account for gasoline and goods stocked at the hospital's housekeeping unit. In this audit, we found that the adequacy of inventory controls varied among hospital units.

Our current review of inventory controls revealed that the hospital has yet to implement adequate controls to reduce the risk of theft, fraud, and abuse of the hospital's consumable goods. Although sound management practice requires that the hospital maintain a perpetual inventory — a balance of its inventory created by maintaining a continuous record of goods received, issued, and on hand — the hospital does not require such a standard for all units. Moreover, units that attempted to implement perpetual inventories have not adequately ensured the reliability of their records. Consequently, there is no assurance that missing items are detected and investigated.

Perpetual inventories are not kept by all units

A perpetual inventory minimizes the risk of theft and the loss of goods and supplies. It also provides managers with useful information for making purchasing decisions.

Our 1997 audit recognized that the hospital's dietary unit accounted for food supplies by showing the balance, receipt, and issuance of each item. Monthly inventories were also performed for all food supplies. We encouraged the dietary unit to continue these inventory controls. However, the dietary unit has since abandoned its perpetual inventory system. Although purchases are recorded, the unit no longer tracks actual usage. The food service manager informed us that the dietary unit completes weekly physical counts to determine ordering needs. However, the actual stock on hand cannot be verified for accuracy as to what should be on hand. Without a perpetual inventory system, the hospital cannot readily identify discrepancies between physical counts and inventory records caused by waste or theft.

Likewise, the housekeeping unit does not maintain a perpetual inventory either. Although the housekeeping unit currently documents the issuance and receipt of goods, it does not maintain an up-to-date balance

of the number of goods it should have on hand. A daily balance of the number of goods that *should* be on hand helps to ensure that discrepancies between actual counts and inventory records are investigated within a timely period.

In 1997, we reported that the housekeeping unit developed new inventory sheets for supplies, but accountability was still a problem. Inventory counts were not always accurate, the issuance of items was not always documented, and some items in storage were not on the inventory list. We also found that patient wards failed to keep inventories of housekeeping items and other supplies received. These concerns were not addressed at the time of our fieldwork by either the housekeeping unit or patient wards.

The warehouse and the central supply unit of the hospital each maintain perpetual inventories of their respective goods. The warehouse conducts a quarterly reconciliation of on-hand balances to inventory records, while the central supply unit reconciles its on-hand balances monthly. We conducted inventories of a judgmental sample of items stored at both units and identified discrepancies between our counts and the inventory lists. For example, 12 bottles of shampoo were missing in the warehouse and 14,600 medical exam gloves could not be accounted for in the central supply unit. Staff at the warehouse and the central supply room need to improve their perpetual inventory records by reconciling these records to actual counts and immediately investigating discrepancies.

Controls to discourage the use of gasoline credit cards for personal use are needed

Since our last audit, the hospital has closed its on-facility gasoline pump. Hospital vehicles are now refueled at two commercial service stations. Credit cards for one vendor have been distributed to each hospital unit. Hospital staff sign these cards out for use, present the cards to gas attendants prior to refueling, and sign and return receipts to the hospital. A limited number of hospital staff are also allowed to refuel specific vehicles at a nearby service station operated by a second vendor. The receipts should show the amount of gas pumped, the vehicle's license number, the dollar amount of the purchase, and a division employee's signature. At the end of every month, the gas receipts are reconciled with monthly invoices.

We reviewed gas receipts for the months of September 1999 and April 2000 and found that established controls are not always followed. We reviewed 165 gas receipts and found that 116 receipts, or 70 percent, did not identify the vehicle license number. Thus, there is no assurance that only hospital vehicles were being refueled.

In cases where the gasoline receipts did identify the vehicle license number, there was no requirement that this information be reconciled to

the hospital's fleet list. We compared vehicle license numbers from a sample of gas receipts to the list of hospital vehicles. Two vehicles that were refueled were not on the hospital's fleet list. As recommended in our last audit, the hospital should compare vehicle license plate numbers noted on receipts to the hospital's vehicle list. This would help ensure that gasoline is purchased only for official hospital business.

Conclusion

The Adult Mental Health Division can improve its management of the mental health system by embracing the elements of sound planning. A statewide mental health plan that sets long-range goals and responds to community needs should be the foundation of the division's activities. Furthermore, the division must be held accountable for its failure to efficiently manage and safeguard resources dedicated to operating the adult mental health system. Until the division addresses these critical issues, it is unfair to expect taxpayers to provide the division with additional funding. The division has already received a significant increase in revenue without adequate justification. The Legislature should demand that the division comply with all planning specifications established in Chapter 334, HRS, prior to allocating any additional funds to support the downsizing and transition of the Hawaii State Hospital.

Recommendations

1. The Director of Health should ensure that the Adult Mental Health Division adequately plans for the provision of adult mental health services in the least restrictive setting available. Specifically, the director should:
 - Develop a statewide comprehensive four-year plan as required by Section 334-3, HRS. The director should require that the four-year plan be developed in response to a formal statewide needs assessment. Once adopted, this plan should direct all activities in the Adult Mental Health Division;
 - Direct the Adult Mental Health Division to encourage community involvement in the development of the state mental health plan. The director should require the division to facilitate the revival of service area boards that have been inactive or have been unable to make decisions due to their inability to achieve a quorum. The division should follow the requirements of Section 334-11, HRS, for developing and submitting a list of prospective service area board members to the governor for approval. The governor should expedite appointing members to service area boards once the list of prospective board members is submitted for review;

- Identify the resources necessary to develop and support the infrastructure needed to support the transition of the state hospital to a psychosocial rehabilitation facility. Federal funds available to shore-up community services should be identified prior to requesting that the Legislature commit any additional state funds to this endeavor;
 - Formally establish and fill positions funded by the Legislature to support the transition of the state hospital. All newly created positions and changes in duties should be accurately reflected in the division's organizational charts and position descriptions; and
 - Seriously consider recommendations made by the division's independent expert, Technical Assistance Collaborative, Inc. Those recommendations deemed feasible *and* appropriate should be implemented in a timely manner. The director should require that the division inform him on the status of all recommendations made and explain any decision not to implement specific recommendations.
2. The Adult Mental Health Division chief should ensure that patients confined to the Hawaii State Hospital are adequately and reasonably protected from harm, and provided with sufficient treatment. Specifically, the division chief should:
- Dedicate the resources necessary to ensure that all direct care staff receive adequate training in psychosocial rehabilitation. Staff training should not be contingent upon downsizing of the hospital. A realistic timeframe for implementing patient psychosocial rehabilitation modules should be developed and failure to implement modules as planned should be reported to the Director of Health;
 - Require that all supervisors discuss job expectations with staff in a timely manner to ensure that staff perform competently. Supervisors should be directed to immediately discontinue the practice of completing employee evaluations prior to the completion of the review period;
 - Require the hospital's personnel office to routinely update its professional licensing renewal status report. This report should be reviewed regularly to identify the currency of licenses of all direct care staff as applicable. Staff who are required to maintain a current license as a condition of practicing their profession should be relieved of their duties if they are unable to provide evidence of a current license;

- Require the hospital's Staff Development Office to track all training completed by staff in order to identify those staff not meeting professional training requirements. The director of the Staff Development Office should be given authority to suspend staff who fail to complete required training. Staff who pose a threat of harm to themselves or others because of outstanding training requirements, should be suspended until training is completed;
 - Clarify that patient safety/sexual harassment training is an annual continuing education requirement for all hospital staff;
 - Direct the hospital to discontinue the practice of internally investigating allegations of patient sexual harassment/abuse and require that all allegations be referred for an external and independent investigation;
 - Require that staff follow established procedures for restraining and secluding patients. The hospital should continue to monitor and follow up on incidents of non-compliance with established procedures. Staff who exhibit a pattern of non-compliance should be subject to progressive disciplinary action up to and including dismissal; and
 - Require the hospital to develop policies and procedures for transferring patients in restraints within the hospital.
3. The Adult Mental Health Division chief should ensure that the treatment planning for patients confined at the Hawaii State Hospital is improved by:
- Reminding staff of the importance of *completing* each patient's initial plan of care. Staff should identify safety risks for patients with suicidal or violent tendencies in order to ensure that the patient, staff, and other residents of the hospital are provided with reasonable protection from harm;
 - Encouraging staff to actively engage patients in discussing their treatment preferences, alternatives, and goals. Patients should be prompted to identify areas in which they need assistance in order to reach their long-term goals. In cases where patients refuse to participate, staff should document their refusal on the goal and treatment preference form. Staff should follow up to offer patients additional opportunities to become active participants in their treatment;

- Directing all members of a patient’s treatment team to attend treatment plan meetings. Staff who consistently fail to attend these meetings should be subject to counsel and progressive disciplinary action as appropriate; and
 - Requiring that treatment teams identify alternatives for those patients who have made no or minimal progress toward their treatment goals. Any decision resulting from this discussion should be clearly documented on the patient’s treatment plan. Treatment teams who fail to document decisions made from these discussions should be counseled and subject to progressive disciplinary action as appropriate.
4. The hospital administrator should improve the operations of the Hawaii State Hospital by:
- Requiring all staff to document the hours they work on daily attendance schedules. Supervisors should be required to reconcile overtime claims back to daily attendance records prior to approving these claims;
 - Requiring the personnel office to investigate all patterns of potential sick leave abuse as identified and agreed to by the collective bargaining units;
 - Requiring that supervisors only approve sick leave in cases where an employee’s absence was due to illness or covered by the state family leave law;
 - Requiring all staff to submit leave forms in a timely manner. Employees who fail to submit leave forms within the required timeframe should be placed on leave without pay status. Furthermore, the personnel office should not allow staff to turn in leave approvals after the established deadline. Personnel staff should discontinue the practice of temporarily posting leaves on employees’ leave records until the close of the calendar year;
 - Developing policies and procedures that require all units and patient wards to maintain perpetual inventories of all consumable goods and to conduct periodic physical counts of goods on hand. The physical count should be compared to the inventory report and discrepancies investigated in a timely manner; and

- Implementing controls that require the mileage per vehicle to be logged and compared to gas receipts for reasonableness. Hospital management should continue to reconcile these receipts to the monthly invoices from commercial gasoline vendors. Staff refueling vehicles should certify in writing that the gasoline was purchased for a hospital vehicle, and that the vehicle was used to conduct hospital business.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on June 6, 2001. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

The department responded that our audit incorrectly concludes that the Adult Mental Health Division did not engage in long-range planning. The department states our conclusion is "perplexing since the report acknowledges that the AMHD does, in fact, have a four-year plan." The department's reference to our recognition of the existence of a long-range plan is taken out of context and misleading.

Our report clearly states that Chapter 334, HRS, makes the department responsible for planning and developing a comprehensive four-year mental health plan. As noted in Chapter one of our report, audit work was conducted between July 2000 and January 2001. We reviewed the department's mental health plans for both FY1999-2000 and FY2000-01 and found that they failed to establish long-range goals and objectives. Our report acknowledges that a four-year service implementation plan was developed subsequent to our audit fieldwork (March 2001); however, the plan focuses on developing community services and does not meet Chapter 334, HRS' requirement that it be *comprehensive* and developed with input from service area boards. The department also referred to its April 1997 Strategic Implementation Plan. It stated that its four-year Implementation Plan for Service Development is an extension of this earlier "long-term" plan. The 1997 strategic plan we received from the division also fails to meet the planning requirements of Chapter 334, HRS since it is limited to the operations of the Hawaii State Hospital.

The department disagrees with our conclusion that inactive service area boards seriously hampered community involvement in the development of the state mental health plan. More specifically, the department disagreed that the Maui Service Area Board was disbanded and later reestablished. The department instead responded that regular meetings of this board were "disrupted" by the resignation and expiring terms of its members. The department did not specifically address the five-year inactivity of the Leeward-Central Service Area Board. We recommended that the department follow the provisions established in Chapter 334 for filling vacancies on these boards in order to ensure the community involvement guaranteed under state law. The department responded that it actively attempts to identify prospective board members; however, it did not indicate whether it would comply with the procedures established in law.

The department disagrees that the Adult Mental Health Division requested over \$34 million without first completing a formal statewide needs assessment. The department contends that the funding requests were based on needs identified by its consultant, Technical Assistance Collaborative, Inc. (TAC). However, the department contracted with TAC to complete a formal needs assessment only *after* it requested and received millions in funding. Moreover, the division's planner confirmed that at the time of our audit fieldwork the most recent formal gap analysis had been completed in 1994—six years before the division requested emergency and supplemental funding. The department argues that its budget request was reviewed and approved by the Legislature; however, it ignores that the approval occurred under pressure from the federal court. In fact, the Legislature initiated this audit because it was concerned that it was being asked to authorize millions of dollars in additional funding without any assurance that the department adequately planned to address the legal requirements of the 1991 settlement agreement.

The department did not specifically address many of our findings relating to patient care and the hospital's management of resources. The department responded that it has a comprehensive risk management program to ensure the safety and welfare of consumers, staff, and the public.

The department agrees that the development of an adequate community infrastructure requires careful planning, and reports that it is in the process of filling staff vacancies. The department also responded that it has addressed our concerns regarding the lack of staff training and community resources to support the transition of the state hospital to a psychosocial rehabilitation facility. The department reports that it has made many changes in policy and procedures that address the issues identified in our audit as well as our recommendations.

Finally, the department incorrectly states that our audit faults the division for contracting with private providers who are either unlicensed or lack the proper accreditation. Our report only states that these are concerns of the Hawaii Disability Rights Center. We are further examining this issue in a separate audit of the division's management of contracted mental health services.

We made some minor changes to the draft report for the purposes of accuracy and clarity.

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917



MARION M. HIGA
State Auditor

(808) 587-0800
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June 6, 2001

COPY

The Honorable Bruce S. Anderson
Director
Department of Health
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Anderson:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Audit of the Adult Mental Health Program*. We ask that you telephone us by Friday, June 8, 2001, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Friday, June 15, 2001.

The Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa ^{hr}
State Auditor

Enclosures

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII



BRUCE S. ANDERSON, Ph.D., M.P.H.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File:

June 20, 2001

RECEIVED

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OFFICE OF THE AUDITOR
STATE OF HAWAII

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

Thank you for extending our response deadline from June 15, 2001, to June 20, 2001. The following are some of our comments based on the review of the findings, comments, and recommendations contained in the draft report entitled, "Audit of the Adult Mental Health Program."

The report states that the Adult Mental Health Division ("AMHD") does not engage in planning (page 10, page 11, page 34). This is incorrect and perplexing since the report acknowledges that the AMHD does, in fact, have a four-year plan (Page 11). The AMHD regularly and appropriately engages in short and long term planning. The AMHD's current four year plan (the "Implementation Plan for Service Development" dated March 15, 2001) has been developed over the past 18 months following extensive communication with community stakeholder groups and input from these groups. The plan is a well-developed extension of our previous long-term plan (the "Strategic Implementation Plan" dated April 10, 1997) developed in collaboration with the Technical Assistance Collaborative, Inc. ("TAC"). In addition, the AMHD regularly prepares annual plans as required by federal law in connection with funding requests. These plans are evaluated annually by an independent external review group to ensure compliance with federal law. Hawaii regularly receives exemplary marks from this external review as well as the federal funding it seeks from the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

On page 13, the report states that the AMHD spent, "millions of dollars for mental health services without first completing a formal state-wide needs assessment to determine and guide funding decisions. The division's request for \$14 million in emergency funding for FY 1999-2000 and \$20 million in supplemental funding for FY 2000-2001 was made without the benefit of a formal needs assessment." This implies a lack of planning with

Ms. Marion M. Higa

June 20, 2001

Page 2

regard to these funding requests and implies that the requests were without basis or justification. This is incorrect. The funding requests were fully developed based on need as identified through consultation with TAC and consistent with the long term plan for community service development in existence at that time (the "Strategic Implementation Plan" dated April 10, 1997). Further, the budget requests were reviewed closely through the internal DOH administrative review process and the external review process coordinated by the Department of Budget and Finance. The budget requests were reviewed and approved by the Governor's Office and the legislature. In addition, through collaboration with TAC, external consultants with specific expertise (e.g., information systems) reviewed and gave input into the above mentioned AMHD funding requests.

The report states that the Department has not sufficiently assessed patient need for purposes of planning (page 10, page 34, Recommendation 1) and that services are not determined by patient needs assessment (page 13). This is incorrect. The AMHD assesses patient need on an ongoing basis and uses this information for purposes of planning. Most recently, the AMHD conducted a state-of-the-art patient needs assessment working with TAC and the Human Services Research Institute. This needs assessment was conducted over a 9-month time period during the Year 2000. The results of this needs assessment were then used to develop the AMHD's most recent long-term plan. Your staff were given the written report of the needs assessment upon which the Implementation Plan for Service Development was based.

On page 11, the following statement appears, "a division planner informed us that it was impractical to develop a long-range mental health plan since changes were occurring rapidly." This statement is false.

Your recommendations related to planning have been completed (i.e., the first two bullet points of recommendation #1 on page 34 and the conclusion stated on page 34). The conclusion which appears prior to the recommendations on page 34 is erroneous in stating that the AMHD does not embrace principles of sound planning or comply with required and accepted planning principles.

The report states that Hawaii State Hospital (HSH) is the "Division's lowest priority" (page 11). This is incorrect. Funding for HSH is approximately \$28.8 million per year. This is the single highest expenditure of the AMHD. Consistent increases to the HSH budget have occurred over the past 10 years. There are no plans to decrease funding of HSH. The context within which the above statement occurs shows that the Legislative Auditor's office staff did not understand the AMHD's report of the community priorities as expressed in the Implementation Plan for Service Development. The AMHD gathered extensive input from over 600 persons representing 5 major categories of mental health shareholders (consumers, family members, staff, including HSH staff, community providers, and advocates/other shareholders) during 36 state-wide community input sessions. The focus of these meetings was to prioritize the most important service areas for further development with new funding over the first year of a four-year process. Within this context, community members rated inpatient services as the lowest priority area for the expenditure of new funding. It is

incorrect to interpret this result as meaning that HSH is the AMHD's lowest priority. The assurance of appropriate services at HSH is one of the AMHD's highest priorities.

The report on page 11 states that, "Communication with community groups needs improvement." The community input referred to in the above paragraph is one of many mechanisms that the AMHD uses to communicate with community stakeholders and to gather input. For example, the AMHD holds public "town meetings" with stakeholders on a regular basis (2-3 times per year) and the AMHD Chief holds a monthly "roundtable" meeting which is open to any interested person and the agenda consists of open discussion. The State Council on Mental Health is an advisory group to the AMHD and is another mechanism by which input is gathered.

The report, on page 11, refers to seven service area boards. Prior to 1997, there were five Oahu Community Mental Health Centers ("CMHC") and three neighbor island CMHCs. However, in 1997, the Oahu CMHCs were reorganized into one administrative structure. Due to the state's economic condition, declining resources resulted in prolonged staff vacancies through funding shortfalls and a reduction in force. Reorganization was necessary to consolidate administrative resources and provide integrated leadership to appropriately restructure the system. Consequently, there is a statutory obligation for one board to represent the Oahu CMHC. However, because the AMHD values community input, the Oahu CMHC is encouraged to consult with wide ranging community groups and regularly collects information from community constituents, including those from the Pearl City and Leeward Oahu area. In an effort to maximize community input, the Oahu CMHC actively maintains and supports advisory groups working the Kalihi-Palama Clinic, Windward Oahu Clinic, and Diamond Head Clinic.

At page 11, the report infers that the Maui Service Area Board ("SAB") was disbanded and re-established in July of 2000. This is incorrect. Regular sessions of the Maui SAB were disrupted as a result of two members voluntarily leaving the board about the same time that the terms of the three of the remaining positions expired on June 30, 1999. (Another four terms expired on June 30, 2000.) Nonetheless, the Maui SAB remains active and regularly gives valuable input to the CMHC and AMHD.

The statements on pages 11 and 12 of the report that service area boards did not have a chance to give input into the state plan is incorrect. The AMHD is organized into four service area centers: The Oahu CMHC, the Kauai CMHC, the Maui CMHC, and the Hawaii County CMHC. Each of these CMHCs works with a service area board to gather community input. Service area boards provide primary input to local service delivery sites, while the State Council on Mental Health is the advisory body which primarily gives input to the AMHD. The State Council on Mental Health includes members from the four service areas. Members of services area boards and the State Council on Mental Health had opportunities to give input into the four-year Implementation Plan for Service Development. Input sessions were specifically targeted to members of service area boards and the State Council on Mental Health. On page 12, the report infers that this input was somehow deficient, i.e., "The division did seek state-wide community input when

developing its implementation plan for service development; however, this process was separate and apart from the community input guaranteed to service area boards.” The community sessions conducted for the review of the Implementation Plan for Service Development provided input from a wider segment of the community in each of the service areas that would have been achieved through individual service area boards alone. Given that community input is a primary reason for the boards, this approach was appropriate.

On pages 11 and 12, the report states that the AMHD does not take sufficient steps to ensure that vacancies on service area boards are filled in a timely manner. The AMHD actively follows the following procedures to identify prospective membership by: (1) publishing a notice of vacancies in all SABs and the State Council on Mental Health (for example, 2-11-99, Advertiser; and 1-24-00, 2 HS&CPN Honolulu) and providing information (verbal and written) to interested persons and forwarding applications to them; (2) soliciting nominations from a variety of sources such as, the State Council on Mental Health, CMHCs, SABs, consumers, through flyers, word-of-mouth, notification of advocacy groups, and submits the nominations to the Governor. If individuals wish to submit their applications independent of our agency, they may do so. (Note: many individuals prefer to submit their applications directly to the Governor’s office even though we encourage the application to be sent first to the AMHD); and (3) A list of prospective nominees is forwarded to the Office of the Governor for review and submission to the Legislature.

On page 16, the report implies that the AMHD has not filled all 69 positions approved by the legislature during FY 1999-2000 and FY 2000-2001. Twenty-five of the 69 positions are not being filled because the functions of these positions are being provided through an agreement with another state agency. The related funds for these 25 positions were used to fund the agreement. As of May, 2001, out of the remaining 44 positions, 11 positions have been filled, 3 positions are under recruitment, and 11 positions were in the process of being established. In addition, commitments to begin employment over the next several months have been received by at least 5 individuals. These results have been attained even though the results of national and local searches have shown that existing salary levels are too low to attract the caliber of qualified competent specialists required to perform the complex tasks required of these new positions.

The report discusses the development of community resources to support discharged patients on pages 17-18 of the report, and infers that the AMHD has made a decision to downsize HSH to 108 beds. The Director of Health has been quite clear that HSH will be as large as it needs to be, even larger than at present (168 beds) if necessary, in order to meet the needs of persons with serious mental illness in Hawaii. However, within this context, it is important to realize that the State is obligated to ensure consumer’s rights consistent with federal and constitutional mandates. The issue of least restrictive setting and best practices as defined by the Olmstead decision are the basis of determining the number of inpatient psychiatric beds that are appropriate, as well as the number and levels of community-based care that will provide treatment and rehabilitation in a setting(s) less restrictive than inpatient hospital level care. The AMHD agrees with the report in that the

development of an adequate community infrastructure requires careful planning and time. The recent Implementation Plan for Service Development is the result of this commitment.

The report states, on page 17, that the AMHD contracts with mental health providers who are not licensed or accredited, and that providers do not hold appropriate credentials. All providers of services are either accredited by CARF, the Commission on Accreditation, or the Joint Commission on the Accreditation of Healthcare Organizations, or are in the process of obtaining accreditation. Other providers are also certified by the International Center for Clubhouse Development (ICCD), a recognized national certifying organization. These accrediting bodies have clear standards with regard to human resources and qualification of providers. The only providers of service who do not fall into one of these two categories and are not required to fulfill the AMHD's accreditation requirement are those very small programs lacking administrative and programmatic infrastructure to support the requirements of national accreditation. These services must maintain standards and requirements established by the AMHD. Services that provide on-site medical services or special treatment services are required to be licensed.

The AMHD has a comprehensive risk management program to ensure that the welfare and safety of consumers, staff, and the public is monitored and managed. Providers are required to have operational quality management programs that review and address concerns from clinical, administrative, and patient protection perspectives.

The report recommends that the Department seriously consider recommendations made by TAC (page 35), and that recommendations deemed feasible and appropriate be implemented in a timely manner. Further, the report recommends that the Director be informed of all decisions regarding TAC recommendations. These recommendations follow earlier statements in the report that, "the division failed to implement the recommendations of (TAC) in a timely manner" (page 14) and, "the division did not implement some of TAC's key recommendations in a timely manner" (page 15). Because the AMHD works with limited resources, it is necessary to focus efforts on implementing recommendations made by TAC according to priority status. TAC has provided valuable assistance to the AMHD and each recommendation TAC suggests is carefully considered. In evaluating recommendations, the AMHD reviews each recommendation using the standards recommended above, (i.e. feasibility of implementation and appropriateness of implementation). Further, recommendations which are feasible and appropriate are prioritized based on available resources and the importance of the recommendation as determined through consultation with TAC and administrative review. As such, some recommendations are only implemented after a period of time has elapsed due to AMHD's focus on higher priority activities. Because of ongoing consultation with TAC, AMHD is able to review implementation activities and reemphasize (or deemphasize) activities based on changing priorities and delays caused by factors outside of the control of AMHD (e.g., funding limitations, delays associated with personnel classification review, and the like). The AMHD has worked very hard, and will continue to work very hard, within the constraints of Hawaii law, rules, and policies, to implement prioritized, feasible, and appropriate TAC recommendations in a timely manner.

On page 35 of the report, you recommend that AMHD identify resources and infrastructure necessary to support the transition of HSH to a psychosocial rehabilitation (PSR) facility, and identify federal funds that can be used to shore up community services. These recommendations arise from earlier comments in the report focusing on the transition of HSH to a PSR facility. On pages 15 and 16, key concerns are raised over: (1) the availability of appropriately trained staff at HSH; (2) PSR leadership at HSH; and (3) the availability of community resources to support this initiative. During the past year, the first two issues have been satisfactorily addressed and, with the newly developed four-year community service plan (the "Implementation Plan for Service Development" dated 3/15/01), the AMHD is well on its way to providing the necessary community resources to support the initiative. Highly trained psychosocial rehabilitation staff have been hired to coordinate and conduct PSR rehabilitation activities during the past year and institution-wide PSR treatment activities have been successfully deployed. Organizational issues have been resolved with the Chief of Psychology now responsible for PSR activities. The Implementation Plan for Service Development provides the recommended identification of resources and community infrastructure necessary to support the transition. Federal Medicaid and Medicare funding, housing, and community block grant development funds have been identified to support the development of community resources. The AMHD is actively working with the Hawaii Department of Human Services to expand the definition of reimbursable services (the "rehab option") in order to access additional federal insurance funds and is presently developing a housing plan which details opportunities in the area of federal housing funds. The housing plan will be available to the Legislature prior to the 2003 session.

We continue to be concerned about the impression of the lack of appropriate management controls at HSH. Since the audit looked at the period of 1999 and 2000, we must note that there have been many changes in policy and procedure that address the issues identified and the recommendations made.

The report recommends that direct care staff receive adequate training in psychosocial rehabilitation (page 35). Psychiatric Technicians are currently being trained in the Activities of Daily Living (ADL) training module which incorporates psychosocial rehabilitation principles and values. The module also teaches therapeutic communication techniques used to coach and motivate behavior change and skill development. Registered Professional Nurses are learning the Johnson Behavioral Systems model, which helps them conceptualize patients' problems from a systemic behavioral point of view. The model teaches nurses a framework for ongoing assessment, and is taught in conjunction with basic mental status assessment skills. Social and Independent Living Skills (SILS) modules training continues along with Family Psycho-education Training, and Dialectic Behavior Therapy training. Additional information can be provided concerning these and other services, if necessary.

The report recommends that a realistic timeframe for implementing patient psychosocial rehabilitation modules be developed (page 35). Psychosocial rehabilitation is not simply a program of modules designed to enact behavioral change. It involves, more basically, than a set

of values and principles that help shape the design of treatment and rehabilitation. These principles include the following:

1. Promoting greater independence in living;
2. Empowering a patient to take charge of his or her own rehabilitation plan;
3. Facilitating vocational rehabilitation;
4. Developing natural supports; and
5. Helping clients achieve their chosen goals.

On page 35 of the report, a recommendation is made that HSH administration require all supervisors to discuss job expectations with staff in a timely manner. Job expectations for all staff are being revised to promote greater self-responsibility. For example, in the direct care area, Psychiatric Technicians (in contrast with Para Medical Assistants) are expected to complete their assignments without constant supervision and reminders from their team leaders. Team leaders are being held accountable for managing and treating their assigned caseload of patients independent of the charge nurse. Charge nurses will be responsible for shift programs and coordinating all services on each unit.

New competencies have been developed for all nursing staff reflecting greater responsibility for understanding and developing the approach to psychosocial rehabilitation. Competencies throughout the hospital are being reviewed and updated to reflect increased individual responsibility and accountability.

The report also recommends that supervisors should immediately discontinue the practice of completing employee evaluations prior to the completion of the review period (page 35). Personnel appraisals are completed in accordance with the current State of Hawaii Performance Appraisal System. However, from time-to-time, some exceptions will occur for those staff on extended leaves, workers compensation, or other reasons of extended absence.

The report recommends that the hospital's personnel office routinely update its professional licensing renewal status report (page 35). As of June 14, 2001, all licensed staff were up to date and all staff have been notified that failure to renew their licenses prior to expiration will result in their being placed on leave without pay pending completion of licensing requirements. The database used to track licensing is being maintained and is up-to-date.

The report recommends that the AMHD chief ensure that HSH patient treatment plans be improved (pages 36). Initial plans of care are developed for every patient admitted to the hospital. Since implementation of the new treatment planning policy and procedure, patients have been encouraged to participate in treatment team meetings on all units. This was not the case previously, as a different model of treatment planning engaged the patient in individual meetings with the treatment coordinator or psychiatrist (MD) to discuss treatment planning. Presently, the patient is asked to meet with the entire treatment team. HSH treatment teams are expected to incorporate the patient's stated goals and vocational rehabilitation goals after discharge into their treatment plans during hospitalization. This will assure that HSH treatment teams include a focus on community reintegration in the treatment planning. Either corrective or

Ms. Marion M. Higa
June 20, 2001
Page 8

disciplinary actions are being taken if staff members are not at treatment planning meetings without an approved excuse (i.e., sick leave, vacation, etc.).

HSH has in place a tracking system that will encourage patient participation in programming through the Patient Incentive Program ("PIP"). This system reinforces patient behaviors through the earning of incentive points that can be redeemed for goods from the PIP store on the HSH campus. The patients' treatment plans reflect selective allocation of PIP points to help motivate participation in essential programs.

The report recommends that the hospital administrator improve the operations of HSH in several areas (pages 37 and 38). The recommendations made are already being or will be implemented. As soon as the unions are consulted, a system that will require all staff to sign in at the beginning of each shift, sign out and in for morning and afternoon breaks and at lunch, and sign out at the end of the day will be implemented. All times will be verified by the supervisor/designee within the start/end of the shift. All allegations of sick leave abuse are investigated in accordance with the respective collective bargaining agreements.

HSH is also in the process of centralizing its purchasing, receiving, and inventory controls into the hospital's business office. This centralization will assist in accountability through the perpetual inventories that will be created on each unit and other areas within the hospital, allowing for timely investigation of losses or discrepancies.

As noted above, this letter describes some of our responses to your draft report. There are many more specific observations and conclusions with which we take issue, and which require more time to address. We will provide additional responses as soon as possible.

Thank you for the opportunity to review the draft report.

Sincerely,



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Director of Health