"Reinventing" Governance of Hawaii's Public Mental Health Delivery System — Problems, Options, and Possibilities

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Report No. 5, 1994

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FOREWORD

This report was prepared in response to Senate Resolution No. 137, S.D.1, which was adopted during the Regular Session of 1993.

The Bureau extends its sincere appreciation to those whose cooperation and assistance made this report possible. The information presented could not have been obtained without the participation of those who provided their time and insight through often lengthy personal interviews and questionnaire responses. These people clearly have a deep commitment to improving the delivery of mental health services in Hawaii. The Adult Mental Health Division of the Department of Health's Behavioral Health Services Administration opened many of their meetings, agreed to numerous interviews, and honestly discussed many of the difficulties they struggle with under the present system. Special thanks are extended to: Masaru Oshiro, A.C.S.W., DOH/BHA Deputy Director; and Sherry Harrison, R.N.C., M.A., AMHD Chief.

Neal Mazer, M.D., M.P.H., CAMHD Chief; and Elaine Wilson, A.C.S.W., M.P.H., ADAD Chief, each spent many hours discussing their respective divisions' operations. Other Department of Health staff who generously assisted in the preparation of this report include Dr. Howard Weiner; Malina Kaulukukui, M.S.W., B.C.D.; Dr. Linda Fox; Dr. Harlan White; Tim Wee; Judith Crockett; Dr. Sondra Doe; Lori Higa; Gerrie Lee; and Tammy Rincone.

Each of the nine Community Mental Health Center chiefs spent hours providing valuable insight. In particular, Dr. Eugene Shooter; Jud Cunningham; and Kathleen Yoshitomi, M.S.W., gave graciously their time and energy. Thanks are also extended to: Billie Hauge; Wayne Law, M.S.W.; Melvin Hayase, M.S.W., A.C.S.W.; William Apaka; Joy Domingues, R.N.; Ida Otake, R.N.; Elnora Guieb; Eva Kishimoto, M.S.W.; and Irving Cohen, M.S.W.

The Bureau also extends thanks to the thirty-four (seventy-seven percent) Community Mental Health Center supervisory personnel who responded to a ten-page questionnaire with helpful comments and information.

Many members of the community generously offered their time and provided helpful insight for this project, particularly Mark O'Donnell, M.P.H.; Professor Susan Chandler, D.S.W.; Juanita Iwamoto, M.S.W., M.P.H.; Deputy Attorneys General Sonia Faust and Charleen Aina; Professor Wes Shera, D.S.W.; Dr. Henry Foley; Dr. Eric Rosenthal; Dr. Henry Goldstein; Martin Porter; Mele Look; and Philip Michaels.

Numerous national mental health experts provided helpful information during the preparation of this report, particularly Wayne Kimmel; Dr. Lenore Behar; Dr. Robert Cole; Dr. Howard Goldman; Lawrence Walker; Dr. David Goodrick; Skip Hibbel, Esq.; Dr. Susan Ridgely; Robert Morimoto; Richard Munger; and Valerie Manderville.

A special thanks is extended to Anthony Bartholomew, Esq. and Nathan Sult, Esq., for their invaluable assistance with the preparation of this report.

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January 1994

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GLOSSARY

ADAD	Alcohol and Drug Addiction Division
AMHD	Adult Mental Health Division
ASO	Administrative Services Organization
B & F	Budget and Finance
BHA	Behavioral Health Service Administration
BPSR	Bio-psychosocial Rehabilitation
CAMHD	Child and Adolescent Mental Health Division
CARF	Commission for Accreditation of Rehabilitation Facilities
CASSP	Child and Adolescent Service System Program
CMHC	Community Mental Health Center
CMI	Chronically Mentally Ill
DOE	Department of Education
DOH	Department of Health
DOJ	Department of Justice
DPS	Department of Public Safety
HCFA	Health Care Financing Administration
HSH	Hawaii State Hospital
PHAO	Public Health Administrative Officer
POS	Purchase of service
QUEST	Quality of Care, Universal Access, Efficient Utilization, Stable Cost and Transformation
RFP	Request for proposal
RWJF CMI	Robert Wood Johnson Foundation Program on Chronic Mental Illness
SPMI	Serious and persistent mental illness
TQM	Total quality management

Chapter 1

OVERVIEW

In May, 1993, the Legislature of the State of Hawaii adopted Senate Resolution No. 137 (1993), entitled "Senate Resolution Requesting a Study on Options for Governance of the State's Mental Health Service Delivery System" (See Appendix A). The premise behind the resolution is that there is a fundamental incompatibility between a mental health service delivery system which must be flexible, innovative and "time-appropriate" and one which is hampered by ponderous and time-intensive government fiscal controls and personnel and administrative policies. The Legislature requested that the Legislative Reference Bureau study the means employed by other states to organize and operate their mental health systems and to consider and suggest various options for governance,[1] administration and funding of the mental health service delivery system operated by the Behavioral Health Administration (BHA) of the Department of Health (DOH). This report has been prepared in response to the Legislature's direction.

Methodology of Study

The second chapter of this study provides an historical perspective of mental health issues, from both a national and state orientation. It examines key legislative and policy-related changes in perspective, law and governance over the years. It also discusses the various lawsuits, consent decrees and national reports which have dealt with the BHA's operations over the years.

The third chapter provides an overview of the present organizational and governance structure of the BHA. It describes the present infrastructure of the various divisions of the BHA and discusses the present structure of governance.

The fourth chapter examines the present system and its various shortcomings. It explores some common perceptions about the problems with BHA's present governance, administrative and fiscal operations. Such perceptions are presented through interviews with over thirty-five "stakeholders" in the system, including community mental health center chiefs, private service providers, mental health advocates (including Mental Health Association in Hawaii, Alliance for Mentally Ill and Hawaii State Council on Mental Health representatives), private consultants, as well as clinicians, planners and management personnel within the BHA.

The fifth chapter discusses components of the crisis in the present system, as well as the financial and social implications of retaining the present system without significant changes.

The sixth chapter discusses Hawaii's experience with the Robert Wood Johnson Program on Chronic Mental Illness Demonstration Project, which supported several United States cities' establishment of mental health "authorities" with centralized administrative, fiscal, and clinical responsibility for public mental health services.

The seventh chapter examines some public mental health care programs operating successfully in other states, including other state public mental health programs for youth.

The eighth chapter discusses some considerations regarding organizational alternatives for the delivery of public mental health services through nonprofit corporations, public authorities and governmental agencies. It discusses Hawaii's experiences in creating analogous organizational structures such as the Aloha Tower Development Corporation, the Research Corporation of the University of Hawaii, the Hawaii Housing Authority, and the Housing Finance and Development Corporation. It describes the Community Hospitals Division of the Department of Health which has experienced problems similar to those presently confronting the Behavioral Health Services Administration. It also describes the Wai'anae Coast Community Mental Health Center, the only privatized community mental health center (CMHC) operating in Hawaii.

The ninth chapter sets out certain fundamental principles which appear to account for successful public mental health service governance structures in other jurisdictions.

Chapter 10 presents the findings and recommendations of this study.

Limitations of Study

This study focuses on the primary divisions within the BHA: the Adult Mental Health Division (AMHD), the community mental health centers (CMHCs) within that division, the Child and Adolescent Mental Health Division (CAMHD) and the Alcohol and Drug Addiction Division (ADAD). Two branches of the AMHD, the Courts and Corrections Branch and the Hawaii State Hospital, are not reviewed in this report. The reasons for this are threefold: (1) the Hawaii State Hospital is presently governed by a consent decree specifically addressing governance issues; (2) the Hawaii State Hospital is presently completing two years of reorganization, which is expected to be finalized soon by the Department of Budget and Finance; and (3) the treatment of the incarcerated mentally ill will be transferred from the BHA-AMHD's Courts and Corrections Branch to the Department of Public Safety under the Corrections Program Services, Health Care Services as of July 1, 1994.[2]

In examining the present system's shortcomings in chapter four, this study does not attempt an in-depth evaluation of the services, programs and operations presently provided by AMHD and CAMHD. Rather, it presents the predominant viewpoints of those interviewed

during the course of this study and the managerial staff of the nine CMHCs who submitted responses to the questionnaires.

The interviews conducted during the course of this study reflect many different perspectives of the BHA system -- past and present deputy directors, division heads, consumer advocates, professional staff, private providers, etc. Such interviews do not by any means purport to represent a complete spectrum of the vast perspectives of the system. For instance, ADAD and CAMHD staff[3] were not interviewed or surveyed. Also, although several mental health advocates were interviewed, the perspectives of BHA mental health consumers are not addressed.

Endnotes

1. Although the resolution does not define the term "governance," the definition used by Osborne and Gaebler in Reinventing Government, is applicable here: "Governance is the process by which we collectively solve our problems and meet our society's needs." David Osborne and Ted Gaebler, Reinventing Government; How the Entrepreneurial Spirit is Transforming the Public Sector (New York: Plume, 1993), p. 24.

2. Hawaii, Department of Health, Adult Mental Health Division, State Plan for the Seriously Mentally Ill, Goals and Objectives for Fiscal Year 1994, Draft, November 8, 1993, p. 5.

3. A series of evaluations of the managerial aspects of the CAMHD was recently conducted by a mental health public policy and management consultant, Wayne A. Kimmel, acting pursuant to a grant from the Gwenfread Allen Fund of the Hawaii Community Foundation. Mr. Kimmel's findings and recommendations, referred to within, were based upon his on-site examinations of the CAMHD and numerous interviews with CAMHD staff.

Chapter 2

HISTORY OF HAWAII'S MENTAL HEALTH DELIVERY SYSTEM

National History

Until Congress enacted John F. Kennedy's Community Mental Health Centers Act (CMHCA) in 1963, servicing people with severe mental illness was considered the exclusive responsibility of the states. The vast majority of people with chronic or serious mental illnesses spent most of their lives in state psychiatric institutions. Upon passage of the CMHCA and subsequent legislation, federal funding became available to communities to support staffing and services developed through locally controlled and governed mental health programs.

Community-based mental health programs expanded rapidly in the 1970s as thousands of patients nationwide were being discharged from state hospitals. The theory behind the move to deinstitutionalize was that patients should be treated in community rather than institutional settings; as patients left the hospitals and returned to their communities, community mental health centers would take responsibility for their care and treatment. Funding that had previously been earmarked for institutionalization was intended to follow the former patients to their communities where it would be used to provide them with an appropriate array of services representing a continuum of care. In President Kennedy's message to Congress, it was announced that "reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability."[1]

This theory of mental health service delivery proved to be simplistic at best and disastrous at worst. Federal funding decreased steadily in the 1970s and the care expected through the CMHCs proved fragmented or even unavailable. In the late 1980s, states were federally mandated to prioritize state-funded mental health services for the mentally ill.[2]

Significant Developments Impacting Hawaii's Public Mental Health System Over the Past Decade

A comprehensive review of the historical problems associated with Hawaii's mental health service delivery is beyond the scope of this report. Nonetheless, a review of some of the key developments of the past decade is quite instructive as to some of the problems and proposed solutions which have repeatedly received public attention over the years.

1984

- Hawaii's Legislature enacts the Mental Health and Substance Abuse Systems Act which, among other things, sets up community mental health centers (CMHCs) to function as centers for the delivery of services in the service areas of mental or emotional disorders and substance abuse. The CMHCs are set up in specific geographical areas to serve as focal points for the development, coordination, and delivery of mental health services.[3]

1985

- Hawaii State Legislature provides $15 million toward the $30 million needed for rebuilding the Hawaii State Hospital.

- Newspaper reports that no more than forty-two of sixty-six clinical psychologist or psychiatric social worker jobs have ever been filled at DOH.[4]

1986

- Hawaii is rated fifty-first in the country for the care of the seriously mentally ill based upon research conducted by the Public Citizens Health Research Group (PCHRG), a private, nonprofit organization associated with consumer advocate Ralph Nader. According to the report ranking each state's programs for the mentally ill, "Hawaii may be paradise for tourists but it is anything but for the seriously mentally ill." Hawaii ranks fourteenth in per capita income, while ranking thirty-sixth in per capita expenditures for mental health. The report states that Hawaii's state hospital for the mentally ill is "third class." (The hospital lost its national accreditation in 1974 by the Joint Accrediting Association of Hospitals based on alleged deficiencies in staffing and recordkeeping.) The report finds services for children to be "especially deficient" and suggests that "[u]ntil a large wave of indignation sweeps over the islands, the plight of the seriously mentally ill is not likely to improve."[5]

- In response to the PCRHG report, Chief of the Mental Health Division of the DOH, Denis Mee-Lee, states, "The bureaucratic procedures and checks and balances necessary to operate state programs sometimes impede progress of efforts to help those in need."[6]

- A federal inspection team reviews the Hawaii State Hospital for the mentally retarded and finds civil rights violations, lack of active treatment programs, leaky roofs and toilets overflowing with water and fecal matter. The team also reports that "there is no effective governing body to adopt and enforce rules and regulations or oversee the health care and safety of the clients. The governing

body fails in its responsibility to secure appropriate staff as needed, to periodically evaluate all staff, and identify problems."[7]

- Hawaii State Hospital loses federal certification for Medicare and Medicaid reimbursements.[8]

- Chief of the DOH Mental Health Division, Dr. Denis Mee-Lee, requests legislators to form a Special Committee on the Seriously Mentally Ill to study the problem of proper mental health care. He reports that "[t]here is no question that services are inadequate and incomplete" and "it's amazing. . . after nine years on the job how little I can do on the fundamental issues that exist."[9]

- Dr. Mee-Lee reports that Hawaii spends only one percent of the total government budget on mental health -- ranking it forty-sixth in the nation. He reports that even when he knows what to do to improve services for the mentally ill, he is "frustrated by lack of state funds and the bureaucratic process."[10]

- Research psychiatrist E. Fuller Torrey (author of the PCRHG report) states that the encouraging aspect about Hawaii's mental health system is, "You can start from almost anywhere and improve it."[11]

- Newly formed Hawaii Advocates for Children and Youth (HACY) reports that efforts by the DOH Mental Health Division have been less than adequate in helping troubled youth and that only a small proportion of the estimated 17,000 Hawaii youths younger than eighteen years old with severe and potentially chronic mental health problems are being helped. The DOH progress report shows that state mental health facilities served only 2,193 children and adolescents in 1986. HACY also claims that the Mental Health Division has failed to develop a statewide children's mental health service plan despite their statutory requirement to do so. It notes that instead of a statewide plan, each local mental health center coordinates the children's programs for only the area it serves.

  DOH coordinator of the Child and Adolescent Service System Program (CASSP), Richard Behenna, notes that there should be more coordination between systems -- mental health, social welfare and educational. Explains Behenna, "Each system has developed independently and doesn't coordinate efforts to serve children."[12]

- DOH Director Leslie Matsubara and DOH coordinator of CASSP, Richard Behenna, announce their respective impending resignations.[13]

- National expert from Ohio reports feeling "sick and outraged" upon seeing the conditions mentally and emotionally handicapped children endure in units at the Hawaii State Hospital and Leahi Hospital. She states that lack of coordination

between various agencies in Hawaii has "severely crippled aid to those youngsters who need help. Coordination must happen between the departments of education and health, as well as agencies of welfare, juvenile justice, mental retardation and mental health."[14]

- Honolulu is named one of nine cities nationwide to receive a $2.5 million grant to improve services for the chronically mentally ill through the Robert Wood Johnson Foundation. The grant is intended to streamline services for the chronically mentally ill through coordination of community programs and supervised housing in the community.

- In announcing his impending resignation as Chief of the Mental Health Division of the DOH, Dr. Mee-Lee states that he has been criticized principally by persons within his own division.[15]

1987

- Experts Dr. E. Fuller Torrey (co-author of the PCRHG report) and Dr. Leonard Stein, University of Wisconsin, participate in a symposium on the chronically mentally ill in Hawaii. Stein notes that Hawaii's system of care for the mentally ill is "fragmented and inadequate" in that crucial community programs are lacking and those that do exist "are not very well coordinated with one another."[16]

  Dr. Torrey urges lawmakers to fund Hawaii State Hospital to "get it back up so it's accreditable." Dr. Mee-Lee announces the state plans to reapply for accreditation later this year. Stein encourages lawmakers to put money into developing community care.[17]

- DOH Director John Lewin states that Hawaii needs to "revitalize its system of eight community mental health centers and prioritize funding so that it can better serve the chronically mentally ill."[18]

- A statewide inter-departmental cluster composed of the departments of Health, Education, Human Services, Family Court and the Governor's Office of Children and Youth is statutorily established with an appropriation of flexible funds to provide for coordinating the placement of children with severe emotional and developmental problems.[19]

- DOH Hawaii State Hospital Administrator, Howard Gudeman, reports that an off-grounds day treatment program for adolescents would keep young people out of the Hawaii State Hospital's twenty-bed adolescent unit. He notes that the Legislature provided five staff positions to set up a pilot program. However, he states, no money was provided for rent.[20]

1988

- (January) DOH announces plans to open a drop-in center in downtown Honolulu for mentally ill street people. DOH asks agencies to submit proposals to run the "clubhouse" program for thirty people. The project has a budget of $200,000 for the first year."[21]

- (February) DOH is unable to get a lease for the drop-in center downtown.[22]

- House Finance Committee hears a bill for funding of $485,450 to strengthen community mental health centers. DOH reports that the Robert Wood Johnson (RWJ) Foundation has committed $2.5 million for improved mental health services for the seriously mentally ill in Honolulu, based on a state commitment to assist with the effort.

  Hawaii Mental Health Association Vice-President Susan Chandler warns that the RWJ Foundation grant requires the State to begin new strategy for the mentally ill and that the foundation is closely monitoring Honolulu and will send a team this month to look for evidence that progress is being made. She notes that the grant is unique because it not only provides substantial funding but requires the State to begin a new strategy for care of the mentally ill.[23]

- DOH announces that state and foundation funds will launch a long-range plan to shift control of the budget for the Hawaii State Hospital to community mental health centers and "radically reshape" services provided for Hawaii's mentally ill."[24]

- Newspaper reports that Alma Takata has been named as interim director of the DOH's Mental Health Division "amid the uproar of the DOH's complete reorganization, which continues."[25]

- Newspaper reports the overcrowded, poor conditions at Hawaii State Hospital (with 220 beds for adults and another 20 for youths) noting that about half of the 78 nursing positions and 12 psychiatric positions are vacant or filled temporarily. To help fill the gaps, the hospital has hired psychiatrists to work on a fee basis and has put recently retired nurses on the payroll part-time.[26]

- Governor John Waihee makes Mental Health Month proclamation, stating that of the more than 10,500 seriously mentally ill adults in Hawaii, only 900 are actively receiving services from the State's mental health system.[27]

- Interim Director of the DOH's Mental Health Division, Alma Takata, reports that in the past four or five years, the DOH Mental Health Division's budget has grown only about $10 million, falling far behind needs and inflation.[28]

- Ground is broken for a $30 million renovation of the Hawaii State Hospital in Kaneohe.

- Hawaii is again ranked fifty-first in the country by the PCRHG and the National Alliance for the Mentally Ill in providing care for the mentally ill in terms of: (1) dollars expended per mentally ill individual; (2) number of staff and services available to deal with these people at the community level; and (3) quality and status of hospital and other institutional care for the mentally ill.

  The report notes that Hawaii spends $21.45 per capita on the treatment of the seriously mentally ill, compared to $45.45 for top-ranked Rhode Island, which has about the same population. But beyond monetary concerns, the report indicates that the State's problems in caring for the mentally ill go deeper. Among the report's findings:

  + "Hawaii is going nowhere" and beyond a handful of concerned families, professionals and legislators, "nobody appears to give a damn."

  + Hawaii State Hospital is "probably the worst public mental hospital in the United States."

  + Salaries for mental health professionals in Hawaii are among the lowest in the country.

  + The CMHCs are under the DOH, which means communications from the Division of Mental Health in Honolulu must go through the health officer on each island.

  The report concludes that "perhaps salvation lies with the Japanese who are purchasing most of the State; they could buy the Division of Mental Health and rehabilitate it as an economic assistance program to a needy country."[29]

- DOH Director Lewin responds to PCHRG report that changes are being made that will make this the last time Hawaii receives such a rating. He states that "we're about to perform a miracle" and predicts Hawaii will move up to the top ten states within the next two to five years. Lewin also notes that the DOH received a Robert Wood Johnson Foundation grant that will provide $2.5 million over five years to help the DOH prepare for the community services it intends to provide for the mentally ill.[30]

- DOH Director Lewin announces that to make the Mental Health Division run more efficiently, it will be divided into three co-equal sections: one focusing on adult mental health, one on child and adolescent mental health, and one on alcohol and other drug-abuse problems.[31]

- DOH Director Lewin tells House Health and Human Services Committee that "there really is a change about to occur," that his commitment to mental health is a "top priority" and he unveils new plan for mental health: an integrated community-based system of care that includes more sophisticated patient management, psychological-social development, extensive housing, crisis service, job training and a revamped state hospital. The plan calls for hiring and training 200 more staff members to work with the mentally ill, developing better communication within the public and private mental health systems and developing homes within communities statewide where patients can reside and receive treatment. The plan will necessitate additional funding for the Mental Health Division, which currently spends about $31 million a year on mental health and alcohol and drug abuse programs for adults and children. Lewin notes that that amount is about $15 million below the national average. He states that the plan will take about six years to implement at a cost of about $6 million to $10 million a year.[32]

1989

- DOH Director Lewin asks Legislature for increase of $10 million for the Mental Health Division's $20 million a year, community-based service program to provide, in conjunction with services offered by each of the State's eight mental health centers, twenty-four-hour emergency and crisis intervention and a rehabilitation-respite center where home-based patients can be lodged on a temporary basis.

  Lewin states that Hawaii plans to spend $15 million over the next 5 or 6 years to buy 75 fee-simple houses to provide "home-like treatment and rehabilitation facilities" for 370 chronically ill individuals.[33]

- House Bill No. 246 is introduced by the House Health and Human Services Committees Chairpersons, Jim Shon and Dennis Arakaki, to create a department of mental health to take over all duties and functions of the DOH's Mental Health Division. The bill suggests that a separate department would be able to find solutions to a multitude of problems and provide the "focus and continuous attention the system desperately needs. . ."[34]

- DOH Director Lewin opposes bill for creation of separate department of mental health, pointing to his plan to reorganize the DOH by placing the Mental Health

Division and its related programs into an Administration for Behavioral Problems Division under the supervision of a deputy director.[35]

- Legislative panel decides to hold off on proposal to split the Mental Health Division from the DOH, in order to give DOH officials a year to work with community groups dissatisfied with mental health services.[36]

- The Hawaii Alliance for Reform in Mental Health Administration Coalition is established (including Hawaii's three major advocacy organizations for the mentally ill: the Mental Health Association of Hawaii, Hawaii Mental Health Consumer Council, and Hawaii Families and Friends of Schizophrenics) to address problems associated with their assessment that the mental health system is riddled with incapable and uncooperative administrators who have failed to formulate adequate improvement plans and a division "staffed by too many people who don't have the slightest idea of what mental health is all about."

  The Coalition charges that: (1) the system shows no signs of improving because the plans remain inadequate and poorly thought out; (2) the plans being presented to legislators concentrate on construction of a new hospital, acquisition of group homes and more staffing, but without specific programs and details on how the programs will be managed; and (3) the division is uncooperative and refuses to share its plans with advocacy groups.

  Alma Takata, Interim Chief of the state Mental Health Division, disagrees with the Coalition's charges and sees the Coalition as a disguise to "run [her] out of town." She states that the fault rests with the lack of funding for needed services.[37]

- Testifying before the Legislature in opposition to a bill seeking creation of a department of mental health, DOH Director of Health, John Lewin, states: "We believe that our mental health programs are on the move. We are restructuring the Department, initiating the sizable increases in funding necessary for meaningful improvement and implementing the new programmatic base needed to deal with the mental health problems of the future period. Upon implementation of our budget initiatives and our reorganization, significant change will soon be evident. . . Our reorganization has been structured to ensure solid health policy development, coordinated service delivery, high quality and fixed accountability. These will direct our invigorated and forward-looking new public health agency."[38]

- Rally held in Capitol urges improvement of mental health services.[39]

- Visiting Yale University professor states that improvements in Hawaii's mental health system will become evident in the very near future because of the Mental Health Division's plan and the staff's "energy and commitment."[40]

- Legislature passes two-year budget which includes $19.7 million to improve and expand mental health programs, with much of the money earmarked for community-based care.[41]

- House Human Services Committee Chairperson Dennis Arakaki reports: "There's definitely a lack of direction and leadership in the area of mental health and in meeting the needs of the seriously mentally ill." House Health Committee Chairperson Jim Shon argues that the State's fifty-first ranking in national surveys is due partly to mismanagement but also to past failure to spend money on hospital facilities, community housing programs and case managers.[42]

- Governor John Waihee proclaims May Mental Health Month in Hawaii and signs bill to add $5.6 million to the mental health services budget to spur new activity in the area of community-based care. This is to be the first appropriation for what is to be a six-year $15 million "Housing Plan for Mental Health consumers" program. About $10 million is to provide "supervised living" for the severely disabled. The rest is to purchase 96 apartments and duplexes for "independent living" arrangements for 165 individuals capable of living on their own. Waihee says the measure and the money that go with it will show that the State's commitment to improving mental health services is "more than a formality."[43]

- Governor Waihee appoints health administrator Henry Foley to be the DOH's Deputy Director in charge of mental health and substance abuse. Foley will head the new Behavioral Health Services Administration which has mental health and substance abuse divisions.[44]

- Ceremony closes Mental Health Week with promise by DOH that "the state mental health system is undergoing a complete overhaul with community emphasis."[45]

- Healthcare Association of Hawaii Convention is held which concludes that "everyone" is to blame for Hawaii's mental health system slipping to the rock-bottom ranking of fifty-first. The DOH reports that it now knows the problems, has a plan to change things and the legislative funding to accomplish the needed changes.

  New BHA Deputy Director Henry Foley declares his priorities are to implement the state plan, establish crisis teams working in the community, more timely resolution of problems in the system and more contracting out of services.[46]

- Having visited Rhode Island, which is rated number one for mental health by the PCRHG report, DOH Director Lewin reports that the difference between Hawaii and

Rhode Island is "not that great" and predicts that Hawaii will make it into the top ten in the next few years.[47]

- United States Attorney General (through Acting Assistant Attorney General James Turner) notifies Governor Waihee of intent to investigate alleged unconstitutional conditions of confinement at the Hawaii State Hospital in Kaneohe and Honolulu, Hawaii.[48]

- DOH mental health budget for the next two years is set at approximately $80 million, with AMHD receiving $26.2 million (65 percent), CAMHD receiving $10.5 million (26 percent) and ADAD receiving $3.7 million (9 percent).[49]

- DOH explains that hospital and community center service budgets are to be integrated with the dollars following the patient to whatever program will serve best.[50]

- DOH reports that Mental Health Division will give each of the CMHCs its own budget for two areas -- adult services and operating expenses. If any of the CMHCs need short-term hospital care for a client, and the client agrees, the center must pay the hospital between $100 and $133 for each day the client stays. The point is to motivate the staff to make sense of their dollars and cents.

  Adult-services money that centers do not use for hospitalization could then be used for housing or patient-support activities. If centers allow hospitalizations at a level that depletes their adult-services funds, they will have to dip into their own budgets.[51]

- United States Department of Justice inspects Hawaii State Hospital to investigate allegations that hospital patients are being deprived of their civil rights. Finding the hospital to be an "abomination," the inspection team reports that the food, clothing and shelter are inadequate. The team reports poor recordkeeping, including clinical documentation in patient charts, undue use of straps and drugs to restrain patients, a serious cockroach infestation in the kitchen, numerous fire hazards, grossly deficient staff (forty-two percent of the nursing positions vacant and fifty percent of the psychologist positions), antipsychotic medication being prescribed for patients without psychotic conditions and medications being dispensed without physician's orders. Finally, they determine that there is no one at the hospital with the ultimate responsibility for the clinical care of patients.

1990

- Following investigation by Department of Justice of Hawaii State Hospital, Governor Waihee is notified of the alleged unconstitutional conditions of confinement at the hospital and the minimal measures necessary to legally remedy these alleged conditions.[52]

- House Human Services Committee Chairperson Dennis Arakaki states that there is "a complete breakdown in the system" and that "Hawaii's mental health system has failed to meet the needs of the majority of Hawaii's children with mental and emotional disorders." He claims the problem is not a lack of funds. Rather, it is a problem of "leadership, direction and not being able to coordinate the services."[53]

- Hawaii Mental Health Association Executive Director Mark O'Donnell states that, "although much is known about effective service delivery systems and treatment, little has been implemented or applied in Hawaii." A system of care for youth must mean a "comprehensive system of community-based care" which addresses a child's physical, social, mental, emotional and education needs. According to O'Donnell, about 75 to 80 percent of the children and teens with serious mental and emotional disabilities in Hawaii do not receive appropriate care.[54]

  BHA Deputy Director Dr. Henry Foley states that "until recently there wasn't a sufficiently creative approach to hiring health care personnel across the State. Within the last couple of weeks, we've hired Dr. Marvin Mathews to implement different, creative, non-bureaucratic approaches to hiring professionals to treat severely disturbed emotional children."[55]

- DOH Director Lewin tells lawmakers that an extra $15 million a year may be required for children's mental health service, in addition to the $10 million presently spent per year on the care of children with mental disabilities.[56]

- State Representative Dennis Arakaki, Chairperson of the House Committee on Human Services, says the Legislature might be willing to spend the extra money to overhaul the children's mental health services, but only if the state agencies involved learn to better communicate with one another. States Arakaki, "We've been piecemealing programs for the past four years and yet we keep hearing that kids are not being serviced."[57]

- DOH estimates that ninety percent of the 17,000 children with serious emotional and mental disabilities get no services at all.[58]

- Newspaper reports that mental health experts acknowledge "the state has pumped substantial new funding into care programs for adolescents in recent years, but said bureaucratic delays dragged heavily on efforts to improve and expand services."[59]

- Testifying before lawmakers, the mother of an autistic child expresses her frustration that she cannot find the highly structured program her son needs: "First, it was money. When funds became available, we couldn't find qualified people. The clock was ticking, and Johnny is getting tougher to manage."[60]

- For the third consecutive time, the Public Citizen Health Research Group (PCHRG) rates Hawaii's mental health program as fifty-first and declares that "Hawaii has the worst system of services for mentally ill adults and children in the nation." The report quotes heavily from a Justice Department report in April critical of patient care and sanitary conditions at the Hawaii State Hospital.

  The report cites filth and mistreatment at the Hawaii State Hospital but states that the "continuing horror story of Hawaii State Hospital is just one in a catalogue of 1,001 tragedies in Hawaii, which keeps vowing to improve but whose attempts inevitably founder when they come up against the state's multiple brick walls of poor management, skinflint funding, local apathy and political patronage." The PCHRG reports that the CMHCs are understaffed and underfunded and programs in Leeward and Windward Oahu, Diamond Head and Maui are "so ineffective they could be buried in a lava flow tomorrow and few mentally ill individuals would miss them."

  The report also charges that the DOH "virtually squandered" a $2.5 million Robert Wood Johnson Foundation grant intended to reform the system but which "to date has been used primarily to hire yet more expensive consultants and create yet more complex levels of bureaucracy and administration."[61]

- DOH reports that the Justice Department's report was based on old data, including past abuses that since have been remedied. BHA Deputy Director Foley points out that this latest report does not reflect the State's progress in building a new hospital and in providing health insurance (covering mental illness) for Hawaii residents. He also notes that the ranking in per capita spending on mental health is based on the 1987 budget, which has since risen from $45 million to $65 million.[62]

- DOH Director Lewin states that the PCHRG report is based on outdated material, some as old as three years. Lewin notes that the report also fails to note that turning the system around has been the department's "top priority for the last three years. Lewin cites positive changes: Administrative and legislative support, a new focus on child and adolescent mental health, $65 million spent this year, and the efforts of people in the system to make it work." Lewin also reports that the new

$35 million Hawaii State Hospital is almost completed and all the problems listed about the present one in the Justice Department report have been corrected.[63]

- Hawaii Mental Health Association President Susan Chandler states that the system is making changes to bring improvements, but notes that "we still see too much piecemeal planning; too little funding; irrational management; little systematic implementation of sustained change; and lost opportunities, particularly within the Adult Mental Health Division." States Chandler, "I'm optimistic that in the next five years that (all) will be there."[64]

- National mental health expert, David Goodrick, disputes Hawaii's last-place ranking of mental health services by the PCHRG and provides an upbeat response to criticism from the report, stating that under the new leadership of BHA Deputy State Health Director Foley, mental health services are improving.[65]

- DOH announces that Hawaii's mental health system will have an ombudsman next year to whom consumers can complain about treatment or other problems and that a crisis coordinator will be available, allowing for twenty-four-hour coverage. Deputy Director Foley announces this year will be the "year of the child."[66]

1991

- State Representative Dennis Arakaki seeks legislative funding of $24 million over the next four years to renovate Hawaii's system of care for mentally and emotionally disturbed youth, following meetings by the Children's Mental Health Task Force, which concludes that most adolescents with serious mental and emotional disorders receive no appropriate mental health service.

  The bill would create a complete system of care that would offer additional day treatment programs for children and expanded therapeutic foster care on Maui, Kauai and Hawaii. It would also include crisis services for youths in danger of being hospitalized; respite care to help support families caring for disturbed youths; and prevention programs for youths.

  DOH estimates 6,000 children and teens have severe mental illnesses, while another 12,000 need professional help with emotional problems. Another 17,000 are at high risk for developing emotional problems if they are not given preventive care. Hawaii Mental Health Association Executive Director Mark O'Donnell states that Hawaii needs a system that focuses on community-based mental health services, but instead has only minimal hospital and community-based care and no intermediate level care.[67]

- The United States Justice Department files suit against State of Hawaii, contending that the civil rights of hospital patients have been violated by inadequate care and unsafe living conditions at the Hawaii State Hospital.

- Hawaii Mental Health Association criticizes proposed budget cuts. The administration initially approved budget increases of $2.2 million over the next two years to hire more case managers for the CMHCs and $2 million to let the centers hire more psychiatrists and offer more job training and rehabilitation services. The State also planned to increase the budget for the Hawaii State Hospital by $16.6 million over the next two years. But in the latest budget message from the administration, more than $3.2 million is taken from the increases requested for the psycho-social, clinical treatment, and case management services at the CMHCs and the Hawaii State Hospital.[68]

- BHA Deputy Director Henry Foley announces he will resign from his position as of June, 1991. He was appointed to his post in October, 1989.[69]

- Salvation Army announces it will close its home for troubled youths because of inadequate funding by the State. The organization has acquired a deficit of more than $1 million because state payments for children at the facility have not covered costs. The State has three months to find alternative homes for thirty-five children.[70]

- State agencies scramble to find programs for children placed in the seventy-five-year-old Salvation Army youth facility that is closing because of operating losses.[71]

- Senator Mary Jane McMurdo requests Governor Waihee to save the Salvation Army's psychiatric treatment facility for youths. The per diem cost of caring for each child is $193, while the State pays $140 per child per day.[72]

- Newspaper editorial: "It's a sorry testament that this foreseeable crisis comes to a head after the Legislature has gone home and can do nothing to resolve it. Each million dollars lawmakers allocate has its own rationale, of course, but some multi-million-dollar projects look frivolous compared to these youngsters' needs."[73]

- DOH announces plan to shift Hawaii State Hospital's eight mental health beds for children to a private hospital in order to reduce costs and increase benefits for the young, disturbed patients. Branch Chief of the Hawaii State Hospital's Residential Services, Harlan White, states that Castle will be more flexible than the state system, responding more quickly to patient needs. This arrangement will save the State money and improve care. Under the proposed contract, Castle would provide the service for $800,000 a year, saving the State about $200,000.[74]

- Lawsuit against State is filed in federal court for closing adolescent unit at Hawaii State Hospital. The suit, filed by the Protection and Advocacy Agency of Hawaii, Inc., a non-profit, public-interest corporation mandated by federal law to protect the rights of the mentally ill, alleges the DOH's actions violate the rights of Hawaii's adolescent mentally ill and asks that the unit not be closed. The suit claims that the patients' constitutional rights were violated because they and their families were not included in the discussions. The group also contends the alternative care programs have no consistent plan to provide universal care to all patients.

  In response to the suit, DOH Director John Lewin states that the adolescent unit is unaccredited because it has insufficient staff, its building is substandard, and certain treatment programs, therapists and ancillary services are not available to some of its patients. Lewin says the unit's staff is excellent, but state salaries are substandard and DOH has trouble recruiting the staff it needs. Castle is accredited and has all the required services and facilities. States Lewin, "I think what we're doing is a step in the right direction. I don't think government needs to be the provider of hospital services, when those services can be provided very well -- at comparable or even lower cost for the same quality of treatment -- by established facilities in the private sector."[75]

- Masaru Oshiro is named DOH's BHA Deputy Director. He states that outgoing Deputy Director, Henry Foley, told him that some of the major problems facing him will be "internal restructuring, placing different people in crucial positions and working with the bureaucracy."[76]

- DOH Director makes three appointments: Terry Rogers will become superintendent of the Hawaii State Hospital, Dr. Naleen Andrade, former superintendent of Hawaii State Hospital, will become AMHD Chief, and Dr. Barry Carlton will become the hospital's clinical director. Within the AMHD, Timothy Wee is appointed Assistant Division Chief overseeing resources management and Sherry Harrison, also Assistant Division Chief, will oversee quality-control management in the Division.[77]

- Settlement agreement is reached between the Department of Justice and the State of Hawaii, requiring the State to hire 200 new medical professionals and staff at the Hawaii State Hospital over the next eighteen months, meet new fire-safety requirements, limit the use of seclusion and restraints on patients, improve recordkeeping for more efficient patient tracking, and provide other reforms in health care, sanitation, environmental safety, and staff training.[78]

- Dedication ceremony is held for $37.5 million all-new 108-bed state hospital in Kaneohe serving the hospital's "civil population" -- non-criminal patients. The hospital's forensic population are to remain in their current facilities at the hospital.

- New Hawaii State Hospital must have about $1.6 million of repair work to remedy the sharp edges, protrusions and other mechanisms built into it.

1992

- Members of the children's mental health task force urge lawmakers to approve a $6 million bill that would increase the number of therapeutic homes and begin home-based crisis services.

  Report notes that State Representatives Arakaki and Shon asked for an additional $24 million in 1991 for comprehensive services, but received only $2.5 million. The total annual child mental health budget is $15 million, which reaches only about 2,000 of an estimated 12,000 children who need professional services for emotional problems, states DOH's Child and Adolescent Mental Health Division Chief Neal Mazer. The State estimates that about 35,000 of Hawaii's 300,000 children are at risk of failing socially or academically. Of that total, more than 6,600 have severe and disabling mental illnesses, about 12,000 have significant emotional problems and 17,000 need preventative services to avoid emotional problems.[79]

- Groundbreaking for a new outpatient clinic for the private, non-profit Waianae Coast Community Mental Health Center is announced. Legislature provided $900,000 in funds for the construction of the outpatient clinic, but the center must raise another $400,000 on its own.[80]

- Hawaii Mental Health Association Executive Director Mark O'Donnell states that the DOH meets about ten percent of the estimated needs for outpatient care through children's teams at the CMHCs. Hospital care is limited to about ten youths at Castle Hospital and Kahi Mohala -- at costs ranging from $100,000 to $200,000 per year per child -- and another twenty-seven to twenty-nine children on the waiting list. There are no intermediate programs. Therefore, "kids must deteriorate to a low level of functioning before they even have a chance of support."[81]

- The Senate version of the supplemental budget cuts the request for funding of adult mental health services by over fifty percent. DOH Director Lewin states he is "appalled" at the Legislature's proposed cuts in community-based programs for the mentally ill and warns that the State will pay later if it slashes mental health funding now. Some $44.1 million was appropriated last year for adult mental health services for the coming fiscal year, including about $24 million for the Hawaii State Hospital for the mentally ill, and $15.5 million for community-based mental health services. The administration proposed boosting the amount for community-based services by another $3.4 million. However, the house and senate version cuts would deeply trim the supplemental request.[82]

- Legislators are told that critical programs for the mentally ill will be discontinued if funds are not restored by the House-Senate budget conferees.[83]

- United States Justice Department states that Hawaii's residential treatment program for mentally ill adolescents is "simply abhorrent" and complains about the lack of treatment programs for adolescent and "abysmal" documentation of treatment, use of drugs and use of restraints. "Most frightening of all was the terribly unsafe manner in which adolescents were placed into restraints" and the poor supervision that accompanied such restraints.

  Chief of the DOH CAMHD, Neal Mazer, responds that the inspection took place at the state facility at Castle Medical Center just before a treatment program for the eight or so youngsters there was about to be introduced. The State has eight youngsters in its children's program at Leahi Hospital and eight more in its adolescent program at Castle in Kailua. Mazer states Hawaii has placed nearly a dozen of its most severely ill youngsters at facilities on the mainland or in Kahi Mohala, a psychiatric hospital in Ewa, because they cannot be accommodated at Castle. Placing these youngsters in facilities that can care for them costs $150,000 a year per child in unbudgeted funds.[84]

- Newspaper editorial: "The legislature provided only $2.5 million of the $24 million sought in 1991, and though the program did better, its $15 million budget enables it to reach about 4,000 young people of an estimated population of those in need of mental health services that ranges as high as 35,000. While the numbers vary, the Mental Health Association estimates that 6,600 young people suffer from severe mental illness, another 12,000 have serious emotional problems, 17,000 are considered at risk and in need of preventive help."[85]

- National mental health expert, David Goodrick, explains that authority must be moved "from the state level to the front lines where services are given." He notes that CMHCs must concentrate on the outcomes of the patients and not on maintaining bureaucracies, noting that "Hawaii's bureaucracy is more than most and more than necessary."[86]

- House Health Committee Chairperson Jim Shon states that the CMHCs will not receive more money until they begin to bill for Medicaid, enabling the State to get matching dollars from the federal government. Shon says the centers promised six years ago to bill for Medicaid, but have refused to do so.[87]

- Upon learning that the CMHCs have not commenced billing for Medicaid, BHA Deputy Director Masaru Oshiro states that, "Whatever the delay over the past few years, the department is committed to pursuing Medicaid billing within this calendar year."[88]

- Castle Medical Center announces plans to drop its residential treatment program for seriously troubled adolescent (set up in July, 1991) citing lack of support from the State. Po'ailani, a private community-based shelter program for severely emotionally disturbed adolescents also closes its doors, citing cutbacks in state funding levels. CAMHD Chief, Neal Mazer, states that Kahi Mohala, a private psychiatric hospital, will probably take over the services Castle provided. Also, the State will renovate another building at Hawaii State Hospital to accommodate up to eighteen youths in residential treatment.[89]

- State children's team psychiatrist, Dr. Sally Connolly resigns, citing the "chronic instability of the CAMHD," which she claims has deteriorated to a "state of constant crisis."[90]

- DOH Director Lewin states that children's mental health needs are the State's greatest immediate public health emergency.[91]

- Newspaper editorial: "Probably no function run by state government in Hawaii is as badly neglected as mental health programs and in no area of mental health is the neglect as bad as programs for adolescents."[92]

- CAMHD Chief, Neal Mazer, reports that "adolescent mental health has finally been made a top priority, but unfortunately, there's no money." Mazer reports that the CAMHD budget cuts are more severe than expected, slashing funds by more than ten percent. He states that the number of severely disturbed adolescents drained the budget, forcing the State to transfer them to expensive local and mainland programs that cost $150,000 annually for each child. States Mazer: "It costs about $10,000 a year to keep each mentally handicapped teenager out of an institution. When we miss that opportunity and must institutionalize, it costs $150,000 a year.[93]

- Hawaii Mental Health Association Executive Director Mark O'Donnell criticizes the State for making emotionally and behaviorally handicapped children "sacrificial lambs for the sake of fiscal austerity."[94]

- Governor Waihee promises to try and divert money from other state programs to address the crisis in mental health services for adolescents. He indicates that he will try to increase the State's mental health budget for children and adolescents by $5 million, to about $19 million. States DOH Director Lewin: "This is first of all an ethical and moral issue. But even if you are a cold, conniving person, you have to realize that this will cost us a fortune in court-ordered health care if we don't address it. . . ."[95]

- State Representative Jim Shon writes to the United States Department of Justice asking it to take control of the DOH mental health program, charging that the state administration and the Legislature have not done enough to help mentally ill children. Charges Shon, "While there are periodic public statements by the state administration that mental health will receive a higher priority, there are no indications that the immediate future will be anything but dismal. . . . If you have believed pronouncements that Hawaii will improve if you just give us a little more time -- you have been duped."

- DOH Director Lewin warns that when the Department of Justice convinced the federal courts to let it take control of the state-run mental health programs in North Carolina, the cost per patient for care went up. "Even with good intentions, the Justice Department is not going to do a good job."[96]

- Kimmel Report: First site visit report of CAMHD by mainland consultant, provides the preliminary findings and conclusions suggesting that the CAMHD is operating with a badly demoralized staff, some of whom are burning out under the pressure of providing services with too few resources. Among the study's preliminary conclusions:

  + "[V]ery low morale and high levels of distress among the division's rank-and-file";

  + "Low productivity among many, but not all, of the regular headquarters staff";

  + An "unbalanced workload among the staff";

  + "A few staff are, by their own accounts, violently and vehemently opposed to the new chief";

  + "The chief and members of the executive staff are now 'overwhelmed.' They have begun to falter and burn out under the pressures of unrelieved and growing work demands. All report being stretched very, very thin. This contrasts sharply with the situation of some staff who seem to be doing little";

  + "The CAMHD headquarters is significantly understaffed. Additional staffing is needed immediately. Intense ill feelings and dysfunctional behavior are evident."[97]

- Newspaper editorial: "[F]ederal action is what focused state attention on the mental hospital in Kaneohe, the prison system and on deficient youth mental health programs at Castle Hospital. . . [The] state needs to break the habit of requiring a Justice Department threat to stimulate action."[98]

- Newspaper reports that the State now expects a forty-four percent boost in its $15 million budget for CAMHD next year. The CAMHD will likely get $6.6 million for projects ranging from crisis outreach to hospitalization. CAMHD Chief Neal Mazer states that if the Legislature approves the $6.6 million, the money will go to the following areas: crisis outreach services (in which teams go to the homes of disturbed children), in-home support (in which social workers spend up to twenty hours a week for four to six weeks to teach communication skills to family members), therapeutic- and foster-care homes for children from fragile homes, and structured, hospital-based services for severely disturbed children.[99]

- Newspaper editorial: "Leaders of the mental health community are encouraged by Governor Waihee's statements of support and the promise of budget growth for the [CAMHD] program. The Legislature has provided minimal funds in past years, and the recent closings of youth mental health programs at Castle Medical Center and at Poailani Inc. properly outraged those involved in improving the quality of such treatment. It's important now that people working actively to help these programs stick with the effort to make sure the promises are kept."[100]

1993

- State Representative Dennis Arakaki states that getting at least $6.6 million and implementing recommendations contained in the report "Future of the Child and Adolescent Mental Health System in Hawai'i" may satisfy the United States Justice Department, which could force the State to provide services.

  Mental Health Association in Hawaii Executive Director Mark O'Donnell states that, "[if] the Legislature approves the $6.6 million, programs for seriously ill children could begin by the end of the year."[101]

- DOH Director Lewin announces plans to find vacant hospital beds and hire a private company to provide care for mentally ill youngsters by the summer of 1993. The new center would combine a number of state services; include long-term care for adolescents who now are sent to private mainland or Hawaii psychiatric hospitals such as Kahi Mohala, and would include beds for short-term hospitalization for youngsters who are to be returned to the community quickly, a twenty-four-hour "crisis intervention" for mentally ill youngsters; and a school the youths can attend while they undergo treatment. Lewin estimates the State can lease a facility and contract with a provider to run it for less than half that cost. And he says that if the State can quickly get the new facility accredited by the federal government, the federal government will pay much of that cost through Medicaid.[102]

- Mental Health Association in Hawaii Executive Director Mark O'Donnell warns that failing to pass a bill for $8 million to the CAMHD may force federal or local lawsuits. He warns that the CAMHD budget is about $13 million annually. With an additional $6.6 million, it still would be less than half of what is needed for the State's adolescent population. State services now help about 1,400 adolescents. Based on national projections, an additional 6,600 adolescents need care now, 17,000 should get care and 35,000 are at risk.[103]

- United States Justice Department criticizes Hawaii's adolescent mental health program, saying it fails to provide a continuum of care for emotionally disturbed children. Hawaii Mental Health Association Executive Director Mark O'Donnell warns that if the Justice Department is not convinced the State will correct the problem quickly, the federal government may take over, ordering an expensive, potentially disruptive solution.[104]

- Governor Waihee presents a five-year Medicaid demonstration program to President Clinton's administration. Under this plan, Hawaii Health Quest will provide mental health (and other) benefits through a managed care delivery system to individuals covered by selected government programs.[105]

- DOH announces plans to convert a building at Kahi Mohala into a consolidated thirty-two-bed adolescent and children's mental health unit for the State.[106]

- Six community agencies file class-action suit against the State in federal court, alleging that children's civil rights were violated by the State's failure to provide appropriate mental health services, education and treatment.

  The suit alleges:[107]

> [D]espite the mandates of federal and state law, the responsible state agencies have failed to advocate effectively before the Governor and Legislature, and have failed to collaborate and coordinate their efforts to provide mental health programs and services and the "continuum of alternative placements" required by law. Instead, these agencies have slashed already inadequate programs and services. Further, these same state agencies have failed to develop any realistic plans to do anything other than provide stop-gap, crisis-based services.
>
> In order to receive services they need and to which they are entitled, children with emotional disabilities in the State of Hawaii are often sent to the Mainland at a high cost to them, their families and the State. Alternatively, these children remain in Hawaii but are often placed unnecessarily in facilities or institutions when less restrictive community based programs and services would be more appropriate. All too often, the needs of these children are simply ignored by the responsible state agencies until intervention by the Courts and juvenile justice system occurs.
>
> The Defendants have failed these children and their families and violated their statutory and constitutional rights.

- Plaintiffs' attorney, Shelby Floyd, states the lawsuit stems from "a chronic lack of funding, planning and cooperation between the [DOH and DOE], forcing parents to send their children to the mainland or leave them untreated." States Floyd, "We are asking the court to stop the excuses, to declare that the state is in gross violation of the federal laws which govern the special education of these children and appoint an expert to take over the public programs which affect these children."

  States Representative Dennis Arakaki, "The people who have been [mental health] advocates have been patient and tried to work within the system but I think they've reached the point where all avenues have been explored and the only way to change the system is through legal action."

  DOH Director Lewin warns that if the court forces the DOH to provide services, it could cost up to $30 million. The court also could appoint an expert to decide what services to offer. Hawaii Mental Health Association Executive Director Mark O'Donnell reports that the State presently has about fourteen children in mainland programs and spends up to $200,000 annually for each.

  CAMHD Chief Neal Mazer describes Hawaii's facilities for the treatment of mentally ill children and troubled adolescents as "an embarrassment."[108]

- Newspaper editorial: "[The] state deserves to be sued. . . It's a sad day when social service agencies and parents have to drag the state into federal court for failing to provide minimal mental health services for young people. . . When pressure mounts, the state shuffles money from one service to the next and back again. It's a shell game, say frustrated mental health advocates. . . It took court action to force the State Hospital into the 20th century. And clearly that's what it's going to take to do the right thing by our mentally ill young people."[109]

- Contents of the Kimmel Report (see November 1992, infra) is reported by the newspaper. CAMHD Chief, Neal Mazer, reports that his staff problems are primarily the work of a few "saboteurs" who fear change and accountability. He reports that Hawaii has the lowest percentage of federal reimbursements of any state in the nation for state dollars spent on mental health services. Mazer reports that his efforts to boost Medicaid reimbursements for state dollars spent on mentally ill children have angered some of his staff who have mounted a campaign to remove him.[110]

- New study by consultant Kimmel finds CAMHD "atmosphere improved." Report:

  + Commends CAMHD Chief Neal Mazer for introducing new treatment methods and recruiting highly trained managers and program officers to staff a reformed mental health program for children.

  + Commends BHA Deputy Director Masaru Oshiro for his weekly attendance at CAMHD staff meetings and CAMHD reorganization meetings.[111]

- Clinton administration approves Hawaii's proposed QUEST health program for lower-income residents. This project is expected to provide cost-effective health coverage to about 106,000 residents who need public assistance. Under this plan, the targeted groups include Medicaid's Aid to Families with Dependent Children, General Assistance and the State Health Insurance Program. The program calls for health organizations to create health plans to serve these populations. The State would pay the health organization for the services provided with the $429 million Medicaid and $14 million SHIP budget.[112]

- Waihee administration tentatively plans to ask Legislature for $12 million in new funding for children's mental health and other programs.[113]

Endnotes

1. David Osborne and Ted Gaebler, Reinventing Government; How the Entrepreneurial Spirit is Transforming the Public Sector (New York: Penguin Group, 1992), p. 153, citing Andrew Bates, "Mental Health Spas," Washington Monthly (December 1990), pp. 26-29.

2. For instance, the majority of AMHD's mental health funding is targeted to the priority population of adults and elderly who are severely mentally ill and dually diagnosed with mental illness and substance abuse or mental illness and a developmental disability; persons in crisis, and who are a danger to themselves or others; the mentally ill who are incarcerated, hospitalized, or involved with the criminal justice system and the mentally ill who are homeless.

3. 1984 Haw. Sess. Laws, Act 218.

4. Honolulu Star-Bulletin, September 26, 1985.

5. E. Fuller Torrey, M.D. and Sidney M. Wolfe, M.D., Care of the Seriously Mentally Ill; A Rating of State Programs (Washington, DC: Public Citizen Health Research Group, 1986), p. 76.

6. Honolulu Star-Bulletin, March 24, 1986.

7. Honolulu Star-Bulletin, March 19, 1986, p. A-1.

8. Ibid.

9. Honolulu Star-Bulletin, April 10, 1986.

10. The Honolulu Advertiser, April 10, 1986.

11. Honolulu Star-Bulletin, March 24, 1986.

12. Honolulu Star-Bulletin, April 25, 1986.

13. Ibid.

14. Honolulu Star-Bulletin, December 12, 1986.

15. Honolulu Star-Bulletin, November 22, 1986.

16. The Honolulu Advertiser, February 21, 1987.

17. Ibid.

18. The Honolulu Advertiser, March 23, 1987, p. A-4.

19. 1987 Haw. Sess. Laws, Act 342.

20. Honolulu Star-Bulletin, November 16, 1987, p. A-4.

21. The Honolulu Advertiser, January 16, 1988, p. A-4.

22. The Honolulu Advertiser, February 20, 1988.

23. Honolulu Star-Bulletin, March 1, 1988.

24. Ibid.

25. Honolulu Star-Bulletin, May 3, 1988.

26. Honolulu Star-Bulletin, August 23, 1988.

27. Honolulu Star-Bulletin, October 7, 1988.

28. The Honolulu Advertiser, October 8, 1989.

29. The Honolulu Advertiser, September 13, 1988 and Honolulu Star-Bulletin, September 13, 1988.

30. The Honolulu Advertiser, September 13, 1988.

31. Ibid.

32. The Honolulu Advertiser, October 8, 1988 and Honolulu Star-Bulletin, October 8, 1988.

33. The Honolulu Advertiser, January 21, 1989, p. A-6.

34. House Bill No. 246, Fifteenth Legislature, Regular Session of 1989, State of Hawaii.

35. Testimony of John C. Lewin, M.D., Director of Health, Department of Health, February 14, 1989; The Honolulu Advertiser, January 31, 1989.

36. The Honolulu Advertiser, February 15, 1989.

37. Honolulu Star-Bulletin, February 12, 1989, p. A-3.

38. Testimony of John C. Lewin, M.D., Director of Health, Department of Health, before the House of Representatives Committee on Health, House Bill No. 246, February 14, 1989.

39. The Honolulu Advertiser, April 12, 1989.

40. The Honolulu Advertiser, April 17, 1989.

41. The Honolulu Advertiser, May 1, 1989.

42. Ibid.

43. The Honolulu Advertiser, May 12, 1989, p. A-6.

44. The Honolulu Advertiser, October 6, 1989.

45. Honolulu Star-Bulletin, October 7, 1989.

46. Honolulu Star-Bulletin, October 20, 1989.

47. The Honolulu Advertiser, October 21, 1989.

48. United States of America v. State of Hawaii, et al., Settlement Agreement, Civil No. 91-137 (DAE), United Dist. Ct. for the District of Hawaii, September 19, 1991.

49. Honolulu Star-Bulletin, November 28, 1989, p. A-8.

50. Ibid.

51. Honolulu Star-Bulletin, November 29, 1989, p. A-8.

52. United States of America v. State of Hawaii, et al., Settlement Agreement, Civil No. 91-137 (DAE), United Dist. Ct. for the District of Hawaii, September 19, 1991.

53. The Honolulu Advertiser, May 31, 1990.

54. Ibid.

55. The Honolulu Advertiser, May 31, 1990

56. The Honolulu Advertiser, July 25, 1990.

57. Ibid.

58. Ibid.

59. Ibid.

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61. E. Fuller Torrey, MD., Karen Erdman, Sidney M. Wolfe M.D., Laurie M. Flynn, Care of the Seriously Mentally Ill: A Rating of State Programs, Published by the Public Citizen Health Research Group and the National Alliance for the Mentally Ill, 1990 Edition, pp. 175-178.

62. Honolulu Star-Bulletin, September 8, 1990.

63. Ibid.

64. Ibid.

65. The Honolulu Advertiser, September 21, 1990; Honolulu Star-Bulletin, October 1, 1990; and Honolulu Star- Bulletin, October 2, 1990.

66. Honolulu Star-Bulletin, October 13, 1990.

67. The Honolulu Advertiser, January 10, 1991, p. C-6.

68. The Honolulu Advertiser, February 7, 1991.

69. Honolulu Star-Bulletin, June 1, 1991.

70. The Honolulu Advertiser, June 8, 1991.

71. Honolulu Star-Bulletin, June 8, 1991.

72. The Honolulu Advertiser, June 10, 1991, p. A-5 and Honolulu Star-Bulletin, June 10, 1991, p. A-6.

73. The Honolulu Advertiser, June 11, 1991.

74. The Honolulu Advertiser, June 20, 1991, p. A-18 and Honolulu Star-Bulletin, June 17, 1991.

75. The Honolulu Advertiser, July 13, 1991 and Honolulu Star-Bulletin, July 13, 1991.

76. Honolulu Star-Bulletin, July 13, 1991.

77. The Honolulu Advertiser, September 13, 1991.

78. United States of America v. State of Hawaii, et al., Settlement Agreement, Civil No. 91-137 (DAE), United Dist. Ct. for the District of Hawaii, September 19, 1991.

79. Honolulu Star-Bulletin, January 14, 1992.

80. The Honolulu Advertiser, January 17, 1992.

81. Honolulu Star-Bulletin, February 26, 1992.

82. The Honolulu Advertiser, April 15, 1992.

83. Honolulu Star-Bulletin, April 16, 1992.

84. The Honolulu Advertiser, July 31, 1992, p. A-1.

85. Honolulu Star-Bulletin, August 5, 1992.

86. Honolulu Star-Bulletin, August 21, 1992, p. A-6.

87. Ibid.

88. Ibid.

89. The Honolulu Advertiser, November 24, 1992, p. A-1.

90. Honolulu Star-Bulletin, November 25, 1992.

91. Ibid.

92. The Honolulu Advertiser, November 25, 1992.

93. Honolulu Star-Bulletin, November 26, 1992.

94. The Honolulu Advertiser, November 27, 1992.

95. The Honolulu Advertiser, November 29, 1992.

96. Honolulu Star-Bulletin, December 1, 1992.

97. Management Improvement Program, Behavioral Health Services Administration, Hawaii Department of Health, Gwenfread Allen Fund Project, Final, November 12, 1992.

98. Honolulu Star-Bulletin, December 2, 1992.

99. Honolulu Star-Bulletin, December 4, 1992.

100. Honolulu Star-Bulletin, December 7, 1992.

101. Honolulu Star-Bulletin, January 15, 1993.

102. The Honolulu Advertiser, February 15, 1993.

103. Honolulu Star-Bulletin, April 10, 1993.

104. Honolulu Star-Bulletin, February 23, 1993.

105. Letter from Director Winona E. Rubin, Director Hawaii Department of Human Services, to the Honorable Donna E. Shalala, United States Secretary of Health and Human Services, April 19, 1993.

106. The Honolulu Advertiser, April 30, 1993, p. A-5.

107. Felix, et al. v. John Waihee, et al., First Amended Complaint for Declaratory and Injunctive Relief, Civil No. 93-00367, United Dist. Ct. (Class Action), pp. 3-5.

108. The Honolulu Advertiser, May 5, 1993, and Honolulu Star-Bulletin, May 5, 1993.

109. The Honolulu Advertiser, May 8, 1993.

110. The Honolulu Advertiser, May 23, 1993.

111. Management Improvement Program, Behavioral Health Services Administration, Hawaii Department of Health, Gwenfread Allen fund Project, Final, May 4, 1993, Reported in Honolulu Star-Bulletin, May 26, 1993.

112. Honolulu Star-Bulletin, October 8, 1993.

113. The Honolulu Advertiser, December 4, 1993.

Chapter 3

AN OVERVIEW OF HAWAII'S PUBLIC MENTAL HEALTH SYSTEM

Department of Health (DOH)

The Department of Health is responsible for fostering and coordinating "a comprehensive mental health system utilizing public and private resources to reduce the incidence of mental or emotional disorders and substance abuse and to treat and rehabilitate the victims in the least restrictive and most therapeutic environment possible." The Department administers "such programs, services, and facilities as may be provided by the State to promote, protect, preserve, care for, and improve the mental health of the people."[1]

Personnel

DOH's mental health program staff are hired with permanent civil service status within the meaning of chapters 76 and 77, *Hawaii Revised Statutes*. Psychiatric positions, however, are statutorily exempt from these chapters and may be hired on a contractual basis.[2]

Behavioral Health Administration (BHA)

The Behavioral Health Services Administration was created when the Department of Health's former Mental Health Division was reorganized in 1989. It is presently one of six separate administrations within the DOH.[3]

BHA's objective is to provide leadership in a public/private partnership to develop three overlapping systems of care -- adult mental health, child and adolescent, and alcoho and drug systems.[4]

Prior to the 1989 reorganization, the divisions of Adult Mental Health (AMHD), Child and Adolescent Mental Health (CAMHD) and Alcohol and Drug Abuse (ADAD) were branches without fiscal independence. The present organizational structure and organization chart of the BHA, as provided in the BHA AMHD 1991-1993 State Plan, is provided in Appendix B.

The DOH Deputy Director of Behavioral Health Services Administration (BHA) oversees each of the three divisions within the BHA -- ADAD, AMHD and CAMHD. In doing so, he is provided with no staff other than a secretary.[5]

All three BHA divisions are presently in the process of reorganizing their infrastructure. However, only the proposed reorganizations of AMHD and CAMHD are described herein.

Alcohol and Drug Abuse Division (ADAD)

ADAD, referred to as "the low maintenance division" by the DOH budget analyst, is widely perceived as an exemplary model of governance for the provision of public mental health-related services. In its relatively short existence, ADAD has succeeded in creating a solid position for itself, even though the "War on Drugs" is no longer front-page news, and the federal and state "war on drugs" has diminished. Its success is attributable to three key factors. It has: (1) clearly defined responsibilities, (2) a strong infrastructure, and (3) continuity of management.

ADAD's History

In 1955, a part-time clinic was established for alcohol abusers, supported by ten percent of the liquor license fees collected on Oahu. It became a full-time clinic in 1959 and was transferred to the DOH Mental Health Division in 1965. In 1971, the Governor created and authorized the Governor's Ad Hoc Committee on Substance Abuse, which became the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) in 1973. The State Substance Abuse Agency was attached to the Governor's Office until 1975, when it was transferred to the DOH. The Alcohol and Drug Abuse Branch (ADAB), which incorporated the former alcoholism clinic and substance abuse agency, was formally organized within the Mental Health Division in 1976. In 1989, the branch was elevated to a separate division within the BHA.[6]

ADAD's Responsibilities

The statutory duties of ADAD are set out as follows:[7]

(1) Coordinate all substance abuse programs including rehabilitation, treatment, education, research and prevention activities;

(2) Prepare, administer, and supervise the implementation of a state plan for substance abuse which may consist of a plan for alcohol abuse prevention and a plan for drug abuse prevention;

(3) Identify all funds, programs, and resources available in the State, public and private, and from the federal government which are being used or may be used to support substance abuse prevention, rehabilitation, treatment, education, and research activities;

(4) Be the designated agency required by, and receive and administer all available substance abuse funds including but not limited to funds received from the federal government;

(5) Encourage and coordinate the involvement of private and public agencies in the assessment of substance abuse problems, needs, and resources;

(6) Coordinate the delivery of available funding to public and private agencies for program implementation;

(7) Establish mechanisms and procedures for receiving and evaluating program proposals, providing technical assistance, monitoring programs and securing necessary information from public and private agencies for the purposes of planning, management, and evaluation;

(8) Review the state plan for substance abuse annually for the purpose of evaluation and make necessary amendments to conform with the requirements of federal or state laws;

(9) Do all things necessary to effectuate the purposes of this part; and

(10) Certify program administrators, counselors and accredit programs related to substance abuse programs in accordance with rules to be promulgated by the Department.

ADAD's Mission

ADAD's mission is "to provide the leadership necessary for the development and delivery of quality substance abuse prevention, intervention and treatment services for the residents of the State of Hawaii The Division is to plan, coordinate, provide technical assistance, and establish mechanisms for training, data collection, research, and evaluation to ensure that statewide substance abuse resources are utilized in the most effective and efficient manner possible."[8]

ADAD's Design

ADAD is an administrative office set up to provide service planning and program oversight. It is responsible for establishing, training and monitoring the direct service providers with which it contracts. It provides services exclusively through purchase of service (POS) contracts with private, not-for-profit direct service providers. ADAD assures that services are provided then monitors those services through a formal program compliance

review protocol. This mission is well-supported by ADAD's solid infrastructure and its continuity in management and leadership.

ADAD devotes a considerable amount of time and energy to program and resource development. This is possible because ADAD is not occupied with providing direct services. It has cultivated successful partnerships with other states. For instance, ADAD brought in staff members from Michigan's equivalent office when it needed assistance with accreditation. According to ADAD's division chief, this saved her staff a year's worth of work in drafting rules and procedures.[9]

ADAD is connected to an electronic bulletin board allowing interaction with counterpart divisions in other states. This enables ADAD to learn from other states' experiences with issues ranging from developing rules on detoxification to sharing requests for proposals (RFPs) for particular services.[10]

ADAD's Infrastructure

In order to qualify for federal grants, ADAD complies with strict reporting requirements, which requires a comprehensive, well-organized, data-intensive, computerized system. ADAD has established such a system.

ADAD's solid infrastructure and data management system, which include two accountants, enable ADAD to track and be accountable for its financial operations and thus be fully responsive to both state and federal reporting requirements. This enables ADAD personnel to devote significant time and resources to effective activities, such as writing grants, providing technical support and monitoring its service providers.

ADAD's organizational charts clearly delineate the actual positions and lines of authority within its division. ADAD has thirty authorized positions (including three presently vacant positions, two temporary and four federally funded positions). As presently constituted,[11] ADAD's staff is organized into four sections:[12]

(1) Administration (2 positions);

(2) Administrative Services (4 positions);

(3) Community and Consultative Services Branch (11 positions) -- this branch provides clinical consultation and training in addition to other planning, coordinating and contract management duties;

(4) Program Development Services (13 positions) -- this branch carries out certification and accreditation activities and develops treatment and prevention programs. The positions under this branch are as follows:

(a) Programs Services Head (1 position)

(b) Research and Statistics (3 positions) -- this branch implements and maintains the data and information system;

(c) Prevention (2 positions);

(d) Accreditation and Certification (3 positions);

(e) Planning (1 position);

(f) Treatment (1 position); and

(g) Secretary (1 position) and clerk-typist (1 position).

According to ADAD's State Plan, six of the thirty authorized positions are administrative: the division chief, PHAO, secretary, two accountants and an account clerk. The Program Development Services Office (PDSO) is staffed by seven program specialists, a secretary and clerk typist, as well as a statewide prevention coordinator (temporary position) and a planner. The Research and Statistics Unit is staffed by two research statisticians and a statistical clerk. The Community and Consultative Services Branch is staffed by a mental health supervisor (CCSB branch chief), a clinical psychologist and five program specialists (two of which are federally funded and three state funded), a training coordinator, secretary and two clerk typists.[13]

ADAD's Budget

ADAD is funded by a combination of state and federal sources. Approximately forty-one percent of ADAD's budget is derived from a federal substance abuse prevention and treatment block grant.

Accountability

When ADAD became a division in 1989, alcohol and substance abuse contracts were managed through the community mental health centers. To enable greater accountability, ADAD assumed direct control of these contracts.[14] Since ADAD manages contracts and does not provide direct services itself, it is able to spend significant time and energy in ensuring accountability.

Each private contractor provides monthly reports through invoices which are reviewed by ADAD's fiscal office and program specialists. ADAD employs a strict program compliance review protocol for purchase of service monitoring and evaluation. ADAD also interviews clients on a voluntary basis, to determine if their needs are being met.[15]

ADAD's Management Stability

ADAD's staff has been relatively stable. ADAD's chief, who has been with the office since its inception, is widely perceived as working effectively within the system. She attributes her success to scrupulous compliance with bureaucratic demands: timely and complete filing of forms, tracking documents and providing follow-up when necessary. As she says, "I believe the system is designed to work and not designed to not work."[16]

Adult Mental Health Division (AMHD)

The Adult Mental Health Division plans and provides comprehensive public mental health services for adults throughout the State. It provides administrative and professional support to community mental health center branches, provides referral and information service to the public, and oversees operation of the Hawaii State Hospital and Courts and Corrections branches.

The objective of the Adult Mental Health program is to reduce the severity of disability due to mental illness through provision of inpatient care case management, psychiatric treatment, housing, and rehabilitation services.[17]

The Hawaii State Hospital provides psychiatric inpatient services and neuropsychology outpatient services. The Courts and Corrections Branch provides mental health evaluations to the state court system, mental health evaluations and mental health services to state correctional institutions, and consultation regarding forensic issues to state mental health centers.

AMHD's Mission

AMHD's Mission, as reported in its State Plan, is as follows:[18]

> [I]n being charged with overall responsibility for the mental health of persons eighteen years of age and above, [AMHD] is committed to providing a comprehensive system of care through which individuals are assisted to function better and live as independently as possible to pursue life goals of their own choosing within the community.

AMHD's proposed amended mission statement (not yet formalized) is as follows: "The mission of the AMHD is to promote, provide, coordinate and administer a comprehensive, integrated mental health system for individuals eighteen years of age and older."[19]

AMHD's Organizational Design

According to its State Plan, AMHD has four organizational units: (1) the office of the chief; (2) central administrative services (including fiscal, personnel, and clerical); (3) program support services; and (4) community mental health centers (CMHCs).

Program support services staff are responsible for coordinating case management and programs for the homeless, family and primary consumers, psycho-social rehabilitation, finances and entitlements, and housing for the mentally ill. Staff responsibilities also include quality assurance, grants management, legislation, management information and data, planning, research, evaluation, contracts and monitoring.[20]

The primary purpose of AMHD is the provision of outpatient services delivered through nine CMHCs and in-patient services through the Hawaii State Hospital. The CMHCs are the primary providers of care for most people in Hawaii receiving publicly-supported mental health services. Each center is designed to provide a variety of mental health programs for its designated area.

The nine CMHCs serve specific sections of the State (called catchment areas). Six centers are on the island of Oahu (Central Oahu Mental Health Center, Diamond Head Community Mental Health Center, Kalihi-Palama Mental Health Center, Leeward Oahu Community Mental Health Center, Windward Community Mental Health Center, and the privately administered Waianae Coast Community Mental Health Center Inc.) and three centers are located on the neighbor islands (Hawaii, Kauai and Maui Community Mental Health Centers).

AMHD Purchase of Service (POS) Contracts

In accordance with chapter 42D, *Hawaii Revised Statutes*, AMHD contracts for approximately fifty services and programs for which approximately $4 million was paid from state funds in fiscal year 1992-1993. Approximately eighty percent of these contracts are directed to services for the severely mentally disabled, including rehabilitation, housing, and crisis intervention.[21]

According to AMHD's State Plan "a monitoring process will continue for all contracting agencies involving periodic data reports and site visits. During periodic site visits compliance with contract specifications is assessed by a multi-disciplinary team of reviewers. These assessments are evaluated in any subsequent proposals for funds."[22]

AMHD's Infrastructure and Present Reorganization Activities

In August 1993, AMHD's chief established a subcommittee of AMHD's Mental Health Committee on Managed Care, named the "AMHD Reorganization Subcommittee" (hereinafter "the Committee") to establish a plan for reorganizing AMHD's central office. Since that time, the Committee has been meeting once a week, for approximately two hours each meeting, to address the reorganization of the division. Members of the committee include AMHD administrative support services and program support services (hereinafter "central office" staff), a CMHC chief, as well as staff from the Administrative Services Office (ASO) and AMHD personnel office.

From the outset, the Committee's discussions about reorganization have primarily focused on two issues. First, the extent to which AMHD is out of compliance with a directive from the chief, Administrative Services Office which mandates:[23]

> Each department . . . is required to maintain an effective organizational structure and detailed departmental organizational information (organization charts and functional statements). Each department must assure that this information accurately reflects its current organization and that organization charts and functional statements are evaluated and updated in a systematic manner.

The second issue is the widespread perception that the present structure does not support the staff in its primary function, which is assuring that mental health services are effectively delivered.

Before the Committee could address the possibility of reorganization, it faced the task of identifying the present structure. This proved remarkably difficult. After numerous meetings focusing on AMHD organizational and position charts, the Committee discovered numerous anomalies. As of June 30, 1992, the AMHD program support position chart reflected twenty-six positions. In fact, the Committee's examination of the actual structure revealed:

(1) Seven AMHD employees presently staffed at AMHD have positions which do not appear on either the Program Support Services Position Chart or the Central Administrative Services Position Chart.[24]

(2) A position for a psychiatrist[25] on the AMHD program support services chart which represents a position which has minimal connection with the AMHD central office;

(3) Positions which appear on the AMHD Program Support Services Position Chart, although they are no longer budgeted AMHD positions, including one

which has not been filled since 1982,[26] and another which has been unfilled since 1988.[27]

(4) Eight positions which are authorized but not established and may be lost if not filled by January 1, 1994.[28]

(5) A person who presently provides data services to the AMHD, who works at the AMHD central office, but whose position still reflects "Hawaii State Hospital Administrator," despite the fact that he has not been so employed for over two years;

(6) The existence of Waikiki and Makiki Mental Health Clinic Team Sections on the AMHD Organization Chart, although no such sections presently exist;

(7) The placement of the Waianae Mental Health Clinic Team Section as part of the Leeward Oahu CMHC on the AMHD Organization Chart, despite the fact that it has operated as a private, non-profit independent service area since July, 1987;[29]

(8) No clear relationship on the AMHD organizational chart between program support services unit and the CMHCs despite the fact that the program support service staff is understood to "support" and serve as liaisons for the CMHCs.[30]

In addition to these problems, AMHD positions have apparently come and gone because they were not timely filled. The resulting "paper" organization and position charts are illogical, chaotic, and clearly not reflective of how AMHD's central office actually operates.

In struggling to design a manageable, logical infrastructure for AMHD, the Committee has confronted several difficult issues. One of these is the very real possibility that the new organization design will not provide positions for certain committee members. Another is the temptation to create positions designed to provide jobs for particular persons.

Notwithstanding the difficulties presented by such conflicts of interest, the Committee has produced a draft organizational structure which appears to be far more workable and logical than the present structure. Essentially, the proposed reorganization divides AMHD's central office into four sections: Fiscal Services, Quality Assurance, Planning and Policy and Human Resources.[31]

A realistic time for implementation of the draft organization is difficult to predict. Although the two-year length of the reorganization effort at the Hawaii State Hospital suggests no reason to be optimistic,[32] the Committee is none-the-less hopeful that the AMHD reorganization can and will be realized in the near future.

Child and Adolescent Mental Health Division (CAMHD)

The DOH is statutorily required to provide preventative and diagnostic services, and treatment and rehabilitation for all those eligible under age eighteen (or under twenty-two if special education certified).[33] Prior to its elevation in 1989 as a separate division within the BHA, the CAMHD was a small, specialized support service branch within the DOH Mental Health Division. As a division, CAMHD is responsible for planning, coordinating and providing statewide services to children and adolescents in need of mental health care through outpatient clinics and children's teams, and is to provide prevention and consultative services to public schools and community groups.[34]

The objective of the Child and Adolescent Mental Health program is to improve the emotional well-being of children and adolescents, and to preserve and strengthen their families by assuring early access to a child- and adolescent-centered, family-focused, community-based coordinated system of care that addresses the children's and adolescents' physical, social, emotional, and other developmental needs within the least restrictive natural environment.[35]

CAMHD Funding

Children's Mental Health Teams, located at each CMHC, are responsible for determining their own program and staffing needs and forwarding these to the state level. CAMHD then creates a two-year budget request based on input from the Children's Teams, the Director of Health, and the Governor's guidelines.[36]

CAMHD's budget received an infusion of $6.62 million, reflecting a forty-two percent annual increase. Approximately sixty-three percent of this annual increase is earmarked for expansion of community-based services throughout the State.

CAMHD External Pressures

Over the past few years, there has been increased pressure on CAMHD to develop an improved and effective mental health service delivery system for Hawaii youths. The United States Department of Justice contends that CAMHD is in violation of a settlement agreement based upon CAMHD's failure to provide the quality and quantity of programs necessary to serve Hawaii's most seriously emotionally disturbed youth.

In August, 1993, a class-action lawsuit was filed against the State by numerous representatives of mental health and child-service agencies (including Hawaii Mental Health Association, the Hawaii chapter of the National Association of Social Workers, and the Protection and Advocacy Agency).[37] The lawsuit's prayer for relief includes the appointment of a special master to assume control of CAMHD.

CAMHD Infrastructure

CAMHD is in the process of reorganizing itself. The proposed reorganization involves clinical, administrative and executive support changes.[38] For instance, the proposed reorganization will restructure the present two branches (Centralized Treatment Branch, providing inpatient services, and Clinical and Consultative Branch, providing outpatient services) to four new branches:

(1) Emergency and First Contact Branch -- to handle emergencies and first contacts on a twenty-four-hour basis; develop initial treatment plans; and coordinate referrals for continued services.

(2) Intensive Child and Family Services Branch -- to provide treatment for the most seriously disturbed youth.

(3) Community Services Branch -- to monitor and coordinate ongoing treatment to ensure that treatment plans are appropriate and implemented.

(4) Prevention and Early Childhood Branch -- two sections:

- Prevention Section will promote mental health of children and strengthening of families and develop school-based mental health services, including outreach services for the population at risk.

- Early Childhood Section will focus on identification of very young children with mental health problems or those at risk for a typical development; and will develop intervention services for children and their families; and will coordinate services with other agencies serving very young population.

The administrative support changes contemplated include:

(1) An office of clinical oversight which will work with the clinical branches to ensure that treatment plans are properly designed, clinically reasonable and meet Medicaid audit requirements; inspect records of services to ensure that federal rules are followed and proper documentation is made; issue credentials to providers and certify programs; and coordinate activities with "Health Quest" and other initiatives related to health care reform.

(2) An office of administrative support to oversee budgets, personnel, business services, contracts and accounting.

(3) An office of program support and training, comprised of two sections. The program support section will coordinate legislation, rules, administrative reports, research and grant proposals. The training section will develop career growth and team building.

The contemplated reorganization is expected to accomplish increased access to federal reimbursements for services provided and a focus by the CAMHD on policy development, planning, program development, program evaluation activities and assurance of quality of services. It is also designed to enable CAMHD to "focus on the integration and coordination of services between CAMHD and other community and state agencies to create a stronger and more effective system of care."[39]

The CAMHD chief considers the implementation of the CAMHD reorganizational plan a necessity if the State expects to avoid future lawsuits and comply with state and federal mandates.[40]

Endnotes

1. Hawaii Rev. Stat., §334-2.

2. Hawaii Rev. Stat., §334-4.

3. The six separate administrations in the Department of Health are: Personal Health Services, Environmental Health, Health Resources, Behavioral Health Services, Health Promotion and Disease Prevention, and Community Hospitals.

4. State of Hawaii Program Structure, December 1992 (effective July 1, 1993 to June 30, 1995) (hereafter "Program Structure") pp. 5-28.

5. Interview with Masaru Oshiro, A.C.S.W., Deputy Director, Department of Health, Behavioral Health Service Administration, August 11, 1993.

6. Hawaii, Department of Health, Behavioral Health Administration, Alcohol and Drug Abuse Division, 1994-1997 State Plan (hereafter "BHA ADAD State Plan"), p. 1.

7. Hawaii Rev. Stat., §321-193.

8. BHA ADAD State Plan, p. 2.

9. Interview with Elaine Wilson, A.C.S.W., M.P.H., Alcohol and Drug Abuse Division Chief, Department of Health, September 28, 1993 (hereafter Wilson interview).

10. Ibid.

11. The Alcohol and Drug Abuse Division has recently begun a reorganization.

12. Alcohol and Drug Abuse Division Staff Listing, September 28, 1993; BHA ADAD State Plan, pp. 141-142.

13. BHA ADAD State Plan, pp. 141-142.

14. Wilson interview.

15. Ibid.

16. Ibid.

17. Program Structure, pp. 5-25.

18. State Plan: 1991-1993, State of Hawai'i Department of Health, Behavioral Health Services Administration, Adult Mental Health Division (hereafter "AMHD State Plan"), p. 2.

19. Hawaii, Department of Health, Adult Mental Health Division Reorganization Subcommittee, Mission Statement (Third Draft), October 12, 1993.

20. AMHD State Plan 1991-1993, p. 8.

21. Ibid., p. 9 and Appendix I. Note: The expected POS payment for fiscal year 1993-1994 is $4,987,025.

22. Ibid., p. 9.

23. Hawaii, Department of Health Administrative Directive No. 90-01, Policy and Procedures for Effecting Changes in Organization, January 26, 1990, p. 3.

24. At least three of these positions are funded through the University of Hawaii under an arrangement which enables, among other things, these positions to be funded at a higher amount than comparable DOH positions.

25. Position 04183E -- Uncl. Psychiatrist III.

26. Mental Health Supervisor III, No. 31646, State of Hawaii, Department of Health, Behavioral Health Services Administration, Adult Mental Health Division, Program Support Services, Position Chart.

27. Ibid., Social Worker VI, No. 02115.

28. Positions 94295 (RPN V-Hd Human Res)
94294 (Clinical Psych. VII)
94393 (Community Program Specialist)
94292 (Soc. Worker V)
94291 (Psychiatrist III)
92759 (Planning Specialist V)
92758 (Eval. Specialist V)
92757 (Financial Specialist V)
92752 (Training Specialist I)
92751 (PMS IV -labor rel.)
90029 (PHAO IV)

29. Hawaii, Department of Health, Behavioral Health Services Administration, Adult Mental Health Division, Organization Chart, June 30, 1992.

30. Hawaii, Department of Health, Behavioral Health Services Administration, Adult Mental Health Division, Position Chart, June 30, 1992.

31. Hawaii, Department of Health, Adult Mental Health Division Organizational Chart (Third Draft), AMHD Reorganization Subcommittee, November 10, 1993.

32. Under the State's settlement agreement with the Department of Justice, the State was required to "develop and implement an organizational structure at the Hawaii State Hospital (HSH) that will establish clear lines of authority and responsibility among the various aspects of HSH operations and personnel" within sixty days of September 19, 1991.

(U.S. of America v. State of Hawaii et al., Settlement Agreement, Civil No. 91-00137 (DAE), September 19, 1991, p. 31.)

Dr. Howard Weiner, who was put in charge of the reorganization, (which is presently under review by the Department of Budget and Finance) notes that "that was sixty days as of two years ago." (Comment, Howard Weiner, AMHD Reorganization Subcommittee meeting, September 8, 1993).

33. Hawaii Rev. Stat., §321-171.

34. Hawaii, Department of Health, Behavioral Health Services Administration, Functional Statement, June 30, 1992.

35. Program Structure, pp. 5-27.

36. Hawaii, Department of Health, Demonstration of a Collaborative Community-Based System of Care for Children and Adolescents with Serious Emotional Disturbances in Leeward O'ahu, Hawaii, Request for Applications, July 16, 1993, p. 21.

37. Felix, et al. v. John Waihee, et al., First Amended Complaint for Declaratory and Injunctive Relief, Civil No. 93-00367, United Dist. Ct. (Class Action).

38. Hawaii, Department of Health, Child and Adolescent Mental Health Division Reorganization Concept Memorandum from Neal Mazer, M.D., M.P.H., Chief, Child and Adolescent Mental Health, to John C. Lewin, M.D., Director, Department of Health, October 18, 1993.

39. Ibid.

40. Interview with Neal Mazer, M.D., M.P.H., Chief, Child and Adolescent Mental Health, Department of Health, October 19, 1993.

Chapter 4

THE PRESENT SYSTEM: PROBLEMS AND PERCEPTIONS

It is not the purpose of this study to analyze in depth the shortcomings of the present system. Therefore, a comprehensive review of the many problems presently impeding effective delivery of mental health services in Hawaii is beyond the scope of this study. However, since the legislative resolution requests recommendations for alternative methods of governance, it is necessary to identify those aspects of the present system which work as designed, those which do not work as designed, and those in which the design is flawed.

This chapter describes the shortcomings of the present system as perceived by many of those who have a direct stake in the system's success. Interviews were conducted with over thirty-five such "stakeholders," including past and present BHA deputy directors, AMHD, ADAD and CAMHD division chiefs, nine CMHC chiefs, numerous local mental health advocates (including university and state mental health advisory council members), AMHD staff, private providers, as well as national experts and consultants (including many who have been hired by DOH in the past). The CMHC chiefs, clinical supervisory personnel and public health administrative officers (PHAOs) were surveyed through a mailed questionnaire asking questions related to the ability of the centers to provide cost-effective, efficient, mental health services. (See Appendix C for questionnaire.) Some of the answers received in response to these questionnaires are provided.

Chart 1 shows the data from the survey. The information is helpful in analyzing the CMHC respondents' perceptions about the present system. It is noteworthy that thirty-four of the forty-four (seventy-seven percent) of the ten-page questionnaires were completed and returned.

* * *

When a butterfly flutters its wings in Topeka, an earthquake occurs in China.

-- Sherry Harrison, Chief, AMHD[1]

Interviews and questionnaire responses reflect a perception of multiple, recurring governance, administrative and fiscal problems presently impeding the effective, cost-efficient delivery of mental health services by the BHA. This chapter describes some of these problems.

Fifteen specific problems are discussed. Although these problems are described separately, they are in fact, interrelated. While each problem may bear directly on different aspects of the governmental, fiscal and administrative components of the system, each affects the mental health services system as a whole.

Chart 1

DATA FROM QUESTIONNAIRE

QUESTIONS	QUESTIONNAIRE RESPONSES					
	ALWAYS	OFTEN	SOMETIMES	RARELY	NEVER	NO RESPONSE/ DON'T KNOW/ N/A
1. Do state policies/bureaucracies constrain the effective provision of public mental health services?	4	23	5	--	--	2
2. Are public mental health services compromised by State's purchasing and procurement regulations?	3	16	12	1	1	1
3. Are public mental health services compromised by:						
...lack of resources	14	14	5	--	--	1
...too much rigidity within system	4	14	12	1	--	3
...lack of accountability	3	14	11	3	--	3
...too much accountability	--	8	10	8	5	3
...non-cost effective system	5	11	9	2	--	7
...too much time and energy spent "finessing system"	4	7	7	6	--	10
...failure of system to operate on timely basis	10	13	8	--	--	3
...fragmented/uncoordinated service delivery	3	14	13	3	--	1
...too little supervision	1	9	11	10	1	2
...too much supervision	--	4	1	17	9	3
...inability to be creative	5	10	11	5	1	2
...unrealistic or unpredictable budgets	16	12	4	2	--	--
...unrealistic/burdensome vendor payments and/or procurement requirements	5	12	8	3	--	6
...delays in vendor payments	6	12	9	2	--	5
...delays in hiring and/or personnel shortages	9	17	4	--	--	4
...high turnover of management positions	2	7	13	8	1	3

QUESTIONS	AGREE	TEND TO AGREE	NEUTRAL	TEND TO DISAGREE	DISAGREE
4. Functions of AMHD central office are clear	1	6	7	9	11
5. Previous AMHD reorganizations have been appropriate	1	5	16	7	5
6. Previous AMHD reorganizations have been effective	1	4	16	9	4
7. Present AMHD organization makes sense	--	7	7	13	7
8. Work is distributed fairly among professions within the CMHCs	1	12	8	7	6
9. Work is distributed fairly among the CMHCs	--	8	14	8	4
10. I have clear understanding of AMHD's mission	3	8	10	7	6
11. I have clear understanding of AMHD's organizational structure	3	11	6	7	7
12. The State is often unable to deliver appropriate mental health services because of:					
...state bureaucracy	16	13	1	4	--
...lack of funding	18	11	3	2	--
...inability to make and follow predictable, long-term budgets	16	11	4	3	--
...timely recruitment and hiring of personnel	23	8	3	--	--
...no incentives within system to provide cost-effective services	16	12	5	1	--

A. Unified "Steering" and "Rowing" Functions Within BHA

One of the fundamental premises of David Osborne and Ted Gaebler's *Reinventing Government* is that effective governments assure that services are provided but do not attempt to provide those services themselves. Effective governance requires a shift to a system where policy decision functions (steering functions) are separate from service delivery functions (rowing functions).[2] The rationale behind this premise is discussed as follows:[3]

> Any attempt to combine governing with "doing" on a large scale, paralyzes the decision-making capacity. Any attempt to have decision-making organs actually "do," also means very poor "doing." They are not focused on "doing." They are not equipped for it. They are not fundamentally concerned with it.

Both AMHD and CAMHD plan, provide, and monitor mental health services. For instance, within AMHD, the central office is responsible for planning, coordinating, and monitoring the direct service providers -- the CMHCs. In doing so, AMHD assumes both "steering" and "rowing" functions.

Clearly, when such distinct functions as planning, providing, and monitoring services all fall under a single administration, the possibility arises that service policy decisions will be motivated by the perceived interest of the service providers rather than the needs of those receiving the services. As one CMHC chief explains, this situation creates a real problem of "divided allegiance." She analogizes it to putting the Hawaii Medical Services Association (HMSA) in charge of deciding what the best health care is for the State. Under such an arrangement, the one who sets the standards for delivery of care may do so with the competing consideration of whether it will be able to meet those standards.[4]

Problems also arise once services are provided and issues of accountability and monitoring come into play. As one CMHC chief suggested, the integration of such diverse functions under a single roof is like "putting a mouse in charge of guarding the cheese."[5]

And, as discussed below, monitoring by AMHD of the CMHCs and private providers is not occurring on a regular basis. One reason for this is that AMHD central office staff are simply too busy attending to daily crises to put their time and energy into effective planning and monitoring. As explained by Osborne and Gaebler, steering functions do not perform optimally when others are not permitted to do the rowing and become very difficult "if an organization's best energies and brains are devoted to rowing."[6]

B. Ineffectual Accountability

Accountability includes many different issues, such as supervision, monitoring, quality assurance and individual responsibility. Among the mental health community and BHA "stakeholders" there is a widespread perception of a lack of accountability within the BHA.[7]

The AMHD chief notes that "authority is placed in many different pockets and therefore no one is really accountable."[8] Reflecting upon Harry Truman's famous adage, "the buck stops here," one CMHC chief notes that "there is no 'buck' within this system."[9]

Regarding this issue, some of the questionnaire responses from CMHC supervisory personnel were illustrative:

> I could go months without the division knowing what I'm doing or not doing. . .
>
> . . .[E]veryone and no one is accountable. That's the problem.
>
> Employees at all levels are allowed to be too lax; when policies and procedures are developed for program activities, many supervisors "expect" that they're not followed and there are no provisions for accountability. Many, many times there's no follow-through. . .
>
> While there appears to be greater requirements for accountability, the reverse is often true -- a major paradox! It is extremely difficult to hold staff accountable when they have permanent civil service status. . .
>
> There is no accountability.
>
> Where does our money go?
>
> There are so many layers, that no one can be held accountable.
>
> There is no system of accountability. . .
>
> No one seems to care upstairs.
>
> Everyone appears to be afraid of taking responsibility and being accountable for mistakes or other things which go wrong. Fingerpointing seems to be a favorite game of state employees, but I believe that the system has created this atmosphere. . . .

Many CMHC professionals feel they are held "accountable" despite their lack of real decision-making and budgetary authority. They feel that the control and authority is removed from the only people close enough to the problems to be able to respond timely and effectively to them. Such sentiments were expressed during interviews with CMHC chiefs, as well as through the questionnaire responses from CMHC managerial professionals. The following questionnaire responses highlight the perception:

> Responsibility is not accompanied by authority or resources.
>
> There is too often responsibility without authority . . . [N]eed to go through so many channels and there are no clear areas of responsibility.
>
> Sometimes we are given responsibility without authority. An example: a center chief decides to deny services to an individual based on that person's not meeting eligibility criteria or not complying with treatment so as to interfere with others seeking help. That person or their family may complain to division, who sometimes calls us to pressure to take the person anyway -- i.e. not backing us up in managing our resources.

> "Passing the buck" at higher levels -- "I'm sorry, but A says you have to" from B, then talk to A and find out it is not true.
>
> We are held accountable and responsible for clients not therapy candidates. Duplication of non-clinically relevant stats.
>
> [There are] layers of approval required for simple actions (actions often approved through the legislature by our budget).

C. Insufficient Programmatic Monitoring

Under the Department of Health's (DOH) rules relating to the mental health and substance abuse system, all mental health services provided directly by or under contract by DOH are required to be monitored and evaluated at least annually.[10]

This required monitoring is simply not happening, as noted by the following CMHC questionnaire respondents:

> . . . The division sets policies and procedures but no one comes around to check, monitor, evaluate or report if those guidelines are being implemented or not. Because of lack of close monitoring, the line staff sometimes chooses not to hear or at best drag their feet.
>
> Division administration does not know how the centers really operate -- they have never visited this center, but are quick to point fingers if there is a complaint.

The acting chief for the Windward Oahu Community Mental Health Center reports that AMHD administrators have not visited the center in an "official capacity" for over two years, despite several invitations from the center to do so.[11] The chief of the Kauai Community Mental Health Center estimates that "formal monitoring" of the Kauai CMHC may not have occurred for as long as ten to twelve years.[12]

Most purchase of service (POS) contracts with private providers are monitored by AMHD. Previously, this monitoring was performed by the CMHCs.[13]

The AMHD State Plan for 1991 - 1993 states:[14]

> During the current biennium, a monitoring process will continue for all contracting agencies involving periodic data reports and site visits. During periodic site visits compliance with contract specifications is assessed by a multi-disciplinary team of reviewers.

Again, despite the claims contained in the State Plan, "assessments" of the contracting agencies apparently are not taking place. This concerns the private service providers with whom BHA enters into contracts for mental health services. When asked about the process for monitoring Wai'anae Coast Community Mental Health Center, Inc. (the only private community mental health center which provides services through a purchase of

service contract), an AMHD central office staff member explained that, "we all know that we are supposed to be monitoring Waianae, but nobody ever does."[15]

The Waianae Coast CMHC's executive director notes that the last time AMHD performed a programmatic monitoring of the services provided by her center was in 1988. She states that she "wishes we could get them out here."[16]

This sentiment is pervasive. Programmatic monitoring of the POS providers is, by many accounts, "non-existent" and, as one AMHD staff person notes, the quarterly reports provided by POS service providers seem to "go directly from the mailbox to the file drawer." In conjecturing why monitoring is not occurring, one AMHD staff member reflected that there is a pervasive feeling that "I know it's bad, but I don't want to know how bad it really is, because that might mean [some kind of action might be necessary.]" It was also pointed out that job performance reviews are done sporadically and often with a desire to not incite grievances and because of this, disciplinary action is sometimes not a realistic possibility.

Private providers are frustrated with BHA's failure to monitor services. One private service provider notes that although CAMHD pays millions of dollars for services provided by her agency, those services have not been monitored for several years, despite her repeated "invitations."

AMHD's failure to conduct on-site monitoring of mental health programs and services leads to feelings of vulnerability on the part of several service providers who indicated, when interviewed, that they would like their programs and services to be periodically monitored and reviewed in the interest of self-protection.

D. Inadequate Supervision

Despite one AMHD psychologist's observation that "good supervision is as beneficial as good therapy"[17] a majority of the CMHC questionnaire respondents report that they generally receive "too little" as opposed to "too much"[18] supervision. Some of their comments are as follows:

> Too little of the right supervision, again because of the varied focuses that are present.
>
> Phone supervision is not always that effective nor is bi-weekly face-to-face with supervisor.
>
> Supervisors need to provide more direct supervision and hold employees more accountable for increased efficiency and effectiveness of services.
>
> My supervisor burned out and is on sick leave. Seems like supervisory positions are pretty punishing.

> Almost zero support at division for supervision of clinicians, i.e. new innovations, encouragement, addressing 'burn out', bringing clinical consultants to the centers. Trainings always seem to have ulterior motive -- i.e. CARF.
>
> I feel extremely guilty because I've not had the time to supervise my employees. The problem has been the number of employees . . . for which I'm responsible and the amount of work, other than supervision, which takes most of my time, e.g. meetings, administrative paperwork, taking on crises, etc.
>
> Almost no one gets detailed and organized orientation when they are new on the job. They are all left to 'fend for themselves.' and it is left to the supervisors who may be also new to the system. . .
>
> For us . . . the lack of clinical supervision sometimes provokes anxiety -- particularly when a clinical decision has to be made. On the other hand, it forces people to learn.
>
> Inconsistent supervision across the board is the problem.
>
> It's not clear to me to what extent the AMHD should be supervising the center. . .
>
> It isn't a question of too much or too little, it's the quality of supervision that's lacking.
>
> The CMHC chiefs are sometimes given poorly thought out tasks to do and find persons responsible at AMHD unavailable or unable to assist.
>
> Perhaps not so much on supervision -- but more not enough teaching, training in some of the more complex tasks.

This apparent failure of supervision within the AMHD may be attributed to several factors. First, under the present organizational chart, all CMHCs as well as the entire AMHD central office staff, report directly to one division chief.[19] Clearly, it is unrealistic to expect any single individual to effectively supervise this number of personnel and activities. Second, it is apparent from interviews as well as questionnaire responses, that many AMHD and CMHC staff spend a great amount of time handling various crises and have little time or energy left to devote to hands-on supervision.

E. Budget Problems and Fiscal Policies

> Most public organizations are driven not by their missions, but by their rules and their budgets. They have a rule for everything that could conceivably go wrong and a line item for every subcategory of spending in every unit of every department. The glue that holds public bureaucracies together, in other words, is like epoxy: it comes in two separate tubes. One holds rules, the other line items. Mix them together and you get cement.
>
> -- David Osborne and Ted Gaebler[20]

Throughout the BHA, there is frustration with budgetary problems and fiscal policies. The foremost concern is insufficient funds and resources. Second, the service providers in the CMHCs widely perceive the budget process as seriously impeding their operations. This is because they view their budgets as unpredictable and unrealistic and outside their control. Finally, such governmental entities as the DOH administrative and personnel offices, the Departments of Personnel Services (DPS), Budget and Finance (B & F) and Accounting and General Services (DAGS), as well as the legislative and executive branches of government are often perceived as intrusive.

1. Inadequate Resources and Funding

> Putting money into mental health is like doing housework -- you keep doing it but the results are fleeting -- it never quite goes away.
>
> --Sherry Harrison, Chief, AMHD[21]

Mental health services in Hawaii have been seriously underfunded for many years. In 1986, Hawaii ranked thirty-sixth in per capita expenditures for mental health while its per capita income ranked fourteenth.[22]

In 1988, the Public Citizen Health Research Group (PCHRG) and the National Alliance for the Mentally Ill ranked Hawaii fifty-first in the country in providing care for the mentally ill in terms of number of staff and services available to deal with the mentally ill at the community level and in dollars expended per mentally ill person. The report noted that Hawaii spent $21.45 per capita on the treatment of the seriously mentally ill, compared to $45.45 for top-ranked Rhode Island, which had about the same population.[23]

In 1990, Hawaii was again rated worst in the country and ranked forty-third in per capita spending on mental health, spending little more than half the national average. As noted by the report:[24]

> . . . [T]he most daunting problem in the state's CMHCs, however, is a dire lack of all the basic resources needed to put together good programs. . . . Administrative funds and support services are also in very short supply at CMHCs, with some centers unable to keep basic equipment such as typewriters functioning. And all programs, even the best ones, have a discouragingly small capacity compared to the need. . .

In 1992, Hawaii increased funding for mental health services in the area of children and adolescents. However, as reflected by the following CMHC questionnaire responses, such funding has not alleviated the present situation:

> . . . Vehicles should be replaced at least every ten years, but funds are not provided.

> The money they allow us for the program and scope they expect is unrealistic. We are under-funded -- we have very little services to "wrap around" us.
>
> We have no admissions clerk, fax machine, group room, addressograph, dictaphone. . .
>
> . . . ADA requirements [affect] our facilities, and [mandate] massive changes, yet we are not given resources to meet the requirements.
>
> Where are our handicapped accessible vehicles for transporting clients? . . .
>
> Insufficient funds, staffing and equipment. The lack of clerical support is significant with the new requirement for client records, let alone all the routine and administrative work that is required.

This persistent underfunding has led to many problems for both consumers and providers of mental health services. As another CMHC questionnaire respondent noted, "The constant need to function with the mentality of being 'poor' does not create therapeutic feelings of empowerment and hopefulness to the clients. . ."

2. Unpredictable, Unreliable Budgets

One of the most prevalent sentiments expressed in interviews with CMHC chiefs and CMHC questionnaire respondents is frustration with the budget process. This frustration is related to many factors, including the DOH Administrative Services Office's (ASO's) role in the budget process, and budgetary restrictions on spending. Finally, there is a widespread perception that funds allocated in the budget to the CMHCs are constantly "siphoned off" to pay for United States Department of Justice -- mandated improvements in the Hawaii State Hospital. In fact, one of the reasons that the Robert Wood Johnson Foundation cut off almost $1 million of grant money promised to Hawaii was because the foundation perceived that there was too much focus on the Hawaii State Hospital and not enough emphasis on the CMHCs.[25]

According to several CMHC staff, the extent of this problem is difficult to confirm, since the appropriation code for the Hawaii State Hospital and the CMHCs merged several years ago. However, the perception is clearly pervasive. As one mental health advocate puts it, the Hawaii State Hospital "has sucked [the CMHCs] dry." Regarding this problem, the former BHA deputy director notes that "this would be scandalous in other states, but has come to be accepted in Hawaii."[26]

The consequences of these budget problems are far-reaching. First, realistic planning is difficult, if not impossible. One acting CMHC chief notes that planning is difficult when "we don't even see our budget until the end of the first quarter because we have to wait until it goes from the legislature to B & F [the Department of Budget and Finance], then to the governor, then to BHA, then to AMHD and finally to us, once everyone has taken their

share."[27] Also, mental health administrators are often not aware of the financial status of their operations since reports produced by ASO are often delayed one or more months.[28]

The following CMHC questionnaire responses highlight some of the frustrations related to the present budgetary system:

> Budget restrictions are frequently mandated. Often times, expenses are incurred that are outside any planned budget -- when it is convenient to the division. You don't have an accurate picture of what's possible and what's not.
>
> Budget restriction and reallocation of funds to Hawaii State Hospital has been a constant problem for the CMHCs. Hiring of staff is delayed or not filled at all to meet budget shortfall. Staff are burned out because they are asked to do more with less.
>
> The budget system is flawed. Appropriated budget as authorized by the Legislature is only on paper, actual allocation to each center is entirely different. Everyone imposes restrictions (governor, director of health and division) not to mention re-allocation of funds to the Hawaii State Hospital to offset budget deficit.
>
> This is always frustrating. Each year you plan how things will work out based on the funding. Then we get cuts or a freeze in spending and your plans go out the window.
>
> Nobody owns a budget unless they're a POS contractor.
>
> We are always having to leave a position vacant (a position that, if filled, would be providing treatment to our clients) to make up for someone's budget restriction -- i.e. undoing the legislature's intent. Recently, we've encountered hiring and budget freezes due to unrealistic budgeting/funding of the state hospital. We run the danger of losing positions when the above actions result in a position being vacant long enough that ASO or someone assumes that we don't need it and takes the position away.
>
> Generally faced with budget restrictions which are arbitrary and last minute which do not allow future planning, let alone present planning. Unable to purchase medications or provide money for client needs.
>
> We never are allocated all the funds to fill our positions. In fact, restrictions occur regularly. Yet, the demand for services increases, the demand for more information increases, the demand to change internal systems all at once abound.
>
> Planning processes identify needs that go unmet due to budget restrictions and lack of funds. Although you have positions, they are frozen and sometimes permanently lost. Funds are administratively reallocated to other program areas.
>
> DOH approves emergency plan then Budget and Finance throws it out. . . . DAGS' control system is fragmented with no clear responsibility or accountability.
>
> We have never had predictable, long term budgets as long as I have worked for AMHD.
>
> It has become a game. Division takes money from centers for other branches (i.e. Hawaii State Hospital), central office, etc. Centralized bookkeeping keeps centers cautious in guessing what's left in their budget.
>
> In the recent past you could have some difficulty in predicting a one-year budget.
>
> . . . [P]resent and future planning is effected by [lack of predictable budget].

If we were a private business, I'm disappointed to say that we would probably be in receivership by now.

There is an expectation that we will be accountable/responsible. And when we are -- another system (branch, etc.) will take away the money that had been saved for other projects or planned uses.

Even during healthier times, the [CMHC] never was allocated funds to fill all the positions. We operate on a tight budget, so every restriction becomes a problem. During leaner times like now, it becomes an even greater problem.

Impossible to plan.

Who gets the money generated at a local level -- i.e. billing?

Unrealistic [budgets] -- not based upon documented needs.

Unpredictable -- restrictions cause hiring delays and lack of operating supplies, etc.

How can anyone operate effectively when you know that the governor and then the department heads have the power to set restrictions? Moreover, you never can anticipate the amount of the restrictions. . .

From year to year, centers never know how much restrictions will be imposed.

Mental health systems budget has always been tampered around with especially with the [Department of Justice] settlement at the Hawaii State Hospital, mental health's budget has been reduced or taken away without any input from the centers.

Budget allocation after restrictions are never enough to fill all positions -- positions that remain vacant are deleted. In desperation, "B" funds are transferred to "A" to keep warm bodies, which in turn depletes "B". It's a vicious cycle."

3. ASO/DPS/B & F Role

Control of the budget and the budget-making process is the way a department defines and clarifies its priorities. Too often, however, the budget is less under the control of administrators than of the budget process, which may be insensitive to how mental illness destroys individuals and families and creates a serious burden to communities.

-- David Mechanic and Richard Surles[29]

The BHA does not have autonomous control over its budget, fiscal and personnel functions. The primary responsibility for such functions rests with many entities including DOH's Administrative Service and Personnel offices, the Department of Personnel Services, the Department of Budget and Finance (B & F), the Department of Accounting and General Services (DAGS) and other legislative and executive offices.

In fulfilling these functions, ASO and DPS in particular, are widely perceived as exercising inappropriate control over policy and clinical decisions made by BHA staff. Notes one CMHC questionnaire respondent, ". . . In personnel actions such as requests for training

authorization, tradeoffs of positions, or other matters, we hope to write up a justification for someone who often has no idea of what we do, to read and approve."

Two examples are illustrative of this problem. First, a decision was made that certain staff should attend a training session. This decision was approved by the CMHC chief, the AMHD chief and the BHA deputy director. Nevertheless, ASO initially refused to authorize the expenditure of funds necessary.[30]

A second instance involved a decision by the then-BHA deputy director to hire a psychiatrist at the Hawaii State Hospital. This was necessary because only a psychiatrist, as opposed to a psychologist or a social worker could prescribe medication within the hospital. ASO again denied the initial request. In so doing, the former BHA deputy director complains, ASO made a programmatic decision for which it is not held accountable.[31]

F. Centralized Control (Budgetary and Decision-making) Resulting in Time-intensive, Unresponsive Services and BHA Staff's Lack of "Ownership" in the Operation

> The impulse to control is embedded in virtually every set of rules by which government operates: the budget system, the personnel system, the procurement system, even the accounting system. Every rule was originally laid down with the best of intentions. But the cumulative effect is gridlock.
>
> -- David Osborne and Ted Gaebler[32]

Under the present structure, a significant amount of decision-making is made at the already stressed and overwhelmed central offices. This creates problems closely related to the problems of "illusory" budgets and minimal authority at the direct service level -- the CMHCs. This centralized control inhibits the system's ability to deliver services in a timely and effective manner. It also leads the line staff to feel that they do not have sufficient control over their own activities to be effective.

In response to a question asking whether CMHC managerial personnel felt their respective CMHCs would benefit from an increase in autonomy, the vast majority of respondents replied "yes," as reflected in the following comments:

> Yes, center based policy and procedures to match the center's staffing, resources, the community. Local control of billing revenues.
>
> . . .[An increase in autonomy] would allow for more responsibility and accountability and force a rational budgeting and planning process. . .
>
> . . .[An increase] in autonomy (and concomitant contractual accountability) would result in a higher quality, more efficient and cost effective service delivery as it has in other areas.

[CMHCs should be able to] determine their own staffing requirements and adjust these as necessary. The centers should receive a block of money and be allowed to spend it as necessary, without the constraints of "A," "B," "C" or "M."

If the state system were to change and to streamline their process and procedures, then autonomy would not be an issue. . . . But, whatever the system, it should be flexible and open to changes quickly and effectively. . .

Budgetary and personnel autonomy is needed. Also needed is flexibility in how funds can be used. There need to be incentives and the ability to control one's funds. We also need to have the ability to make decisions on the center level on the organizational, operational, and programmatic matters.

[Autonomy would] reduce so much waste and bureaucratic red tape. For example, hiring practices will be more efficient and cost-effective.

[The CMHCs could] decide, based on their specific community needs, what services they will provide and who would be best qualified to provide them. Also, we wouldn't have to wait for permission from above to do them.

[Autonomy would increase our] ability to integrate services into communities. The population served by centers need home- and community-based services -- not just periodic office visits. Without the autonomy to develop and fund alternatives, the staff is hamstrung.

. . . [An] increase in autonomy will also give [sic] the centers to set policies and procedures that best fit their needs and the population they serve. The Center can act on a timely basis to solve their problems and make decisions as they see fit.

. . . Those who control resource allocation are very far from where the resources are needed.

We would benefit in most areas by being more autonomous. It appears that many of the problems mentioned above are due to a lack of trust on the part of the various levels of government, possibly exacerbated by the need to protect their own positions -- i.e do something that looks productive. We often have our purchase orders, personnel action, etc. reviewed by five levels of government, covering several departments. . . .[Who is] overseeing the overseers?

G. Hiring Delays and Budgetary Restrictions Precluding Timely Recruitment and Retention of Necessary Staff

In business, personnel is a <u>support</u> function to help managers manage more effectively. In government, it is a <u>control</u> function -- and managers bitterly resent it.

-- David Osborne and Ted Gaebler[33]

The budgetary and bureaucratic problems described above seriously impede effective staffing of the various BHA divisions. Salary levels are perceived as often too low to attract and retain sufficient staff. Aside from the low salaries, perhaps greater frustration is caused by the bureaucratic delays and red tape associated with creating and filling needed staff positions. In fact, many of those interviewed consider this problem to be the most profound reflection of the rigidity and ineffectiveness that they experience within the present system. In

response to a survey question asking whether the State is often unable to deliver appropriate mental health services because of delays in timely recruitment and hiring, twenty-three of the thirty-four respondents "agreed," eight responded that they "tend to agree," and three responded "neutral."

At present, an average of thirty percent of the positions within each CMHC are vacant.[34] As one CMHC Public Health Administrative Officer (PHAO) explains, it can take as long as five months for DPS to approve the filling of a position. Once the position is approved by DPS, it often takes four additional months to receive an approved internal list of applicants. If that list is insufficient, an external list must then be reviewed resulting in further delay.[35] As a consequence, as noted by the AMHD chief, it can actually take up to two years to fill a given position.[36] Obviously, by that time, many if not most of the applicants (particularly the most qualified) may have found positions elsewhere.

Moreover, this problem leads to a further dilemma. Notwithstanding the fact that it can take up to two years to fill a position, the position may be lost altogether (under the premise that it is not a truly "necessary" position) if it remains unfilled for too long. According to the chief of the Kauai CMHC, this is precisely what happened to their center, which actually lost its only psychiatrist position simply because the position remained unfilled for too long and was therefore deemed "unnecessary."[37]

In December, 1993, three other CMHCs lost positions that were being filled by psychiatrists working on "fee-for-service" arrangements since such positions were considered technically "vacant."[38]

There is another aspect to this problem. One of the few means of rewarding, and therefore retaining, good personnel is by "upgrading" their positions. Such upgrading is severely inhibited under the present system since promotions are controlled by the personnel departments and not the managers. Again, the experience of Kauai's CMHC is illustrative. Three years ago, the Kauai CMHC attempted to upgrade the position of a social worker who had been with the center for several years from a Social Worker III to a Social Worker IV. This social worker had been involved with Kauai's rehabilitation program which was one of the few "bright stars" of the Fuller-Torrey Report on Hawaii's deficient mental health services.[39]

The center chief submitted the request for the upgrade three times over a three-year period. Finally, after three years, DPS denied the request. The center now has thirty days in which to appeal the decision. However, the center chief is certain that the social worker will simply terminate his employment and the center will lose a good worker who they have spent time and energy training.[40]

Hiring freezes present another problem. In one case, a registered nurse who headed a unit and was responsible for overseeing a program that served sixty-five clients, terminated her employment during a hiring freeze. The remaining two licensed practical nurses (LPNs) on the same unit were statutorily required to operate under the direct supervision of a

registered nurse.[41] However, because of the hiring freeze, the registered nurse position went unfilled for at least five months. During those five months, the LPNs were in the legally untenable position of practicing nursing without the statutorily mandated supervision.[42]

Some of the frustrations expressed by CMHC questionnaire respondents regarding various problems with hiring and staffing are as follows:

> On paper we have the resources -- in reality we don't. We could have fifty staff authorized but are only able to fill forty because of funding. Yet planning is predicated on fifty staff.
>
> Funds are available, but program unable to get them in a timely manner. Positions are available, but unable to recruit and hire in a timely manner.
>
> At center level, budget appropriations to begin with, do not cover the salaries for total authorized positions as it is reasoned that all positions are never filled for an entire fiscal year. We therefore must compile and track and project personnel expenditures constantly because of special compensations, new hires, resignations, retirements, funding restrictions, transfers to operating fund for personal services (fee-hire), etc.
>
> The longer we have particular positions vacant, the greater the threat of losing them from authorized position count -- it is felt that we did without them and therefore, they are not necessary. In reality, the primary reason for not filling them is because of funding restrictions and because we haven't found suitable applicants. If indeed the latter became a problem, we could consider transfer/tradeoffs for more appropriate positions. This past year, we finally got an accounts clerk but this was obtained through trading off a clerk-steno position.
>
> It took two years to establish a vocational rehab specialist position in BPSN program which was approved and money allotted by the legislature three years ago. When it came time to finally fill this position, there were no funds to fill this position which was badly needed. If we can't fill this position for longer than a year, we will lose the position entirely.
>
> . . .[T]he "reorganization" process. . . can take years, but position reallocations that are justifiable cannot be done without reorganization. It's a "catch-22."
>
> To hire, fire, [is a] long process utilizing staff in moving staff around is almost impossible without staff, union, civil service, DPS, B & F approval.
>
> Getting personnel on board takes too long. DPS lists of qualified applicants are often old and out-of-date. PRO seems to help, but this applies only to selected disciplines. In addition, processes, e.g. obtaining purchase orders, are cumbersome because it seems to pass through many hands before the purchase order is approved. A mistake in the request generates a process of returning the request through the same chain, thus creating another time-consuming activity.
>
> Hiring personnel is a good example of too much rigidity within the system.
>
> . . . This makes it very difficult to get good employees/applicants. They go somewhere else where they can get picked up much faster (one or two days vs. months).
>
> . . . In addition, personnel shortages occur, primarily clerical, when employees are constantly on sick leave or other types of leaves.

Takes forever to clear ASO.

We will be getting two 19-hour psychiatrists working fee for service instead of a full-time position. Go figure.

Staff turn over in case management means forty clients are without a case manager until position papers are processed and funded and positions are released.

I would be very interested in knowing how many highly qualified applicants were lost because of the prolonged wait they had to endure before being hired. I know that I waited three months from the time of handing in my application to my first interview.

DPS certified lists take too long -- by the time we get them, applicants already are employed. It takes too long to establish a new position -- delays in hiring force us to use the vacant position money (illegible) restrictions -- next budget go-round, position is deleted because we didn't fill it.

Our programs budget gets reduced or taken away and we have to delay hiring vacant positions to save money or to catch up so that we will have enough funds. This happens fairly often.

Establishing positions is a year long process. I guess it's to keep growth of the civil service in check.

Recruitment is still a slow and horrendous process. There must be a better way. . . to have open recruitment or at least accept applications for any state position and have a list of applicants on hand even before vacancies occur. Names on lists in current practice are old and people already were hired elsewhere.

. . . An additional problem is the underpayment of the professional positions. We are also unable to freely allocate staff as needed. This last point has mainly created problems at other sites where staff threaten union actions on attempts of reassignment. Windwards' staff have been very cooperative on these actions (our problem is the bureaucratic nightmare of a reorganization).

H. Lack of Coordination

. . .[S]cattered agencies are often unable (or unwilling) to coordinate their activities around the common aim of serving the mentally ill. As a result, a mentally ill person may re-enter the "system" at many different doors, but may not receive coordinated services. He or she may either be shuffled off to another agency, receive duplicative services, or "fall through the cracks" altogether. This fragmentation (coupled with multiple funding streams) makes it extremely difficult for services to follow clients as they move through a complicated system of care. Lack of linkages between such agencies also hinder continuity of care for the client. The result is confusion and frustration for all concerned -- patients, families, caregivers, referring agencies, and the general public.

--Miles F. Shore, M.D.[43]

The delivery of effective mental health services in Hawaii is seriously impeded by two factors. First, delivery of services is highly fragmented. Responsibility for various mental health services is widely scattered among a variety of governmental and private departments, divisions, and agencies. They involve service providers from many different clinical and

professional orientations who do not ordinarily work together.[44] Second, in practice, the various departments, divisions, and agencies engaged in providing mental health services operate with little or no coordination. Various aspects of these problems are described in the sections which follow.

1. Fragmentation Between Departments and Outside Agencies

> Traditional public systems -- even those that put resources in people's hands -- are designed for the convenience of administrators and service providers, not customers.
>
> -- David Osborne and Ted Gaebler[45]

Programs and agencies providing mental health services are scattered among a variety of government departments and divisions as well as private agencies. Entities dealing with issues related to corrections, education, housing, disabilities, general health, juvenile justice, etc. must also deal with issues related to mental health.

There are many problems associated with this. First, it is difficult for people in need of mental health services to know where to go to receive the help they require. Second, they may be shuffled from agency to agency, with no one taking responsibility for the problem.[46]

2. Lack of Coordination Between Departments

In situations where different state departments have responsibilities which overlap, there is frequently a lack of coordination between them. A case in point is the Departments of Health and Education which share certain responsibilities in providing mental health services to Hawaii's youth. State law requires these departments to describe in a memorandum of agreement how they will coordinate mental health services to public school children.[47]

The departments issued the memorandum of agreement in 1985. In examining the memorandum of agreement and the departments' collaborative process, the Legislative Auditor recently reported that the two departments "have not demonstrated sufficient commitment to a collaborative process that would keep the memorandum of agreement up to date and help resolve operational issues."[48]

3. Lack of Coordination Between State Agencies and Private Service Providers

It is widely perceived that the operations of the BHA and its divisions and its private service providers are poorly coordinated. For example, one private provider of services claims that CAMHD does not know the community and does not know the extent and range of mental health-related services and programs being provided by non-BHA entities within the

community.[49] She notes that input from the service providers regarding the Hawaii State Plan is requested only "after all the boxes are already in place" and is sought merely "to comment on those boxes."[50] The same service provider points out that requests for proposals (RFPs) are often sent out without any prior input from either BHA line staff or the private providers as to what services are actually needed. CMHC staff are not always informed of what services have been contracted for by BHA or how to access services which they may know are available.[51] Obviously, such problems result in people in need of particular mental health services not receiving those services.

4. Lack of Coordination Between BHA Divisions

As noted by the CAMHD chief and the executive director of the Mental Health Association in Hawaii: "Despite the fact that children with serious emotional disturbances may be vulnerable to substance abuse, the two DOH divisions responsible for child and adolescent mental health and substance abuse do not presently coordinate information such that children with dual diagnoses (those having both a mental health problem and a substance abuse problem) tend either to be served by just one division or participate in both division's services separately with little or no coordination to focus on the interactive nature of the problems."[52]

Asks one member of the state mental health advisory council:

> How could you expect it to be anything but fragmented given the way that information is supposed to flow and the design of the organizational structure?
>
> You have AMHD, CAMHD and ADAD set up as separate entities located in separate buildings. Under AMHD, you have nine CMHCs which, technically, come under AMHD's authority. Yet within each CMHC is both an Adult Team and a Children's Team. The Children's Teams, of course, are under CAMHD, yet housed at a center under AMHD's control. Two of the BHA divisions are broken out by age factors (AMHD and CAMHD) and another is broken out by function (ADAD). And since the majority of users of CAMHD and, perhaps AMHD also have substance abuse problems, there should be constant information flowing between these divisions. . . .

5. Intra-divisional Lack of Coordination

Within BHA, coordination seems poor even within specific divisions. This lack of coordination is reflected in problems identified within CAMHD. For instance, lack of intra-divisional coordination may be inferred by the BHA Management Improvement Program's initial findings that some CAMHD work "long, intense hours and days," while others "appear to be coasting, are working only part-time or are doing minimal work."[53] In a more recent report, the consultant notes that morale within CAMHD has improved but that "[a] personality/personnel problem continues to rank high among pending problems to be resolved at CAMHD according to division officials."[54] Regarding a second division, AMHD, the AMHD

planner laments, "we cannot even serve each other within the division," noting that she received only two of sixteen requested reports necessary to draft the federally-mandated State Plan.[55]

CMHC questionnaire respondents discussed coordination issues as follows:

With the lack of standards and understanding, the service delivery is fragmented. Too many different ideas are not coordinated.

Many gaps in services. No good continuum of care in community -- e.g. what options do we have to avoid hospitalization besides the limited resources of CRSP?

The system is compartmentalized and on a tiered structure; the center is "responsible" for assessing and addressing the mental health and substance abuse needs of the service area, but services are contracted by a variety of levels in the organizational structure and by different jurisdictions -- all of which the center has little or no control over. People's problems and the process needed to obtain services are not consistent with the system.

We always talk "coordination"; but it seldom truly occurs.

Fragmented and uncoordinated due to division's lack of direction and standardized policies and procedures for all branches.

Idea of "treatment team" is fantasy given patient load and staffing. Inpatient to outpatient [is] uncoordinated.

Lack of consistency on who, how services are provided. No single focus in assisting people. Focus on getting people off the streets, out of jail, hospital, etc.

There has always been a question of who's going to be responsible to service the gap groups -- e.g. mentally ill -- mentally retarded, mentally ill -- substance abusers, etc. There is seldom a firm direction on who we're going to service or not service.

Staff at [this CMHC] get the same line from me always -- "What's in this patients' best interest" -- doesn't matter whether living in another center's service area, belongs to private provider, etc. Can't say same for other [CMHCs.]

[Coordination] is a problem within [DOH] programs and with programs under other departments.

We spend much time either duplicating services or the right hand not knowing what the left hand is doing. This causes much friction, confusion and chaos. . .

We are sometimes so caught up with the bureaucratic machinations of our own division, it's easy to forget we operate with many other agencies in the community.

Better coordination is needed with contracted services.

Each [CMHC] does their own thing. There must be some uniformity in operations in order for staff to know what to do. It should also stand the test that it will be the same no matter who is in charge.

Within is not much of a problem at our CMHC. However, coordinating services with some privates (e.g. Castle's inpatient psychiatric unit) is difficult at best, impossible usually.

I. Planning Deficiencies

> Strategic planning is not something done once, to develop a plan, but a process that is regularly repeated. The important element is not a plan, but planning. By creating a consensus around a vision of the future, an organization or community builds a sense of where it is going among all its members. This allows everyone -- not just leaders -- to understand what direction they need to take. It helps them seize unexpected opportunities and deal with unexpected crises, without waiting for word from the top.
>
> -- David Osborne and Ted Gaebler[56]

It is almost universally perceived that meaningful planning is lacking at the BHA. As acknowledged by the CAMHD chief, the governing philosophy of the present system is "don't plan ahead but cover your [behind.]"[57] As noted by the National Alliance for the Mentally Ill and the Public Citizen Health Research Group in 1990, Hawaii's Mental Health Division has "wonderful plans on paper and the plans improve each year. But that is all that happens."[58] Interviews with various stakeholders suggest that plans and resources "go where the pressure is." Priorities are in constant flux, depending upon external pressures and the particular vision of the person in charge. Plans are produced in response to federal requirements, and are consequently not viewed as "real plans" in which the stakeholders are truly vested.

Many of those interviewed describe the frequent "planning" meetings which are held as unproductive and ineffective. One attendee notes, "though we constantly trudge off to various meetings, it is not at all clear what purpose they serve." Another notes that it is not even clear "what interests we are supposed to be representing at these [AMHD] meetings." Others note that, while input is frequently requested, it is rarely implemented.

Persons throughout the system describe resources and priorities constantly being diverted to meet immediate problems, without regard to long-term planning. Upon occasion, this diversion of funds and resources is unavoidable in light of external circumstances. For instance, despite indications that conditions at Hawaii State Hospital were unacceptable, little was done until the United States Department of Justice actually initiated a lawsuit. When the suit was filed and subsequently settled, the State had no choice but to comply with the requirements of the settlement. This "unanticipated" circumstance hurt the system in two ways. First, it cost more than it otherwise would have and second, the need to satisfy the requirements in a relatively short time span meant that money had to be taken from other sources -- such as the CMHCs.

Similar concerns have arisen with regard to the lawsuit presently pending against the State, in which plaintiffs claim that the State has "failed to develop any realistic plans to do anything other than provide stop-gap, crisis-based services."[59] Several of those interviewed expressed concern that the departmental response to this suit will be to "give the plaintiffs everything they ask for" to alleviate the immediate pressure of the lawsuit, without meaningful long-term planning which might avoid future similar lawsuits. As noted by Osborne and

Gaebler in *Reinventing Government*, "Our ship of state is like a massive ocean liner, with all the luxuries above decks but no radar, no navigation systems, and no preventive maintenance below. Instead of anticipating the problems and opportunities of the future, we lurch from crisis to crisis."[60] As one BHA stakeholder notes, "There must be a real plan and it must be based on needs assessment. And that plan shouldn't change everytime the State is sued or a chief or director reads a good book, has a new idea or meets another consultant."[61]

Other sentiments expressed by CMHC questionnaire respondents are as follows:

> 5 year plans change weekly.
>
> Division administration pushes for [CMHCs] to have a case management systems, without planning or coordination.
>
> Unclear mission, no planning (e.g., try to get someone into State Hospital from outer islands).
>
> Relative to staff/client ratios, services provided, members served -- no one seems to care. There are no standards or consistency between centers when it comes to resource allocation favoritism. The state/center plan is another example -- every two years, [CMHCs] develop a plan with goals and measurable objectives that no one seems to care whether they are accomplished or not. Format and content change every two years -- budget attached is unrealistic, idealistic and pure bunk. Whole process is an exercise in futility.
>
> Every two years, the [CMHC] goes through the exercise of developing a state plan setting goals and objectives. At the end of two years, there is no report (as far as I know) that would evaluate how and what each [CMHC] accomplished. There is no monitoring and/or follow-up of the state plan. It is not clear who should lead on this undertaking.

J. Lack of Continuity in Leadership

> Continuity of leadership is critical in transforming public systems.
>
> -- Osborne and Gaebler[62]

With the exception of ADAD, division heads within the BHA have constantly changed over the years. The AMHD division chief has changed four times within the past six years. Similarly, there have been seven permanent or interim CAMHD chiefs over the past six years. The deputy attorney general representing the DOH states that "There has been tremendous turnover at the top so that it's gotten to the point where I don't even expect continuity."[63]

This turnover of leadership creates problems. As one CMHC chief puts it: "It's hard to fix the nuts and bolts on a car when the car keeps changing. It may be exciting for the driver, but it's very difficult for everyone else."[64]

Many BHA staff perceive that the turn-over of top management causes significant change in the operational priorities within the divisions. For instance, it was noted by a public policy and management consultant hired to assist in formulating and implementing a BHA

management program, that within the CAMHD, "[a] long history of high turnover in chiefs, with attendant sometimes abrupt changes in philosophy, style of operation and sense of mission has contributed to instability and turmoil within the [CAMHD]. The staff is now viewed as largely reactive rather than proactive."[65]

This lack of stability in division management causes problems for the division chiefs as well as the line staff. For instance, the current AMHD chief has set two priorities for the CMHCs: achievement of CARF accreditation and maximization of Medicaid billings. The response by some of the CMHCs to these objectives is perceived as somewhat "unenthusiastic." In several interviews, this anemic response was explained as a function of a perception by the CMHC staff that these directives merely reflect the "whims" of the present division chief. These CMHC staff apparently believe it does not matter whether or not they respond to the present division chief's priorities since a new chief may not share these priorities. So, as one CMHC chief asked, "why bother?"

Other comments noted by CMHC questionnaire respondents are as follows:

> Constant change in administration brings changes in the division. Therefore, there can never be a continuity of services because we are always going through reorganization. Administration is far removed from caring about client services.
>
> This effects (sic) leadership -- there is burn out -- there are other jobs that management can go to which pay more, less stress, more job satisfaction.
>
> [Turn-over is] particularly at the division chief level.
>
> I'm not aware of a problem regarding a high turnover of high and middle management people. However, I'm aware that many in management positions are very frustrated, especially those in the lower management levels, e.g. supervisory.
>
> Look at all the changes in AMHD in the last ten years. They start something and leave.
>
> AMHD chief -- each one that comes in has her/his priorities. And there we go again.
>
> . . . Constantly changing priorities and directives from AMHD. [S]taff are not receptive and enthusiastic to most of these changes.
>
> At the branch level, little problem [with management turn-over] but at the division level, the changes have been pretty quick in the last four to five years. Hopefully, it will be stable until elections.
>
> Operationalizing a service delivery program such as this [CMHC] on a consistent and efficient basis becomes difficult because it is too closely tied with the political structure which too often rely on the whims and fancy of individuals.
>
> Changes at head of AMHD results in fragmentation, lack of continuity and responsibility.

K. BHA Managerial Problems

> Many employees in bureaucratic governments feel trapped. Tied down by rules and regulations, numbed by monotonous tasks, assigned jobs they know could be accomplished [if they were only allowed to be creative], they live lives of quiet desperation.
>
> -- David Osborne and Ted Gaebler[66]

In the 1992 BHA Management Improvement Program referred to in previous sections, a public policy management consultant was hired to review the present BHA management structure. When interviewed, this consultant noted that "the BHA is without adequate and appropriate management organization and staffing for executive management functioning (e.g. budget, personnel, management information systems development) to function effectively."[67]

There are serious management-related problems with both the BHA's Adult Mental Health Division and Child and Adolescent Mental Health Division. The problems within CAMHD have recently been the focus of a series of reports under the BHA Management Improvement Program, discussed above. These reports contain various recommended changes, such as the recruitment of a mental health administrator/manager, creation of two division deputy-level positions to support the chief (a program/clinical director and an executive officer).

In AMHD, the two most pervasive problems are a perception of secrecy and poor communication within the central office and between the central office and the CMHCs. This problem of poor communication, noted by numerous stakeholders within the BHA, persists in spite of frequent meetings specifically intended to facilitate communication.

There is a perception that, according to one CMHC questionnaire respondent, management is "too far removed from the front lines and out of touch with the service deliverers." Another respondent notes that "the staff who have been with the system get set in their ways and resist or sabotage changes. There is so much mistrust and lack of faith in the system as well as the higher-ups."

These perceptions may arise, in part, because "management" is too busy responding to daily pressures of the job to engage in time-consuming "management by consensus." Further, there are no intermediary levels of management within the division. As one AMHD central office staff member observed, "everything always has to go to the [division chief] for approval and comments." As one CMHC acting chief noted, even the most consensus-oriented division chief can become dictatorial. Says he, "It's an occupational hazard."[68]

L. Poor Data Management

> What I've noticed about bureaucratic programs is that for all their rules and red tape, they keep very little track of what actually happens to the people they're serving. . .
>
> -- Tom Fulton, President of the Minneapolis/ St. Paul Family Housing Fund[69]

One CMHC questionnaire respondent discussed the cost-efficiency of BHA's operations as follows: "No one seems to know if services provided by centers are cost-effective or not. Private agencies can prove that they are cost-effective. We cannot." This is in keeping with the assessment by Osborne and Gaebler that "most governments have no idea how much it costs to deliver the services they offer. Even if they can give you a budget figure for each service, it typically excludes 'indirect costs,' such as administrative over-head, capital costs and employee fringe benefits."[70]

To a certain extent, the inability to effectively assess cost-efficiency is the result of poor data management. By all accounts, the poor data management within AMHD and the CMHCs is substantially due to limited resources. As noted in the AMHD State Plan:[71]

> The Mental Health Field Assessment and Statistical Information System (NFASIS), established in 1984, is comprised of a Wang CPU VS 45 and 22 workstations. . .
>
> Although the system has an adequate file structure and software, it is severely limited in that users do not have direct access to the data. Retrieval of reports must be developed by the systems analyst, only one of whom is available to access data for the outpatient sector of the entire [AMHD] division. In addition, there is lack of sufficient hardware and telecommunication with only two personal computers being available at each [CMHC] rather than one PC being available for every three clinicians. Furthermore, a bifurcated system of reporting exists between the public and private sector with hand tallies being provided by contractual providers since on-line capacity does not exist.
>
> . . . Improvements dependent on fiscal increases are not forthcoming due to decreased state revenues.

Likewise, the CAMHD State Plan notes as follows:

> An inadequate computer information system tied in with Adult Mental Health existed in this year. Data was not entered reliably and it took a long time to retrieve information, which was not always accurate. Much children's data was not being entered into the system. At best, only inpatient and outpatient data were available.[72]

Because of these "primitive" data processing capabilities, staff at AMHD and the CMHCs spend inordinate amounts of time and energy handling data. This causes low efficiency and high frustration. For instance, many of the CMHC chiefs indicate that billing for Medicaid reimbursable expenses is unnecessarily time-consuming since codes and

information must be processed manually. The AMHD Planner spends long hours laboriously compiling raw data to prepare statistics necessary for the federally mandated State Plan. In light of readily available computer hardware and software, this expenditure of time is clearly not cost-productive.

Another reported problem with data management in AMHD is that not all CMHCs are rigorous in providing statistics. A participant at an AMHD Managed Care Conference noted that certain CMHCs simply had not complied with central office's requests for specific types of information.[73] However, some CMHC staff report that certain types of information are not provided, based on the centers' perception that doing so is a meaningless exercise. One CMHC chief notes that the lack of administrative positions sometimes results in the submission of "dirty data" to AMHD.

Many CMHC staff complain of constantly being asked to provide data without explanation for the requests. For instance, according to one CMHC chief, for many years AMHD requested service record sheets from the CMHCs. These records were apparently ignored and the practice was eventually discontinued. Recently, however, AMHD central office renewed the request for these records. Given the prior history, notes the chief, the CMHCs' response to this new request has simply been to "blow it off."

Certain informational requests with short lead times require time-intensive responses; often, they are of questionable usefulness. One CMHC chief recalls staying up all night to finish a report requested by AMHD, only to learn later that the report was never reviewed. Incidents such as these lead to a "sense of futility" within the CMHC staff. As one CMHC questionnaire respondent reports:

> Management information system is standardized with the division via MFASIS. Some of the data is seemingly useless to the division staff. Some center chiefs have been known to disregard maintaining this system and they have been permitted to excuse themselves -- this costs those center chiefs who [actually comply with the requests] time and effort in collecting data which is useless to the division.

And finally, a mental health advocate notes that the necessary information flow is compromised when there are three segregated divisions, operating out of three discrete offices and providing services that should be, but are not, coordinated.

M. Inefficient Organizational Infrastructure

AMHD's present infrastructure is chaotic. This has produced a structure which is "non-user-friendly" to those who need it most -- the CMHCs. As detailed in chapter three, this infrastructure is presently being reorganized. However, until the reorganization is finalized, AMHD's central office is expected to provide technical support to the CMHCs. Unfortunately, CMHC staff often do not know what support is available or how to access that support. This is a product of both managerial and organizational confusion. As one respondent suggests,

"If [the present system] makes sense to anyone, they probably need mental health services. . ."

The AMHD program support service staff are not even clear about their roles vis-a-vis the CMHCs. As one notes, "Right now, everyone does everything." Another recalls a meeting held several years ago where several AMHD staff discussed what each perceived their role to be, but came up with no conclusions. Another notes that AMHD program support service staff "each have areas of expertise but the lines are very elastic."[74]

Some CMHC staff survey responses to the question regarding the functions served by the AMHD central office and its organizational structure underline the confusion in the present system:

> If you know where everyone is in the organizational structure of AMHD, please tell me! They've been talking of restructuring the AMHD since I've been a staff here and I've still to see a draft or anything in writing to suggest that a reorganization plan has been started.
>
> If you talk with ten different people regarding the functions of the central office in AMHD, you'll receive ten different answers. The staff changes functions as [often] as Lex Brodie changes tires.
>
> Because they have been in a state of flux for so long, and discussed and proposed a number of structures, I don't know what it is currently.
>
> It took me five years to gradually grasp [the organization] since no one ever explains this to you. I once asked my supervisor about the organizational structure for AMHD [but] he totally evaded or ignored my question.
>
> This too changes too frequently. Every time they change the division chief, they change the organization. I don't think you can get anyone outside the division to give a clear view of the division structure.
>
> This has been long standing to me. [Where] is the organization chart? What are the functions? Who are the players? What help are they for the [CMHCs]?
>
> Currently unclear as to what functions the office serves.
>
> I am not clear what AMHD is to do.
>
> Because I have been in the system a long time, I know which staff to call for assistance. The strange faces I see when I go there, I don't know what functions they serve.
>
> Not truly clear. I have some guesses. . .
>
> We don't know who is who [at the division level] and what their responsibilities are because of the turmoil in the division administration.
>
> AMHD reorganization has been in a state of flux for the last five years. Don't know what the current organizational structure is.
>
> Some are clear; some less clear. . .
>
> I am not aware at all what is the present organization -- It has never been explained to staff at the centers.

> Am not aware of how it's organized. There does not seem to be accountability of what central office staff are doing.
>
> Don't know organization.
>
> . . . How can it possibly make sense when you don't know what people do up there?! You also have people doing fifteen different things.
>
> I still do not understand what this reorganization is or was all about.

Although many BHA staff feel the system must be reorganized, some view repeated calls for reorganization with skepticism and feel they are merely "cosmetic" attempts to address the fundamental problems of the present system. As one mental health advocate notes, "The motto for CAMHD has always been: when in doubt, reorganize."[75] Some additional questionnaire comments on this issue are as follows:

> I can't recall when [previous reorganizations] occurred, if at all. The Division went through some reorganization during the DOH's major reorganization but things apparently never occurred.
>
> The reorganization has not been shared -- am not really aware of what's going on within the AMHD currently.
>
> [The previous reorganization involving the] breaking out of children's and ADAD has resulted in fragmentation and lack of coordination of community level.
>
> Only the focus seems to have changed, not aware of any reorganization. Previous organizations do not seem to be significantly different.
>
> The last reorganization was senseless and only served to establish more levels of bureaucracy.
>
> [Previous reorganizations] have fragmented us more.
>
> Never carried out long enough to evaluate.
>
> I feel that it was difficult to assess because the rationale for reorganization was not clear.

N. Delays in Vendor Payments

BHA's delays in paying its private service providers are a critical and constant source of irritation to those with whom it contracts for services. According to one mental health advocate there is a perception that there are not enough private service providers in the community. However, as one mental health advocate noted, the private providers are there but "nobody in their right mind would want to contract with the state."[76]

CAMHD contracts with Catholic Services to Families for family-based treatment for children and adolescents who would otherwise require some form of institutional care. According to its executive director, Catholic Services to Families is presently owed $300,000 by CAMHD for services provided but not paid for. She states that even though the program serves youths with significant emotional, social, and/or behavioral problems in either

Professional Parenting Homes or Teaching Family Homes,[77] the Catholic Services Board has considered discontinuing such services because of CAMHD's failure to pay. She notes that her only recourse when payments are not forthcoming is to "scream to the CAMHD chief, the BHA deputy director and sometimes even the DOH director himself." Remarkably, when she told CAMHD that her agency's ability to provide the services was threatened by delays in processing her payments, a staff member at CAMHD initially suggested that her agency consider taking out a bank loan.[78] CAMHD's failure to pay Catholic Services to Families forces the agency to "live off other resources." Fortunately, it has other resources to live off of. This is not necessarily the case with smaller agencies with whom BHA contracts.[79]

When BHA fails to make timely payments, it is often line-staff who must deal with irate private service providers. Explains one CMHC chief, "it is very difficult when you're 'at the front' having to explain to a psychiatrist that there's a tie-up with his payment. I am answerable, but have no way to speed things up."

Some of the comments expressed by CMHC staff on this issue are as follows:

> [Late payments] make vendors less likely to agree to [serve] us.
>
> Vendors have complained constantly about delays in payment from the state. Programs have been unable to get certain vendors as these vendors have been discouraged with this late payment problem and opt not to deal with the state anymore.
>
> Some businesses won't do business with the state due to delays in payment.
>
> . . . [O]ur vendor payments are always late. This is a bad, bad business.
>
> The occasional, unusual purchases usually come with a strict time limit. The result is overdue penalties added to the payment.
>
> I understand that vendors for our Respite Care Program will need to wait about three months to get paid for their services. This has been a problem before.
>
> It's embarrassing for the state to take so long to pay people. It also costs more since we have to pay interest.
>
> Some vendors refuse state purchases because of delays in payment.
>
> Many agencies/stores do not want to accept a purchase order because it takes forever for them to get paid.
>
> This is a very embarrassing situation. It is a shame that everyone accepts it as a fact that the state is always late in making payments. Small companies are unable to deal with the state. In contracts, vendors are expected to cover expenses for the first several months, especially at the beginning of a new a contract period.
>
> I received a bill for a workshop I attended as the state had not paid it over one month after the workshop. I know of a consultant on the mainland who waited ten months to get paid.
>
> Sometimes wait for long periods for reimbursement. . .

O. Cost-inefficiency

By all accounts, BHA's present system of operating is pervasively inefficient. This inefficiency costs the State a significant amount of wasted money, which might otherwise be spent on services for the mentally ill. There are, in general, five basic reasons for the "cost-inefficiency" of the present system. First, present budgetary policies often encourage wasteful spending. Second, the system provides few incentives to deliver services in a cost-efficient manner. Third, there is a lack of continuity in BHA planning and policy which results in significant amounts of money being expended to develop and implement programs which are subsequently altered or abandoned. Fourth, the complicated requirements of the present system have created what amounts to institutional "gridlock" within the system. Finally, BHA lacks sufficient infrastructure and resources to maximize the cost-efficiency of its operations. As one CMHC staff member notes, BHA is "saving pennies, but losing dollars."[80]

BHA's cost inefficiency is, to some extent, a result of state budgetary policies which often encourage wasteful spending. With BHA, as with other state entities, budgeted funds which are not expended by the end of the fiscal year revert to the state general fund. In theory, this policy allows "extra" funds to be preserved for use where funding is needed elsewhere. In practice, however, this policy encourages wasteful spending because administrators: (1) are reluctant to lose funds within their control and (2) fear the consequences in future budgets of an appearance that they require less funding.

For example, one CMHC chief recently noted that his CMHC has funds intended for medical and office supplies which are unspent. Recently, they have been informed by AMHD that unspent funds may soon be "frozen." As a consequence, the CMHCs are scrambling to spend the funds before the freeze occurs.[81]

The overall budgetary problem was described by the AMHD chief, who noted that: "the [CMHCs] live with a famine mentality. They have been starved for so long that they are scared to give back what they don't need and don't want to tell the guy in the next center what they have for fear of losing it . . . "[82]

This calls to mind the observation of Osborne and Gaebler in *Reinventing Government*:

> [I]f managers do not spend their entire budgets by the end of the fiscal year, they lose the money they have saved and they get less next year. Most public managers know where they could trim 10 to 15 percent of their budget. But why go through the pain of transferring or laying people off, if you can't use the money for something more important? Especially if your savings are going to be handed to some other manager who overspent his budget! Who in their right mind would save any money, under these circumstances?
>
> Smart public managers spend every penny of every line item, whether they need to or not. This explains why public organizations get so bloated; *our budget systems actually encourage every public manager to waste money.*[83]

The second reason for BHA's cost-inefficiency is that the current system provides minimal incentives to the CMHCs to maximize their cost-efficiency. This situation persists despite BHA's experiments in providing financial incentives to CMHCs to improve their services.

For example, within the last several years, many states implemented policies to give local mental health authorities (analogous to CMHCs in Hawaii) financial incentives to reduce occupancy at their respective state hospitals. This was accomplished by means of a payment to the local authorities calculated from an annual utilization target.

In 1989, the DOH publicly announced its plan to restructure its operations in a similar fashion. Under the DOH plan, each of the nine CMHCs would be provided its own budget for two areas -- adult services and operating expenses. To provide an incentive to the CMHCs, adult services money that CMHCs did not use for hospitalization could then be used for housing or patient-support activities by the centers. However, if a client of any of the CMHCs needed short-term hospital care, that client's CMHC was required to pay a set daily fee for each day of hospitalization; these fees were paid from the CMHC adult services funds.

The new plan was designed to encourage the CMHCs to structure and provide services which would alleviate the need for institutionalization. One newspaper report hailed the new plan, noting that the plan was designed to "motivate the staff to make sense of their dollars and cents."[84]

Following implementation of the new system, the CMHCs set out to improve their services and thus decrease their hospital referrals. The present acting chief of Windward Oahu CMHC, who was at that time a center case coordinator, reports that his CMHC saw this plan as a "golden opportunity." The CMHC reduced its hospital census from approximately forty to twenty beds. He says that he actually went to the hospital to personally check on the "bed day" numbers.[85]

The center expected a $50,000 to $60,000 revenue windfall which was to be spent on a van for the center's case managers and for call-crisis coverage for group homes. However, the anticipated windfall was never realized. The program was disbanded altogether within months of its inception. According to this CMHC chief, "The money simply never materialized. We were never told why."[86]

A similar experience was reported by the executive director of the Waianae Coast Community Mental Health Center, Inc. She reports that her center managed to reduce its hospital census from approximately thirteen down to four. She recalls that the center received a windfall of approximately $500,000 which was spent on purchasing a van and opening a respite house. However, when the program was discontinued after six months, the funds were reclaimed by the State and the respite house was forced to close down.[87]

Several reasons have been suggested for the termination of the "conversion plan" six months after it was implemented: (a) approximately seventy to eighty percent of the Hawaii State Hospital patients are forensically placed and the CMHCs have no control over these patients; (b) there are inadequate programs and services within the various CMHC catchment areas to provide a continuum of care so that hospitalization does not become necessary; and (c) it is often difficult to determine from which CMHC catchment area a given patient came from, making it difficult to assess which CMHC to bill.

Even though there may have been good reasons to discontinue the conversion plan, the whole experience was detrimental for several reasons. First, several CMHC staff have expressed great frustration at having taken full advantage of an opportunity to improve their services only to have the incentive for that effort taken away without adequate notice or explanation. Second, when the conversion program was discontinued, the system reverted to its prior structure in which a person could be institutionalized or discharged from the hospital without the CMHC case manager being informed.

The third general cause of cost-inefficiency in BHA is a lack of continuity in planning, developing and implementing programs and strategies. There are instances when this lack of continuity has resulted in significant expenditure of funds on programs, which have been abandoned resulting in the effective loss of the funds expended.

One example of this problem is the recent decision to abandon, after six years of discussion and development, the creation of a "case management" series of positions within the CMHCs. This program was conceived in conjunction with the Robert Wood Johnson Foundation program for which Hawaii received significant funding.[88] It was intended to provide a program of case management which would coordinate client access to public entitlements, vocational rehabilitation services and employment. This would ensure that each chronically mentally ill (CMI) person would have a worker who could be identified by name as "someone who would help them" -- each CMI would be the responsibility of a designated center and a case management system would be developed so that every CMI would have a case manager.[89]

In explaining the intended role of the "case manager," the former AMHD interim director explained that from the time a patient entered the system, he or she would have a case manager to coordinate treatment and monitor medication, rehabilitation, vocational training, housing, community support, and crisis response. The manager would be a "contact and an advocate available to the CMI's family."[90]

AMHD spent over six years on the development of the case management series of positions necessary to staff this program. After years of discussion between a variety of professionals, in June, 1992, a Case Management Position Description Task Group subcommittee designed and submitted the final (sixth) draft of the position descriptions for three levels of case management to the main Task Group for approval.[91] In developing these positions, "[c]onsideration was given to developing functional differences between the levels.

The relationship of case management to other professional disciplines in the mental health clinic setting was addressed."[92] Clearly, by this time the BHA had invested significant resources, in time and money, in the development of these positions.

As recently as March 1, 1993, in its Request for Extension of the Robert Wood Johnson Foundation grant, AMHD informed the Foundation that a case management system was established with case managers assigned to each severely disabled mentally ill (SDMI) client.

CMHC staff fully expected that the positions for the case management series would be finalized up until approximately October, 1993, when the AMHD chief announced that the case management functions will be provided through social work and social service assistant positions. The reason for the decision is that case management functions too closely parallel social work duties to allow for a separate distinct class series in the civil service system.

One mental health advocate who has been involved with the case management series implementation process from its inception, estimated that she spent at least one hundred hours working on the creation of the case management civil service series positions and noted that the AMHD chief had devoted at least twice that amount of time and energy to the project. She also estimated that the State had spent approximately $500,000 in time and labor on the development of the case management series. After the recent announcement of the AMHD chief, she noted, "The case management series is now dead in the water via a fiat from the top. It took us six years to get nowhere."[93]

One CMHC staff supervisor reacted to the decision to eliminate the case management series of positions as follows:

> This week, we received a letter from [the AMHD chief], stating that the case management positions will be converted to a social work/social services aide series. After four or more years of working on a case management classification, and saying that case management series will be permanent any time now, they suddenly have adopted this [new] series. This will mean that many of our case managers across the centers will be affected. This will mean a decrease in pay for many, some will not qualify for these new positions. In our center, maybe three out of ten people will be able to stay at a lesser pay (approximately $5 to $6,000 annual decrease) but everyone else will probably move on.
>
> The impact of the hundreds of clients we have in the case management unit will be great. The case managers here have been instrumental in providing most of the direct services, groups and other programs here at the center because we lack the "professional staff". What will happen to these clients? Many programs will cease to exist and we will go backwards again.
>
> This is an example of how the state operates. At the time that they are trying to implement CARF and go for accreditation, they decide to eliminate half of the staff who are trained. They say you can hire other staff for less pay. There is no way we can become accredited by August, 1994 if we have to start all over again and retrain people who will be on board in July.

> Also, many of these case managers have excellent skills, have been committed to the state. They have gone back to school for the minimum twelve credits that were required of them to have when these positions became permanent. Some of them passed up jobs that paid more because they were dedicated to the system.
>
> Verbally, they were told that any day now, this series will be permanent only to be told that they should have known that this was only a temporary exempt position. I have seen people "burned" by the system. I can imagine the impact on our clients who now seem to be involved in many activities. They too will be penalized by this decision. This is just an example of how the state system operates.

Several CMHC staff and mental health advocates also note that significant state revenue through federally reimbursed funds is lost based on decisions to (1) not license social workers and (2) not permit social workers to bill for therapy and diagnoses.

The present BHA system is universally perceived to be so complicated by rules and regulations that a form of institutional gridlock exists. Indeed, many of the CMHC chiefs note that operating within the present system requires significant expenditure of time and energy "circumventing" the myriad rules and regulations governing their activities. One CMHC chief notes, "we have all learned to manipulate the system to get what we want," and cites, by way of example that if a CMHC feels that certain training would be beneficial to its staff yet has no "training funds" in its budget, it may secure the desired training by manipulating contracts with its POS providers, thereby accessing funds which have been budgeted.

Another CMHC chief notes that the CMHCs were given a mandate to proceed with rigorous Medicaid billing, but his center was not provided with a staff billing position. In order to comply with the department mandate, the CMHC chief involved used an available clinical position to make an emergency hire. Therefore, until a "trade-off" position transfer could be accomplished, a staffer designated as "vocational rehabilitation specialist" was attending billing meetings, a bureaucratic subterfuge common under the present system. As another CMHC chief notes: "We have learned to function in such a way that changes can be made without having to process mounds of paperwork, which, even if processed, might be denied."

Such bureaucratic "finessing," even though common-place, is none-the-less uncomfortable for the managers involved. As one CMHC chief notes, the system is so rigid that anytime something creative is needed, the typical reaction from above is "do what you need to do -- just don't tell me." For instance, on one occasion a CMHC needed to arrange housing for clients, but found landlords reluctant to deal with the State because of its reputation for late payment. This dilemma was only resolved by means of a lease personally signed by staff members from both AMHD and the CMHC, a clear violation of the rules. In a similar situation, on one occasion a CMHC staff member personally advanced funds to keep a residential unit off the market until state funding could be arranged.

Some BHA stakeholders consider such methods "creative ways to handle a rigid system." However, others express fear that what is perceived as today's "ingenious ploy" may become tomorrow's "scandal." As one CMHC chief asks, "We often spend more time

trying to get around the system than we do working within it. Does that make any sense? We really need to be asking that question."

Finally, BHA is cost-inefficient because it lacks the infrastructure necessary to operate efficiently. Staff at all levels of BHA must contend with insufficient equipment, staff positions, support services, training, and consistent procedures. These deficits clearly impede the cost effective delivery of service. A prime example of how this insufficient infrastructure makes BHA cost-ineffective is the present effort to maximize Medicaid billings.

Hawaii has the poorest record in the country concerning the recoupment of federal reimbursements.[94] In 1991, a survey by the National Council of CMHCs indicated that CMHCs nationwide received approximately sixteen percent of their revenues from Medicaid. At that time, Hawaii CMHCs did not bill at all for Medicaid reimbursable expenses. In 1992, AMHD and CAMHD initiated a program to bill the federal government for Medicaid-reimbursable funds. However, to date billings have fallen quite short of expectations. In 1992, it was projected that each CMHC would generate approximately thirty to forty percent of its budget from revenues derived from Medicaid billings. One CMHC projected that it would receive $78,200 in Medicaid billing revenue in 1993. As of early November, 1993, this CMHC had generated actual revenues of only $17,000.[95]

BHA's poor record for Medicaid billings has persisted despite efforts to maximize revenues from Medicaid billing. Numerous mainland consultants have been hired, BHA personnel have attended conferences and meetings; and seminars and training sessions have been conducted for BHA staff. All of these efforts have been designed to maximize third-party billing by AMHD and CAMHD. Nonetheless, Medicaid billings continue to fall short of expectations.

Several reasons have been reported for the inadequate billings. For instance, as one CMHC questionnaire respondent notes, "The [BHA/AMHD] expects us to implement a billing system for services but provides for no clerical support or equipment -- i.e. a computer to process billing data." One CMHC chief attributes the problem to inadequate training and notes that, despite AMHD's initial assurances that the CMHC would receive a one-month training session on billing procedures, only one week of training was actually provided.[96] Other CMHC staff complain that the CMHCs have not been provided with a written policy for billing procedures; therefore, each CMHC has had to develop a billing process independently. Other complaints include: insufficient training with no follow-up, no allotment of staff to perform the complicated clerical tasks involved in Medicaid billing, and no computers to facilitate the billing process.[97]

As an example of the effect of these problems, although AMHD provides case management services to over a thousand Medicaid eligible adults with severe mental illness, and received approval from HCFA for Medicaid reimbursement for these services in October, 1991, BHA is not yet billing Medicaid for these reimbursable case management services.

An additional example of BHA's failure to implement billing procedures is that several CMHCs have not been provided by AMHD with authorization codes necessary to bill for Medicare. This creates problems when a client is covered under both Medicare and Medicaid, because, under such circumstances, any submitted Medicaid billing is denied. However, since the CMHCs do not have the Medicare authorization code, they are limited to billing Medicaid which results in significant confusion and frustration and unnecessary paperwork. According to one CMHC chief, he has waited over a year for this code while two CMHCs have somehow secured the code without AMHD's assistance.

Further, the inadequate Medicaid billings may be explained, to some extent, by an apparent sentiment in the CMHCs that they have little to gain from a diligent effort to maximize their CMHC billings. This is because revenues generated through Medicaid billings by the CMHCs do not clearly benefit the CMHCs.

In 1991, the Legislature created a special fund into which all revenues and moneys collected from treatment services provided by state mental health and substance abuse programs are to be placed. These moneys include revenues generated by CMHC Medicaid billings. Pursuant to the statute, revenues deposited into this fund are credited to accounts for each revenue-generating program and are then available for use by the respective program.[98]

Despite this statutory provision, some CMHC staff note that they do not have access to special fund revenues. They feel that, regardless of how much revenue is actually generated by their Medicaid billings, in actuality, these funds are not available for their use. One CMHC chief notes that the CMHCs will not have the benefit of the special fund. In fact, the amount each CMHC collects will be deducted from its budget. This means that if a CMHC fails to bill its targeted amount, the CMHC will actually have a budget deficit. Clearly, the present system does not encourage the CMHCs to vigorously pursue Medicaid billings, as evidenced by their actual performance.[99]

Some of the comments by CMHC personnel regarding their perceptions of the cost-efficiency of the present system are as follows:

> . . . The fiscal system allows for little flexibility in a timely manner. I cannot simply apply for the variety of [money] that is out there, either privately or publicly, and upon approval, receive the funds, deposit and use it wisely in a timely manner.... If a client needs temporary emergency funds we cannot advance the funds. It is not a simple matter to lease or rent homes/apartments for clients. Staff are often risking their resources to get the job done efficiently rather than wait for the center to respond.
>
> Good and hard working staff get rewarded by getting more work assigned to them. . .
>
> Without standards and high enough expectations, we have been non-cost effective.

We are forced to buy medication through DAGS' list. Medication provided is often near expiration and not available on an emergency basis.

A public system -- out of taxpayers' dollars -- is often set up to protect and account for every penny and action so to avoid the embarrassment/appearances of graft, theft, prejudice, etc., systems are set up -- all too often more costly than what it is supposedly trying to save

Top heavy. Redundant at division. Squeaky wheel phenomenons. Fee-for-service bandaid clinicians rather than full-time coded positions. Clinicians spend time doing clerical work -- stupid.

True overhead costs are very high in relation to direct services. A business would go bankrupt. Because revenue is tied to "positions" rather than services provided and/or service outcomes.

DOH, DJ and DPS having purchase of service contracts with the same provider for a service. It could be cheaper to fund and staff one department to provide the service for all.

Some staff need not be productive, institutionalization of staff-lower expectations. Too much "not my job." Too much duplication, administrative requests take time away from direct services.

Overall, I think that there is much waste in staff time as well as the equipment and supplies.

We have many employees who are doing duties out of their series, e.g. MD, who is paid MD salary, is working with program development items; highly paid nurses are asked to work on P & Ps; we're asked to work evening hours but work output is very low (management refuses to change).

Conclusion

Clearly, the various stakeholders in Hawaii's public mental health system perceive many serious problems in that system. Taken as a whole, the perceptions reflected in this chapter present an unmistakable picture of a system in dire need of reform. As perceived, it is a system that: (1) is often paralyzed by bureaucratic gridlock and thus unable to respond effectively to the needs of those it serves; (2) is constricted by inflexibility; (3) is fragmented and lacking coordination between its various components; (4) is crisis-driven so that policy and planning is often reactive and not proactive; and (5) the participants are frequently angry, frustrated and demoralized.

Endnotes

1. Comment by Sherry Harrison, R.N.C., M.A., Chief, Adult Mental Health Division, AMHD Managed Health Care Meeting, October 13, 1993.

2. David Osborne and Ted Gaebler, Reinventing Government; How the Entrepreneurial Spirit is Transforming the Public Sector (New York: Penguin Press, 1992 (hereafter "Osborne and Gaebler"), pp. 34-37.

3. Osborne and Gaebler, p. 30 citing Peter F. Drucker, The Age of Discontinuity (New York: Harper Torchbooks, 1978), p. 233.

4. Interview with Kathleen Yoshitomi, Chief, Kalihi-Palama Community Mental Health Center, October 1, 1993.

5. Comment, Jud Cunningham, Chief, Maui Community Mental Health Center, AMHD Subcommittee Reorganization Meeting, August 24, 1993.

6. Osborne and Gaebler, p. 30.

7. The questionnaire results make clear that the CMHC respondents feel that mental health services are compromised far more often by "lack of accountability" than by "too much accountability." A few survey responses, however, indicate that there may be too much accountability factored into the present structure:

   ". . . I wish they'd trust us more and leave us alone."

   "Lots of watchdogs and only a few hens. We have more people concerned with quality assurance than we have doing direct out- patient service -- absurd. Problems exist but the watchdogs only diagnose."

   "Lots of wagging fingers but few helping hands."

   "Increased paperwork which is time consuming and questionable as to showing accountability."

8. Interview with Sherry Harrison, R.N.C., M.A., Chief, Adult Mental Health Division, August 11, 1993.

9. Telephone interview with Wayne Law, M.S.W., Chief, Kauai Community Mental Health Center, November 17, 1993.

10. Hawaii Administrative Rules, chapter 11-175 (Mental Health and Substance Abuse System), section 11-175-20.

11. Interview with Dr. Eugene Shooter, Acting Chief, Windward Oahu Community Mental Health Center, November 4, 1993.

12. Law interview, November 17, 1993. Mr. Law notes, however, that this situation will change if the Commission on Accreditation of Rehabilitation Facilities (CARF) is implemented.

13. Comment, Dr. Linda Fox, AMHD Reorganization Subcommittee Meeting, November 10, 1993. A few CMHCs monitor certain purchase of service contracts themselves. However, as one CMHC chief noted, this too presents problems since clinicians often serve as monitors and are not necessarily trained in how monitoring is to be performed.

14. Hawaii, Department of Health, Behavioral Health Services Administration, Adult Mental Health Division, State Plan: 1991 - 1993, p. 9.

15. Meeting with AMHD Central office staff, July 28, 1993.

16. Interview with Billie J. Hauge, Executive Director, Wai'anae Coast Community Mental Health Center, Inc., November 12, 1993.

17. Comment, Dr. Howard Weiner, AMHD Reorganization Subcommittee Meeting, August 24, 1993.

18. When asked whether the CMHCs receive "too much supervision," most reported that this was not a problem. Typical responses include:

   "Are you kidding?"

   "Centers are left to fend for themselves."

   "I have never seen this happen."

19. This problem has been addressed in the proposed Adult Mental Health Division reorganization plan.

20. Osborne and Gaebler, p. 110.

21. Interview with Sherry Harrison, R.N.C., M.A., Chief, Adult Mental Health Division, September 15, 1993.

22. E. Fuller Torrey, M.D. and Sidney M. Wolfe, M.D., Care of the Seriously Mentally Ill; A Rating of State Programs, Public Citizen Health Research Group, 1986, p. 76.

23. The Honolulu Advertiser, September 13, 1988, and Honolulu Star-Bulletin, September 13, 1988.

24. E. Fuller Torrey, M.D., Karen Erdman, Sidney M. Wolfe, M.D., Laurie M. Flynn, The Rating of State Programs for People with Mental Illness, Published by Public Citizen Health Research Group and the National Alliance for the Mentally Ill, 1990 Edition, pp. 175-178.

25. Memorandum to Dr. Joshua Agsalud, Administrative Director, Office of the Governor, from John C. Lewin, M.D., Director of Health, Department of Health, March 9, 1993.

26. Interview with Dr. Henry Foley, former Deputy Director, Behavioral Health Services Administration, October 14, 1993.

27. Shooter interview, November 4, 1993.

28. Law interview, November 17, 1993.

29. David Mechanic and Richard C. Surles, "Challenges in State Mental Health Policy and Administration", Health Affairs, vol. II, no. 3, Fall 1992, p. 44.

30. Interview with William Apaka, Chief, Leeward Oahu Community Mental Health Association, October 1, 1993.

31. Foley interview, October 14, 1993.

32. Osborne and Gaebler, p. 112.

33. Ibid., p. 125.

34. Interview with Judith Crockett, Program Planner, Adult Mental Health Division, November 3, 1993.

35. Interview with Elnora B. Guieb, Public Health Administrative Officer, Windward Oahu Community Mental Health Center, November 4, 1993.

36. Harrison interview, August 11, 1993.

37. Law interview, November 17, 1993.

38. Shooter interview, December 10, 1993.

39. Law interview, November 17, 1993.

40. Ibid.

41. Hawaii Rev. Stat., §457-2.

42. Shooter interview, November 4, 1993.

43. Miles F. Shore, M.D. and Martin D. Cohen, M.S.W., "The Robert Wood Johnson Foundation Program on Chronic Mental Illness: An Overview," Hospital & Community Psychiatry, vol. 41, no. 11, November 1990, p. 1212.

44. In his book, Neighborhood Services, John Mudd writes: "If a rat is found in an apartment, it is a housing inspection responsibility; if it runs into a restaurant, the health department has jurisdiction; if it goes outside and dies in an alley, public work takes over." Osborne and Gaebler, p. 132, citing, John Mudd, former New York City official.

45. Osborne and Gaebler, p. 187.

46. With the exception perhaps of the Family Court (which, as the Department of Health deputy attorney general notes "often re-writes CAMHD's budget") no one entity has authority to make necessary financial decisions across areas of care. Interview with Sonia Faust, Supervising Deputy Attorney General, September 27, 1993.

47. Hawaii Rev. Stat., §321-174.

48. Hawaii, Office of the Auditor, Marion M. Higa, State Auditor, "A Study of the Memorandum of Agreement for Coordinating Mental Health Services to Children" A Report to the Governor and the Legislature, Report No. 93-1, January 1993, p. 5.

49. Interview with Juanita Iwamoto, M.S.W., M.P.H., Executive Director, Catholic Services to Families, October 28, 1993.

50. Ibid.

51. Ibid.

52. Hawaii, Department of Health, Neal Mazer, M.D. and Mark J. O'Donnell, M.P.H., "The Future of the Child and Adolescent Mental Health System in Hawai'i" (Executive Summary), prepared in response to Senate Concurrent Resolution 123 and House Concurrent Resolution 245, 16th Legislature, 1991), pp. 4-5.

53. Hawaii, Department of Health, Behavioral Health Services Administration, Wayne A. Kimmel, Management Improvement Program, Gwenfread Allen Fund Project, Year One: Site Visit Report No. 1 (hereafter "Kimmel"), November 12, 1992, p. 3.

54. Ibid., Year Two: Site Visit Report No. 1, August 10, 1993 Draft Report, p. 6.

55. Comment, Judith Crockett, Program Planner, Adult Mental Health Division, October 6, 1993.

56. Osborne and Gaebler, p. 234.

57. Interview with Neal Mazer, Chief, Child and Adolescent Mental Health Division, August 18, 1993.

58. E. Fuller Torrey, M.D., Karen Erdman, Sidney M. Wolfe, M.D., Laurie M. Flynn, Care of the Seriously Mentally Ill; A Rating of State Programs (Washington, D.C.: Public Citizen Health Research Group and the National Alliance for the Mentally Ill, 1990), p. 177.

59. Felix v. State of Hawaii, et al., First Amended Complaint, Civil No. 93-367, Class Action, U.S. Dist. Ct., Dist. of Haw., August 3, 1993, p. 4.

60. Osborne and Gaebler, p. 221.

61. Iwamoto interview.

62. Osborne and Gaebler, p. 192.

63. Faust interview, September 27, 1993.

64. Interview, Melvin T. Hayase, A.C.S.W., Chief, Central Oahu Community Mental Health Center, October 1, 1993.

65. Kimmel, Year One Report, p. 5.

66. Osborne and Gaebler, p. 38.

67. Interview with Wayne A. Kimmel, Public Policy and Management Consultant, October 8, 1993.

68. Shooter interview, November 4, 1993.

69. Osborne and Gaebler, p. 138.

70. Ibid., p. 217.

71. Hawaii, Department of Health, Adult Mental Health Division, State Plan for the Seriously Mentally Ill, Goals and Objectives for Fiscal Year 1994, Draft, November 8, 1993, p. 7.

72. Hawaii, Department of Health, Child and Adolescent Mental Health Division, Section II, State Plan, June, 1993, p. 9.

73. Comment, AMHD Managed Care Conference, August 13, 1993.

74. Comment, Malina Kaulukukui, M.S.W., B.C.D., AMHD Reorganization Subcommittee Meeting, October, 6, 1993.

75. Interview with Mark J. O'Donnell, M.P.H., Executive Director, Mental Health Association in Hawai'i, September 10, 1993.

76. The problems with POS contracting are not limited to delays in vendor payments. Another problem is that private providers are generally guaranteed only two years of funding. As noted by one private provider, "it is very difficult to create innovative programs under this arrangement." And, as noted by Elaine Wilson, A.C.S.W., M.P.H., Chief, Alcohol and Drug Addiction Division, "the state system of two year contracts is deadly to providing quality services" as the contractual process ties up a large amount of staff time and energy. (Wilson interview, September 28, 1993.)

77. Catholic Services to Families, Na'Ohana Pulama Description Statement.

78. Iwamoto interview; indeed, the privatized Waianae Coast Community Mental Health Center has had to do just that in order to meet its payroll, though such drastic measures have not been necessary recently. (Hauge interview, November 12, 1993.)

79. Iwamoto interview.

80. Interview with Eva K. Kishimoto, M.S.W., Admission Director, Wai'anae Coast Community Mental Health Center, Inc., October 1, 1993.

81. Shooter interview, November 4, 1993.

82. Harrison interview, September 15, 1993.

83. Osborne and Gaebler, pp. 118-119.

84. Honolulu Star-Bulletin, November 29, 1989, p. A-8.

85. Shooter interview, November 4, 1993.

86. Ibid.

87. Hauge interview, November 12, 1993. Ms. Hauge also notes that the closing of the respite house left a huge gap between hospitalization and no hospitalization.

88. The Robert Wood Johnson Foundation program is discussed more fully in chapter six.

89. The State of Maine Systems Assessment Commission defines a case manager as "an assertive community or consumer support person, advocate and facilitator who, while not necessarily a mental health professional, understands the systems, is responsive to consumer wishes, and is effective in making the collection of systems work for the consumer's environment" but notes that the "case management" label is impersonal and should be changed to "community support person." (Final Report of the State of Maine Systems Assessment Commission, "Mental Health and a Healthy Society: Transforming Maine's Mental Health System by the Year 2000, January 25, 1991, p. 13.)

90. Honolulu Star-Bulletin, May 3, 1988, citing Alma Takata.

91. At one point, six levels of case management positions were being considered. (Interview with Professor Susan Chandler, D.S.W., U.H. School of Social Work, November 16, 1993.)

92. Memorandum from Jerry Watson, Department of Health, Office of Mental Illness, to Sherry Harrison, Acting Chief, Adult Mental Health Division, July 29, 1992, p. 2.

93. Chandler interview, November 16, 1993.

94. Memorandum to John C. Lewin, M.D., Director of Health, through Masaru Oshiro, A.C.S.W., Deputy Director, from Neal Mazer, M.D., M.P.H., Chief, CAMHD, October 18, 1993.

95. Shooter interview, November 4, 1993.

96. The Waianae Coast Community Mental Health Center, Inc., contracted with Ernest and Young to provide training on billing. (Interview with Billie Hauge, Executive Director, Waianae Coast CMHC, Inc., November 12, 1993.)

97. Except for the private Waianae Coast Community Mental Health Center, Inc., which has developed its own computerized billing process, billing in the other CMHCs is accomplished through a manual system which is complex and time consuming.

98. Hawaii Rev. Stat., §334-15.

99. Law interview, November 17, 1993.

Chapter 5

PROBLEMS LOOMING ON THE HORIZON

Chapter 4 described the basic problems with the structure of the present public mental health system in Hawaii. This chapter discusses several problems which will certainly arise if the present system is not corrected. These problems, (1) pending litigation against the State and (2) the possible cap on federal Medicaid reimbursements, are discussed here for two reasons. First, if these problems are not addressed or corrected soon, the consequences to Hawaii will certainly be felt in the very near future. Second, the potential financial and social costs of failing to effectively address and correct these problems will be significant.

Pending Litigation

There are two lawsuits stemming from the alleged failures of the present mental health system presently pending against the State of Hawaii. In the first of these lawsuits, filed in March 1991, the United States Department of Justice filed suit against the State of Hawaii pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA).[1] The suit alleged that the confinement, care and treatment of patients at the Hawaii State Hospital, and the Children and Adolescent Residential Services[2] violated patients' constitutional rights.

The suit was filed one year after the United States Attorney General provided Governor John Waihee with written notification of the alleged unconstitutional conditions at the hospital and detailed the minimal measures necessary to legally remedy these alleged conditions.[3]

This lawsuit might have been averted had the State provided the United States Department of Justice with reason to believe that the suggested remedial measures would be implemented by the State. This is suggested by statements in a report issued by the Public Citizen Health Research Group and the National Alliance for the Mentally Ill in 1990, which notes that Hawaii's response to the Department of Justice's concerns is "emblematic of why public services for the mentally ill in Hawaii are so deplorable" and goes on to state:[4]

> In February 1988, Hawaii State Hospital was inspected and found to be in abysmal shape -- the worst state psychiatric hospital in the United States. . . Ensuing cries of "mea culpa" and promises of improvement by state officials echoed from Barbers Point to Kaneohe. Such promises are as common as hibiscus leis in Hawaii -- and last just about as long.
>
> In December 1989, Hawaii State Hospital was again inspected, this time by the United States Department of Justice to investigate allegations that hospital patients were being deprived of their civil rights. They found the hospital still to be in abysmal shape -- "abomination" was the word used in the official report. . .
>
> In February 1990, the department announced that it had hired -- for a considerable sum -- "a high level team of mental health and management professionals to assess the weaknesses of Hawaii State Hospital and set up a program to correct them."

> File drawers at the Department of Health are overflowing with reports of past consultants and experts who have made countless recommendations that were never put into effect. Hawaii needs more consultants like it needs more waves. The money for the "high level team" would have been much better spent improving the salaries of nurses or buying clothes for the patients.

In any event, the United States Department of Justice did file the lawsuit and a settlement agreement was ultimately reached. Under this agreement, the State was required to make a variety of improvements. Some of these improvements had to be implemented immediately, such as providing adequate monitoring of all patients placed in physical or mechanical restraint or seclusion. Satisfaction of these conditions required the immediate hiring of numerous personnel at significant state expense.

It is presently clear that conditions at the Hawaii State Hospital are vastly improved. Many of the settlement agreement conditions have been met and it is possible that the lawsuit will be dismissed soon. However, this lawsuit and the cost required to resolve it should serve as a clear example of what can happen when unsatisfactory conditions are allowed to continue unaddressed. It is a case of "pay now or pay later."

In addition to the United States Department of Justice lawsuit, the State is presently defending a separate lawsuit filed by numerous representatives of mental health and child service agencies in which the plaintiffs charge the Department of Health and the Department of Education with gross violations of federal law for their alleged failure to provide adequate mental health services to Hawaii's seriously emotionally disturbed youth. Quite apart from the serious mental health issues raised in this lawsuit, the financial implications of the lawsuit are staggering.

This is clearly demonstrated by the experience in North Carolina. There, the State has faced the expense of satisfying a court-ordered mandate to provide services following a lawsuit similar to that presently pending in Hawaii. In 1979, a class action lawsuit was filed against the state of North Carolina on behalf of emotionally disturbed, violent and assaultive children. In this suit, the plaintiffs alleged that the state failed to provide children with severe emotional disturbances and chronic aggressive behaviors with the treatment, education and rehabilitation services they needed.[5] In 1980, the parties signed a consent decree which required the State to provide educational and treatment services to the class members. This settlement led to the development of, in effect, two separate mental health systems for children and adolescents: one designed to serve those children meeting the specific criteria identified in the *Willie M.* lawsuit, and one designed for those children who do not meet this criteria. This resulted in significant additional expense to the taxpayers of North Carolina who had to absorb the administrative costs of supporting a separate program for one class of children, as well as a court-appointed panel to monitor state compliance with the settlement which has been operating for the past twelve years.[6]

The North Carolina experience illustrates the clear implications of the present litigation in Hawaii. For instance, one possible result of the present suit is the appointment by the court of a special master, to administer the terms of any settlement which may be reached. This special master would have significant power to dictate to the State how its resources will be spent and what services shall be offered. As noted by Hawaii's Director of Health, should the court force DOH to provide services, it could cost up to $30 million.[7] Under these circumstances, some CMHC staff, who are presently convinced that funds allocated to their centers are being "siphoned off" by the Hawaii State Hospital to satisfy the settlement of the consent decree with the Department of Justice, are concerned that resources reserved for their use may be further consumed to satisfy this lawsuit.

Ten years after the *Willie M.* litigation, the North Carolina Mental Health Study Commission found that "North Carolina knows what should be done; knows how to do it; and *knows the terrible price of failing to act.*[8] It remains unclear whether the experience in Hawaii will be any different.

Potential Cap on Federal Medicaid Reimbursements

In Chapter 4, this report documents the BHA's poor performance in collecting Medicaid reimbursements from the federal government. As noted in that section, the BHA collects only a small percentage of federal funds to which it is entitled. As a consequence, Hawaii's publicly funded mental health service system is heavily dependent on state funding.

While virtually all other states have been collecting substantial Medicaid reimbursements,[9] Hawaii's AMHD and CAMHD have only recently begun billing for Medicaid reimbursements. CAMHD was the first BHA division to bill for Medicaid, and began billing in January, 1993. As of July 15, 1993, twenty-four percent of the 1120 registered consumers served at CAMHD were Medicaid recipients.[10] All of CAMHD's Children's Teams are presently billing Medicaid for traditional mental health Medicaid services, including evaluations, group and individual psychotherapy and counseling, and medication management. CAMHD anticipates that as the Children's Teams become more efficient, initial billing errors are corrected, retroactive billing is conducted, and billing for Targeted Case Management Services is implemented, Medicaid reimbursements will increase. However, as of July 30, 1993, the accumulated total of Medicaid reimbursements received by CAMHD amounted to only about $10,000.[11]

In addition to the obvious concern that BHA is collecting only a portion of Medicaid reimbursements to which it is entitled, there is a second, less apparent, basis for concern: several national experts[12] have predicted that the federal government will soon "cap" Medicaid reimbursements to the states. Since, following imposition of this "cap", Medicaid

payments may be based upon each state's historical billing record,[13] Hawaii faces the imminent risk that its future ability to collect Medicaid reimbursements will be limited to its current level of billing. Given the currently inadequate level of Medicaid billing, the possible cost of this cap could be financially devastating.

Endnotes

1. The Civil Rights Institutionalized Persons Act (CRIPA), enacted by Congress in 1980, gave the Department of Justice authority to investigate state institutions believed to be depriving people of their constitutional rights and civil liberties. Previous to the enactment of CRIPA, the Department of Justice could only be involved as amicus curiae, or third parties, in lawsuits against state mental hospitals. CRIPA permitted the Department to initiate court actions on behalf of persons whose rights are believed to have been violated. 42 U.S.C. Section 1997 et seq.

2. The Children and Adolescent Residential Services constitute those non-acute residential placements for children and adolescents operated by the DOH's CAMHD.

3. United States of America v. State of Hawaii, et al., Settlement Agreement, Civil No. 91-137 (DAE), U.S. Dist. Ct. for the Dist. of Hawaii, September 19, 1991, p. 2.

4. E. Fuller Torrey, M.D., Karen Erdman, Sidney M. Wolfe, M.D., Laurie M. Flynn, Care of the Seriously Mentally Ill; A Rating of State Programs (Washington, D.C.: Public Citizen Health Research Group and the National Alliance for the Mentally Ill), p. 176.

5. North Carolina, Mental Health Study Commission, Willie M Study Committee, Willie M Study Report, February 28, 1991, p. 9.

6. Interview with Lenore Behar, Ph.D., Head, Child and Family Services Branch, North Carolina Department of Human Resources, Division of Mental Health, September 30, 1993.

7. Honolulu Advertiser, May 5, 1993, citing John Lewin, Director of Health.

8. North Carolina Mental Health Study Commission, p. 6.

9. Neal Mazer, M.D., M.P.H., "Demonstration of a Collaborative Community-Based System of Care for Children and Adolescents with Serious Emotional Disturbances in Leeward O'ahu, Hawai'i, Request for Applications No. SM 93-02," Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Child and Adolescent Mental Health Division, Hawai'i Department of Health, July 16, 1993, p. 15.

10. Hawaii, Department of Health, Child and Adolescent Mental Health Division Medicaid Billing Update, August 13, 1993.

11. Ibid., p. 1.

12. In a presentation to the Indiana Medicaid Task Force in 1990, national Medicaid consultant Bruce Berger, noting that states must act quickly to expand resources through Medicaid, stated that "Indiana can be capped at either a high rate or low rate, and then no longer have the choice to access more federal dollars." (Bruce Berger, presentation to the Indiana Medicaid Task Force on October 30, 1990, cited in Mental Health Needs and Local Service Delivery, September 1991, Senior Citizens, The Disabled and Children in Indiana, Evaluation Audit, Indiana Legislative Services Agency, p. 55.)

13. Telephone Interview, Robert F. Cole, Ph.D., Deputy Director, Mental Health Services Program for Youth at the Washington Business Group on Health, October 9, 1993.

Chapter 6

HAWAII'S EXPERIENCE WITH THE ROBERT WOOD JOHNSON FOUNDATION PROGRAM ON CHRONIC MENTAL ILLNESS

The Robert Wood Johnson Foundation is a nationally-respected foundation which addresses many issues related to public systems for effective delivery of mental health services. This is reflected in the Senate Resolution requesting the instant study, in which the Legislature cites the Robert Wood Johnson Foundation as having established certain characteristics as "the hallmarks of exemplary community mental health systems for the severely mentally ill."

Therefore, it is important to examine Hawaii's experience with the Robert Wood Johnson Foundation's Program on Chronic Mental Illness (RWJ CMI) -- a history of how Hawaii's inability to follow through on promised meaningful reform of its present mental health delivery system resulted in a significant "lost opportunity" for badly needed funding and consultation. This history, although perhaps unfortunate, demonstrates an important reality: fundamental change in Hawaii's public mental health system, which is clearly necessary, will be difficult to achieve.

In 1985, the Robert Wood Johnson Foundation Program on Chronic Mental Illness offered funding and technical assistance to selected United States cities in an effort to improve services to persons with chronic mental illness. In its program announcement, the foundation stated that the purpose of the program was to develop "community-wide systems of care offering a broad range of health, mental health, social services, and housing options to help the chronically mentally ill function more effectively in their everyday lives and avoid inappropriate institutionalization."[1] The underlying premise of the program was that most problems in delivering care to persons with chronic mental illness are not due to the nature of the available services, but rather to poorly organized systems of care.[2] The foundation believed that changes in the organization and financing of systems of care, in particular through the creation or strengthening of local mental health authorities, would lead to the development of a comprehensive system of mental health and social welfare services. This, in turn, would improve the quality of life of individuals with severe and persistent mental illness.[3] Consequently, central mental health authorities could provide a "cornerstone of improved systems of care for persons with chronic mental illness in urban areas."[4]

The basic strategy of the RWJ CMI program was to integrate mental health services, including both community mental health centers and community support programs. This integration of services was to be achieved by forming public/private partnerships, combining the efforts of private providers and public authorities. The project focused on creating or

strengthening local mental health authorities by "operationalizing and centralizing its administrative, fiscal, and clinical functions."[5]

It was expected that the local mental health authorities would assume financial responsibility for inpatient care, gain control of state mental hospital budgets, and reduce reliance upon costly hospital care. Reallocating state mental hospital dollars was viewed as the most important mechanism for maximizing resources for providing community services.[6]

A mental health authority would be a "new or existing public or private organization that holds a fiduciary responsibility to assure that the mental health and some social welfare needs of the chronic mentally ill persons within its jurisdiction are met."[7]

The authority, which in some cases would be a private, not-for-profit corporation, would accomplish this objective by centralizing administrative, clinical, and fiscal responsibility. The mental health authority was to assume responsibility for planning, delivering, and overseeing services for chronic mentally ill persons (i.e. administrative authority), for setting clinical policy and monitoring clinical performance (i.e. clinical authority), and for making fiscal decisions and controlling the financial resources for providing mental health services to its community (i.e. fiscal authority)."[8]

To be eligible for participation in the program, each applicant city was required to develop a service system incorporating a centralized mental health authority to deliver services to persons with chronic mental illness. The application guidelines specified that the central authority must be provided operational and administrative responsibility for delivering care to persons with chronic mental illness. The authority must operate all hospital and community-based services within its jurisdiction and have access to funds from state, county, and local sources.[9]

The authority would have to provide a full range of services, including emergency, inpatient, and partial hospital care; outpatient services; social and vocational rehabilitation; and medical and dental care. These services were to be accessible and the central authority was to set up mechanisms for identifying and responding to persons underserved by existing programs.[10]

In addition to ensuring continuity of care and a plan to make housing available for persons with chronic mental illness, the applicants had to have a plan to ensure that state, county and city funds could be combined in a single stream. Moreover, applicants were encouraged to seek new sources of revenue and to experiment with financing models to create incentives for program innovation and improved quality of care.[11]

Honolulu was one of nine U.S. cities[12] to receive a grant from the Robert Wood Johnson Foundation's Program on Chronic Mental Illness. The program's principal investigator for program evaluation notes that, in reviewing Hawaii's qualifications, it was determined that Hawaii presented a "high-risk, potentially high profit" opportunity for reform and was selected for this reason.[13] Hawaii was to receive a $2.5 million grant over a five-year period and a $1 million low-interest housing development loan as well as technical assistance and consultation. Monitoring was to be performed through a highly developed program offered through the foundation. Hawaii's receipt of this prestigious grant was the source of considerable enthusiasm, hope and optimism within the local mental health community.[14]

The University of Hawaii was the original recipient of Hawaii's grant from the RWJ Foundation program. The original grant was intended to support a demonstration project focused on the privatization of mental health care and the creation of a "health insuring organization" under Medicaid.[15] The program was controversial, and because of opposition among state officials and mental health providers, the plan and the grant agreement were terminated. Honolulu was invited by the foundation to reformulate its plan and a new grant was awarded. This time the grant recipient was the Hawaii state government. The Governor appointed a sub-cabinet committee of department directors to function as the governing body of the "mental health authority" required by the terms of the foundation grant.[16] The Mental Health Division of the Department of Health was to serve as the operating arm, providing inpatient services directly at the Hawaii State Hospital and through purchase of service contracts at Queen's Medical Center. Outpatient services were to be provided by six community mental health centers on the island of Oahu. These community health centers were to be privatized by 1991.[17] According to one of the initial reports assessing Hawaii's progress with grant-related activities:[18]

> Currently, the . . . community mental health centers operate with a ceiling on the number of inpatient beds they can use at the state hospital. The centers are provided with financial incentives to reduce hospital use. The arrangement with the Waianae center is a prototype for an integrated financing plan to transfer fiscal, administrative, and clinical authority to the community mental health centers. The plan is under discussion for implementation in 1991.

However, as described in chapter four, the community mental health center "financial incentive" plan was discontinued within a year of its implementation. Further, none of the public community mental health centers was ever privatized.

In a 1990 report discussing the preliminary evaluation of the cities the following observation was made:[19]

> The prestige of the foundation and the threat of embarrassment associated with failure to meet expectations have more than once served as incentives to innovation and as motivation for overcoming the usual resistance to change in the status quo.

However, neither the "prestige of the foundation" nor the "threat of embarrassment" was sufficient to motivate Hawaii to achieve the promised necessary changes in its public mental health governance system. Consequently, the foundation grew increasingly frustrated by Hawaii's lack of progress. One of the foundation's concerns was that there was too much focus on the Hawaii State Hospital to the detriment of the community mental health centers.

Apparently because the foundation perceived[20] that Hawaii was unable to make changes in its mental health service delivery system, and that the state government was not truly committed to following through on the grant's goals, the foundation recently canceled the remaining nearly $1 million of Hawaii's grant allocation. The other eight grant receiving cities had varying degrees of success, but Hawaii was the only recipient to be discontinued by the foundation.

In an apparent reference to Hawaii's inability to fulfill its commitments to the Robert Wood Johnson Foundation program, the program investigator stated:[21]

> From the outset, one of the sites determined that the new resources offered by the RWJF program were not sufficient to effect comprehensive change in its system of service and decided instead to identify a few areas of need for innovation and fund only those activities. The rest of the system remained basically unchanged (and very undeveloped) throughout the demonstration.

According to one national report, Hawaii "virtually squandered" the grant money intended to reform its mental health service system by spending the money on hiring "yet more expensive consultants and [creating] yet more complex levels of bureaucracy and administration."[22] Finally, a mental health advocate who was part of the original RWJ grant task force concluded that Hawaii's experience with the RWJ CMI "proves that [Hawaii] cannot manage innovation within the present state system."[23]

Endnotes

1. The Program for the Chronically Mentally Ill: Program Announcement. Princeton, New Jersey, Robert Wood Johnson Foundation, 1985, cited in Howard H. Goldman, Joseph P. Morrissey, M. Susan Ridgely, "Form and Function of Mental Health Authorities at RWJ Foundation Program Sites: Preliminary Observations", Hospital and Community Psychiatry, vol. 41, no. 11., November 1990, (hereafter "Goldman, et al. 'Form and Function'"), p. 1222.

2. Ibid., p. 1212.

3. Howard H. Goldman, Joseph P. Morrisey, M. Susan Ridgely, Richard G. F. Frank, Sandra J. Newman, and Cille Kennedy, "Lessons from the Program on Chronic Mental Illness", Health Affairs, vol. 11, no. 3, Fall 1992, (hereafter "Goldman et al., 'Lessons from the Program'"), p. 54.

4. Miles F. Shore and Martin D. Cohen, "The Robert Wood Johnson Foundation Program on Chronic Mental Illness; An Overview", Hospital and Community Psychiatry, vol. 41, No. 11, November 19, 1990, (hereafter "Shore and Cohen"), p. 1212.

5. Goldman, et al., "Lessons from the Program", p. 55.

6. Ibid., p. 56.

7. Goldman et al., "Form and Function", p. 1223, citing Shore and Cohen.

8. Ibid.

9. Shore and Cohen, p. 1213.

10. Ibid.

11. Ibid.

12. Fifty-six of the sixty eligible cities submitted proposals for participation in the RWJ CMI program.

13. Telephone interview with Howard H. Goldman, M.D., Ph.D., Professor of Psychiatry and Director, Mental Health Policy Studies Program, University of Maryland School of Medicine in Baltimore, October 29, 1993.

14. See e.g., Honolulu Star-Bulletin, November 22, 1986; Honolulu Star-Bulletin, March 1, 1988; and The Honolulu Advertiser, September 13, 1988.

15. Goldman et al., "Form and Function", p. 1226.

16. Ibid., p. 1227.

17. Ibid., p. 1224.

18. Ibid., p. 1227.

19. Goldman et al., "Form and Function," p. 1227.

20. The RWJF requires that each demonstration site develop its program in close collaboration with the national program staff, who were in constant contact with the sites to monitor progress and conducted numerous site visitations to help solve problems as they arose and monitor the progress of each grant recipient.

21. Goldman, et al., "Lessons from the Program on Chronic Mental Illness," p. 64.

22. E. Fuller Torrey, MD., Karen Erdman, Sidney M. Wolfe M.D., Laurie M. Flynn, Care of the Seriously Mentally Ill; A Rating of State Programs, Published by the Public Citizen Health Research Group and the National Alliance for the Mentally Ill, 1990 Edition, pp. 175 - 178.

23. Interview with Professor Susan M. Chandler, D.S.W., University of Hawaii School of Social Work, November 16, 1993.

Chapter 7

OTHER STATES

Senate Resolution No. 137, S.D. 1, expressly requests the Legislative Reference Bureau to "study the means employed by other states to organize and operate their mental health systems, particularly those states which operate with significant autonomy and effectiveness." The apparent basis for this request is an assumption that the system or structure employed by other states can perhaps be duplicated in Hawaii and thereby improve Hawaii's system. However, discussions with a number of mental health experts, including several nationally recognized mental health consultants, suggest that the particular economic, political, social, and cultural circumstances found in each state are sufficiently unique that the structure or system employed in one state, however successful in that state, may not necessarily be effective or appropriate if it is precisely super-imposed on another state. This fact was expressed by a participant at a national mental health conference, who when asked by an AMHD social worker attending the conference, how other states were structuring their systems of governance, replied: "Once you've seen one state, you've seen one state."[1] According to mental health experts,[2] the various states' approaches are each unique and have developed strategies within their "own political and economic contexts."

Therefore, it seems clear that a comprehensive review of the structure of mental health systems would be of little utility here. However, it is equally clear that certain general principles may be identified which operate in those states which are perceived as doing an effective job of delivering public mental health services to their citizens. Accordingly, this chapter includes brief descriptions of the structures of several public mental health systems in several states. The particular states are described for two reasons. First, several of the states have recently initiated extensive reforms of their public mental health systems. These reforms have been prompted by problems which appear somewhat analogous to the problems presently confronting the Behavioral Health Administration, making it appropriate to examine these states. Second, several of the states have been selected for discussion since they are providing "significant autonomy and effectiveness" in the delivery of public mental health services.

The general principles of effective delivery of public mental health services which can be derived from study of the experience of other states, are fully discussed in Chapter 9 of this report.

Georgia

Georgia was selected for discussion in this report because it is presently engaged in a major reform of its public mental health system. The problems which led to the present reorganization appear similar to those presently faced by Hawaii's mental health service delivery system.

In 1992, in response to serious concerns related to problems with the Georgia public mental health system, the Georgia General Assembly created the State Commission on Mental Health, Mental Retardation, and Substance Abuse Service Delivery (hereafter "the Commission") to develop a "comprehensive plan for an improved service delivery system for the treatment and habilitation of people with mental illness, mental retardation, and substance abuse problems."[3]

In assessing the shortcomings of the Georgia mental health system, the Commission found that the system lacked accessibility, accountability, equity,[4] integration, consumer empowerment, and privatization. The Commission also found that the problems resulting from these deficits were increasing as greater demands were being placed on the system.[5] Stated the Commission:[6]

> We have currently a system that is not just simply broken. It is so fragmented, so non-responsive, so top heavy with bureaucracy, so consumer-unfriendly that we feel strongly that just tinkering with the system would be a waste of time at best and deceiving to the public at worst. The changes that are needed are deep and profound.

One proposal made by the Commission was to formulate a new concept of governance "better suited to ever-changing demands." The Commission recommended separating planning from delivery of services, and proposed that regional governing boards be established for planning purposes, and that local governing boards be established for delivery of services.[7]

Following publication of the Commission's report, the Georgia General Assembly enacted legislation[8] which restructured the Georgia system into nineteen regions. In each region, "sub-state" governing entities called Regional Planning Boards provide local oversight and accountability for all resources, and ensure that mental health services are effective, coordinated, and cost-sensitive. These boards are expected to develop and coordinate a network of providers.

These Regional Planning Boards provide a single point of accountability for fiscal and client service issues within the service delivery system for each region. They are responsible for planning, assessment, service coordination, contracting, needs assessment, resource allocation, and outcome evaluation. Members of the boards are appointed by the governing authorities of the various counties served by each board. A majority of the membership of each board is composed of consumers of mental health services and members of their families.[9] In short, the role of the Regional Planning Boards is to "assure that consumer participation flourishes, the system is smooth and ideally 'seamless,' and the consumer is unaware of the bureaucracy behind the system."[10]

The recently passed legislation also changes the role of the state Division of Mental Health, Mental Retardation and Substance Abuse (MHMRSA), which is analogous to Hawaii's Behavioral Health Administration. Under the new structure, the Georgia MHMRSA is to be a "policy-driven entity" rather than a provider of services, as the new structure makes the Regional Planning Boards "the direct brokers for services." This relief from managing the delivery of services will enable the MHMRSA to expend its resources on the creation of "a more streamlined policy-making system [which will] proactively identify the information required to meet its public policy and federal mandates, and. . .develop a mechanism for rapid change and technical assistance to assure evolution of the community based system to be developed."[11]

The intent of these structural changes is to shift power and control of the system from the state to the local level. Delivery of services is to be privatized to the greatest extent possible, although this may be a relatively slow process due to the present limited availability of qualified and willing private service providers.[12]

The Regional Planning Boards assume legal authority for the planning of mental health services in July of 1994. As this date approaches, the mental health community in Georgia is reportedly experiencing both excitement and terror. This ambivalence is expressed by the Acting Co-Director for Georgia's Mental Health Services Division[13] as follows:

> We are excited about moving from a "top-down structure" to a decentralized structure which will provide greater flexibility and fluidity to the delivery of mental health care services, This excitement, however, is tempered with a healthy dose of trepidation. . . . No matter how much you philosophically like the terminology, it's tough to let go. . . It's a constant struggle to bring the values and principles "down to earth" and make them operational.

Washington

The State of Washington's mental health system has been significantly reformed in recent years. In 1989, the Washington Legislature enacted legislation[14] designed to address serious problems in the Washington State mental health care delivery system, which was characterized by a state legislative report as "badly fragmented both in the way it is funded and in the way programs and services are delivered."[15]

Among the problems identified by the Legislature was that authority and responsibility for planning, development, and administration of mental health services were centralized at the state level with little formal local community responsibility and involvement.[16] Another problem was that Washington relied too heavily upon its two state hospitals to provide care for citizens with severe and persistent mental illness. This required individuals to be hospitalized away from their home communities. Hospital stays were prolonged and upon discharge and

return to the community, there were "inadequate mental health programs and resources to maintain client stabilization and prevent rehospitalization."[17]

In response to these problems, Washington's Mental Health Reform Act of 1989 decentralized the authority and accountability for mental health services in the State. The legislative intent in making the policy shift to regionalization was "to ensure local flexibility to develop services necessary to assure mental health clients access to the least-restrictive treatment alternatives appropriate to their needs."[18] The legislation transferred the authority and responsibility for mental health services to local communities through the development of Regional Support Networks (RSNs). These county-formed RSNs were designed to fiscally integrate the planning, administration, and delivery of a full range of mental health services at the local level.

The legislation requires each RSN to reduce short-term state hospital admissions outside the RSN by eighty-five percent within three and a half years of achieving RSN status. Within six years of its formation, each RSN is expected to have created a system that can accommodate all the service needs of targeted mental health consumers in the region.[19] This is to be accomplished by provision of an expanded array of services which emphasize living arrangements and supports in the local community. Further, the Legislature increased mental health funding significantly and transferred budget authority to the RSNs. This shift of budget authority provides the RSNs with greater autonomy and flexibility in decision-making.[20]

Washington's mental health services are funded through state funds, federal Title XIX and other federal sources, local tax levies, and donations. Funds from all of these sources are consolidated and provided to the RSNs in a single amount. The RSNs have the authority to determine how these funds are to be allocated.

Under this system, actual delivery of services is primarily provided through contracts between the RSNs and community mental health centers (CMHCs) to provide services. Most of the CMHCs are private non-profit organizations although there are also some which operate on a for-profit basis. The CMHCs provide mental health service and often subcontract with other community providers.

In November, 1992, the Washington Legislative Budget Committee and the University of Washington issued a preliminary report which focused on the experience of seven RSNs implementing the Mental Health Reform Act and concluded that:[21]

> [G]enerally good progress has been made towards implementation of the Act. Locally controlled community services have been developed. Changes in client outcomes are generally positive although small at this point. We conclude that implementation of the reform should be continued as planned. However some changes are needed.

Although the evaluation contained in the Washington legislative report is a mid-course assessment and should be viewed as only a preliminary indicator of trends observed, examination of some of the specific report findings[22] is nonetheless instructive:

1. Services to Clients and Client Outcomes

There has been expansion of case management and crisis intervention services. Crisis response and involuntary treatment functions are more closely integrated. More services have been delivered and more clients have been receiving services. Crisis intervention staff are available 24 hours a day to respond to consumers experiencing crises.

Continuity of care between the state hospitals and the community has increased. Clients released from the state hospital receive community services more rapidly than prior to the legislation. Additionally, in-hospital discharge planning is more likely to occur. However, at the end of 1991, approximately forty percent of clients did not receive services after discharge from the hospital.

Development of residential services has been difficult at this early stage of regionalization due to the magnitude of the efforts necessary to develop housing.

Efforts to expand vocational services have been made but more are needed.

Concerns about lack of coordination between the programs that serve mental health clients and substance abuse programs persist. Additional concerns are raised about the disincentives of categorical funding to interprogram communication, and a perception that, because the community mental health system received enhanced funding, clients who could benefit from other program's services were referred to the mental health system.

There has been a reduction in total commitments at the state hospital, in part, due to expanded crisis services and case management in the community.

Increased crisis services and case management efforts supporting clients in the community and increased hospital/community coordination appear to have led to decreased hospital readmission rates.

2. Organizational Outcomes

Collaborative planning has been performed to manage the changes required to implement the reform and respond to problems as they arose.

3. Resources and Efficiencies

Funds have been consolidated to allow RSNs autonomy in planning and managing local service delivery. Consolidated funds include some funds that were shifted from individual provider control to RSN control and large increases in new funding for RSN development. The funding changes resulted in more services delivered to more clients and a possible trend towards more services per clients. Also, funds have been used to develop organizations which provide better continuity between state hospitals and the community, and to make progress toward achieving the 85 percent goal.

However, there is concern as to whether the statutory goal of reduction of administrative duplication and administrative cost have been achieved.

Resource concerns are prevalent. Mental health agencies state that the development of comprehensive services to address consumer needs has resulted in more consumers accessing the mental health system. They report that many of the consumers currently accessing the system are new to the system. It will become more important for local authorities to determine who are priority populations in order to ensure that scarce resources are applied to meet legislative intent.

4. Data Concerns

Reliable outcome data will be necessary to determine whether the legislation is achieving its objectives. The data systems will need to be improved to provide such information.[23]

Ohio

Ohio provides an example which clearly illustrates the impact that hard-fought political consensus and sensible legislative reform can have on the effectiveness of state public mental health services. In 1986, Ohio was rated twenty-third in the country in its provision of mental health services by the Public Citizen Health Research Group.[24] In 1988, Ohio's ranking had advanced to seventh and in 1990, Ohio was ranked fourth in the nation.[25]

This dramatic improvement (at least in the eyes of the evaluating entity) in the delivery of public mental health services was the direct result of a five-year reform effort. When Governor Richard Celeste took office in 1983, the Ohio Mental Health System was biased toward institutional care and relied heavily on drug treatment.[26] Deeply committed to a shift from this institutional focus to provision of a broad array of community-based services,

Governor Celeste appointed Pamela Hyde as director of the Ohio Department of Mental Health (ODMH) to manage this transformation.

Prior to Hyde's appointment, the ODMH was divided into three divisions, one of which -- the Division of Business Administration -- made all the fiscal decisions without regard to program needs. Thus, mental health policy decisions were driven by budgetary considerations.

Hyde restructured this unsatisfactory arrangement to one where program needs dictated budget, by directing the business division to report budget decisions through the program office. She also brought in two consultants to help change ODMH's management and organization.[27] Over the next five years, Hyde led a process of reform which ultimately required major legislative and political initiatives culminating in passage of the landmark Ohio Mental Health Act of 1988.

The central provisions of the legislation shifted both legal responsibility and budgetary control for care of mentally ill individuals from the State to community mental health boards. These provisions are summarized as follows:[28]

> Under the bill, community mental health boards would become legally responsible for mentally ill individuals, through commitments to the local boards rather than to the state. It would be up to the county to decide whether a person needed hospital care or could be treated in a community setting. The change in financing mental health care calls for a gradual shift of state funds currently used to operate state hospitals. These funds would be used by the local mental health boards to purchase inpatient services, in a manner similar to how boards currently contract for services provided by local agencies. Boards could purchase inpatient services from state hospitals, which would continue to operate under state control.
>
> The proposed legislation also calls for other changes in Ohio's mental health system that would: increase the involvement of clients and their families in the treatment process; enhance the clinical training of mental health professionals; update and strengthen the licensing requirements to assure quality housing and residential placements; put into law the components of a community support system, which includes case management; and modernize the Department of Mental Health's organizational structure.

In a political accommodation with Ohio's governmental employee unions, the shift of state funds used to operate state hospitals to the local mental health boards was effected incrementally over a five-year period:[29]

> Although the Ohio Mental Health Act has many facets, its central strategy is fiscal incentives to local mental health authorities ("boards"). The law allows boards annually to divert an increasing percentage of state funding away from state hospitals toward locally managed community alternatives. A consolidated budget account was created to combine state hospital resources with some new community funding under the Mental Health Act. Beginning in 1990, boards could elect to use up to 10 percent of their allocated funds for community services. This ceiling rose to 20 percent in 1991 and then by 20 percent annually. By 1995 -- the final year

of the anticipated implementation period -- boards will be able to use up to 100 percent of their allocated funds for community services. Each board must also plan for and "buy" whatever hospital services it uses.

The 1988 Reform legislation provides[30] that each of Ohio's community mental health boards constitute a single authority for the mental health system in each community, especially for severely mentally disabled children, adolescents, and adults. A key mechanism for the exercise of this authority is the Community Mental Health Plan that lists the services the Board intends to purchase, projects inpatient and community-based services the Board proposes that the Department operate, assesses the number and types of residential facilities needed, presents a budget, and provides such other information as the Department of Mental Health requests. The plan is submitted to the Department of Health which may approve or deny the plan in whole or in part.[31]

Each board is to establish, to the extent resources are available, a community support system, including elements such as identification of persons in need of mental health services, assistance to obtain the services to meet basic human needs, mental health care, emergency services, assistance to obtain vocational and educational services, housing support, grievance procedures and recognition and protection of client rights, case management, and encouragement of natural support networks.

Any person civilly committed to the state public mental health system is to be committed to a board, or an agency that the board designates, rather than a state hospital. The board is responsible for providing the least restrictive and most appropriate alternative for any person committed to it. These alternatives include inpatient care in state or non-public hospitals, as well as a variety of non-hospital service settings, both public and private.

Additionally, the legislation provided for the creation of a broadly representative sixty-member commission (the Study Commission on Mental Health Services) to monitor and evaluate implementation of the Mental Health Act and to issue periodic reports of the Governor and Legislature. The process of change was also to be evaluated by the Ohio Department of Mental Health (ODMH).

The Mental Health Act of 1988 has "rapidly and substantially altered patterns of service for people with serious mental illness in Ohio."[32] The primary shift is in the redirection from state to community care. State hospital use has decreased as communities developed alternatives. The reduction in inpatient utilization accelerated subsequent to the legislative reform and the phasing in of the funding formula. Moreover, the decrease in state hospital use has tracked increases in community mental health funding.

In reporting on Ohio's Mental Health Systems Reform, a Maine Commission[33] noted its impressions as follows:

> Ohio since the mid-1980's has been able to establish infrastructure necessary to support a balanced service system, and it has just passed an inflection point where the fiscal unification of the state and local systems of mental health is beginning. Efforts to develop real jobs, real housing, and community integration of people with severe mental illness or emotional disturbance are supported by strong executive agency collaboration, and have helped prepare the state for this major policy change. The state is strongly supportive of consumer involvement in program and policy decisions, and is attempting to use this to advocate for change as well as design meaningful services in all settings. The uncertainties over the future of State operated services as a way to help move staff into the community are offset to some degree in that there are clearly positive effects of the refinancing scheme on hospital use. The effort to develop case management in the community is portrayed as one solution. The state's apparent effort to develop quality standards for services, combined with growing funds in the face of declining federal grant revenues for mental health suggests that Ohio's tenacious focus on systems development is beginning to bear fruit.

New Hampshire

In terms of the provision of mental health services for adults, New Hampshire was considered the best in the country[34] by the Public Citizen Health Research Group and the National Alliance for the Mentally Ill in 1990.[35] New Hampshire's national recognition as an innovative leader in the provision of mental health services has been attributed to the following factors:[36]

> Development of broad based community services in ten CMHCs enabling the transition from institutional care to community-based care for the majority of the seriously mentally ill population, with well defined systems of accountability in place;
>
> The completion of a fully accredited state-of-the-art acute care psychiatric facility for the most seriously impaired clients;
>
> The development of the first affiliation of a private medical school (Dartmouth Medical School) with a state psychiatric hospital to provide psychiatric services and to staff an office of applied research to evaluate the quality of services;
>
> The establishment of continuous treatment teams, funded in part by private grants, which are seen as highly effective mechanisms for achieving continuity of care and sharply reduced hospitalization rates;
>
> The funding of model programs, notably a job training and employment program; and
>
> The establishment of innovative training programs with the New Hampshire Vocational technical system to train residential staff and improve the quality of services.

New Hampshire's public mental health services are administered by the Division of Mental Health and Developmental Services.[37] This division is one of six in the state Department of Health and Human Services, which itself is one of twelve executive departments.

In providing mental health services, the Division is governed by a state policy to provide persons who are severely mentally disabled with care that is: (1) adequate and humane, (2) offered within each person's own community and is the least restrictive of each person's movement and ability to function normally in society, to the extent possible while meeting the person's treatment needs, and (3) directed toward eliminating the need for services and promoting the person's independence.[38]

State-funded mental health services in New Hampshire are primarily provided by two state hospitals and ten CMHCs. The CMHCs which are private, non-profit organizations, comprise the core of the state's community-based service system. As mental health centers, they collect insurance reimbursements. The centers generally administer directly or indirectly all state-supported community mental health services in their respective regions.

The Division contracts annually with the CMHCs, which may also offer additional services not contracted by the Division.[39] The CMHCs provide services to the chronically and severely mentally ill, including housing and vocational services, case management, and partial hospitalization. The Division monitors and assesses the centers' provision of contracted services including emergency, brief and partial hospitalization, children's, elderly, case management, housing, vocational, and other services. Several Division-contracted services are limited to those clients certified as severely or chronically mentally ill, based on Division criteria. Almost all persons admitted to the state hospital are first screened by CMHC staff.[40] However, the CMHCs are not required to bear the cost of services provided by the state hospital.[41]

New Hampshire has actively and with apparent success, sought to expand its programs through leveraging federal Medicaid funds, through increased general fund appropriations and by development of management information systems.

In reporting its impressions of New Hampshire's mental health service delivery system, the Maine Systems Assessment Committee in 1991 noted as follows:[42]

> New Hampshire is a state where there is a strong commitment to increasing the quality, efficiency and accountability of services to people with serious mental illnesses who are at risk of institutional placement. The transition of the New Hampshire Hospital from an asylum into a tertiary care facility has been supported by careful development of administrative, housing and vocational services, as well as a basic crisis response capacity throughout each of the community mental health center regions. The most remarkable aspects of the state presented in this survey is the consensus that New Hampshire has been able to achieve the control they have been able to sustain over community development. This is testimony to the

importance of executive and legislative commitment and the ability of the Division to interact with Medicaid and other parts of the Human Service system. It is also testimony to the effect of developing programs in a context of where -- subject to sunset legislation and increasing competition for public funds -- they must remain lean and relevant.

Colorado

In 1990, Colorado ranked sixth in the nation in the effectiveness of its public mental health services for persons with serious mental illness.[43] Colorado also rated as one of seven states which gets "the best quality of service per dollar spent."[44] The statutory mental health authority in Colorado is the Colorado Department of Institutions, which administers public mental health services through its Division of Mental Health. The Division of Mental Health has the following responsibilities:[45]

> To provide community-based mental health services through purchase-of-service contracts with community mental health centers and clinics;
>
> To allocate state funds appropriated for community mental health services;
>
> To develop standards, rules, and regulations for community mental health centers and clinics;
>
> To monitor the services purchased from the centers and clinics;
>
> To provide technical assistance and conduct research;
>
> To administer the state psychiatric hospitals;
>
> To regulate the provision of emergency and involuntary mental health services through Division-designated facilities.

The Division purchases services from seventeen mental health centers that have approximately seventy-five statewide offices and three specialty clinics. Community mental health centers and clinics provide a broad array of services including therapy, rehabilitation treatment, living skills training, residential placements, employment services, case management, in-patient care, and consultation and education. All of the centers are private, non-profit organizations, except for one which is a county agency. The community mental health centers receive most of their funding through purchase of service contracts with the State, and additional funding through private insurance, federal mental health grants, contributions from local governments, client fees, fundraising activities and donations. There are also two state psychiatric hospitals. Pursuant to federal law, the Colorado Division of Mental Health has prioritized mental health services to the severely mentally ill.

Development of Colorado's public mental health services to their present position of sixth in the nation has not been without its difficulties. This is demonstrated by the experience in Denver which in 1981, experienced reductions in mental health spending prompting a class-action suit against the city and the State. In 1986, as part of a court-

ordered remedy, the State was required to produce a plan to improve mental health services in Denver.[46] This plan formed the basis for system reform efforts which included state-level planning activity and contemporaneous efforts by Denver mental health administrators to develop services that bridged the four city catchment areas.[47] At about the time of these initiatives, Denver became a grant recipient of the Robert Wood Johnson Foundation (RWJF) program on Chronic Mental Illness.

Prior to its participation in the RWJF program, Denver did not have a unified mental health "authority." The State Division of Mental Health had contracted separately and directly with Denver's four community mental health centers. In 1989, Denver created the Mental Health Corporation of Denver, which was set up as the recipient of all state funds for mental health services. Administration of the four existing CMHCs in their respective catchment areas, was consolidated within the corporation's organizational structure.[48]

The Mental Health Corporation of Denver (MHCD) is a private, non-profit corporation,[49] providing mental health services to Denver residents. As the primary contracting entity with the Colorado Division of Mental Health, the corporation provides services designated by the state. Services are provided at approximately thirty sites in the city, and in fiscal 1992, over 6,000 persons were served. The corporation is governed through a board of directors appointed by the mayor.[50] The corporation has no control over inpatient resources at the state mental hospital. However, it has an allocation of bed days and responsibility for staying within that limit.

The corporation has experienced several problems. First, there was a problem in creating one system out of four previously existing systems. The problems in consolidating the four community mental health centers into one "unified" system were described by the Assistant City Attorney in Denver[51] as follows:

> There were four different community mental health centers each operating with its own style, its own theory as to what constitutes "chronically mentally ill" -- even its own personnel system and each of these centers was consolidated into one corporation. If you were to put it in corporate terms, when the corporation was formed and the four existing community mental health centers were absorbed, it was a "hostile," or at least "unfriendly" take-over.

Consolidation of the four centers into a single operating authority required "commitments and concessions" from the various participants in the mental health system -- families, consumers, providers, unions, bureaucrats and clinicians.[52] Intense negotiations on such issues as job security, benefits, and service location occupied a great deal of the project staff's time.[53]

Denver also encountered financial difficulty when the Robert Wood Johnson Foundation grant money ran out. This resulted in personnel lay-offs and cancellation of some

services.[54] The impact of these financial problems on the effectiveness of Denver's mental health services was recently discussed in an article providing preliminary assessments on the program:[55]

> In Denver. . .severe financial problems threatened the new authority and undermined public confidence in the system of services. The system had been underfunded relative to the volume of services that the mental health authority tried to deliver, and it had difficulty finding replacement dollars for services funded by the foundation. The Denver project attempted to produce extensive and costly change in an environment of relative resource scarcity. The Denver example illustrates both what is possible in terms of dramatic change and what cannot be accomplished without considerable added, ongoing resources.

Although the final evaluations of the RWJF project are not due for publication until 1994, the principal investigator for the program evaluation has stated that among the nine grant recipients, the one achieving the "most dramatic" results is Denver.[56]

Other State Public Mental Health Programs for Youth

Programs for adolescents and youth are outside the primary focus of this report. A comprehensive report on this subject was submitted to the Legislature last year by the Child and Adolescent Mental Health Division Chief and the Executive Director of the Mental Health Association in Hawaii.[57] Nevertheless, some discussion of recent developments across the nation in mental health services for youth is appropriate here, because many of the general characteristics of effective mental health services are especially germane where programs for youth are involved.

The Mazer and O'Donnell report, *The Future of the Child and Adolescent Mental Health System in Hawai'i*, describes two of the most innovative child and adolescent mental health programs being offered in other jurisdictions. One of these programs, Ventura County's (California) unified service system with extensive interagency collaboration, has been praised by advocates nationwide and has been replicated in several other states.[58] The Ventura County model has five basic components which present a framework for planning systems of care: a clearly defined target population; a system-wide goal of family unity and community-based treatment; interagency coalitions; treatment services and standards; and systems monitoring and evaluation.[59]

The philosophy of interagency coalitions is based on the premises that: (1) combining agency resources to treat the full range of problems that put the child at risk is cost-effective, and (2) collaborative efforts better meet the service needs of the "whole" child rather than parallel efforts that attempt to treat categorical segments of the problems. Therefore, mental health services must be carefully coordinated with social services, special education, and juvenile justice programs. "New programs should blend and complement services, staff and

funding across agencies allow a community-based, integrated continuum of services based on formal, written agreements among public and private agencies."[60]

The Robert Wood Johnson Foundation recently initiated a Mental Health Services Program for Youth. This project, patterned after the Ventura County Model, funds state efforts to develop community-based systems of care for disturbed youth. Programs developed through this project have created innovative approaches to structuring systems of support to emotionally disturbed adolescent and youth. These programs, though still evolving, may provide useful models for reform in Hawaii.

The fundamental premise underlying the Robert Wood Johnson project is as follows:[61]

> [Y]outh with serious emotional disturbances are passed back and forth among agencies that have a partial, but not comprehensive, responsibility for their treatment: schools, child welfare, public health, and juvenile justice -- as well as mental health -- agencies. Rather than being treated effectively, these children and adolescents are overprocessed, and their needs so escalate that they must be placed in hospitals and residential treatment centers at great expense. In fact, they and their families might benefit more from individually tailored services -- including early intervention -- provided in their homes, schools, and communities.

Nationally, eight local projects[62] are presently being funded by the Robert Wood Johnson Foundation Mental Health Services Program for Youth, which is intended to establish successful state-level multi-agency partnerships. At the state level, the program seeks to foster the coordination of mental health and other child-serving agencies and to expand funding strategies. At the community level, it strives to promote interagency cooperation and to develop new services. The program requires collaboration among the state and local mental health, public health, child welfare, juvenile justice, and educational entities responsible for planning, providing, and financing services for children. The state provides the policy leadership, and the locality provides the operational initiative.[63]

According to the project's directors, the movement to create multiagency systems of care for seriously emotionally disturbed youth is founded on three basic assumptions.[64] First, the best treatment occurs in the natural setting of the child's family and community. Second, genuinely intensive care is possible in normal settings, for instance at home or in school, and the structured treatment often prescribed for a troubled child can be provided through a highly individualized and complex package of services "wrapped around" the child and family. Third, service delivery must be organized to respond consistently to the everchanging needs of young patients who are growing and developing.

The program's eight local projects are working to manage and deliver services and develop financing strategies to ensure financial stability and capital for expansion beyond the grant period. In the first two years of implementation, the program sites shared four basic values, which have guided communities and organizations in developing a "balanced and

continuous system of care."[65] The first value is "individualization of care"[66] which requires that a comprehensive program of care be tailored to the specific health, mental health, and other needs of the individual child, and be provided through effective interagency collaboration.

The second value is that of "organization" or "management" of care,[67] which requires that management of a child's program involves the family, and enable the family, in concert with professionals, to manage the complete program of care over the long term and not simply to meet momentary crises.

The third value is that of "normalization of care"[68] which requires that carefully crafted, integrated services be "wrapped around" the child, supporting and enabling families to manage their child's care. These services must be available within the family, school, and community environments. Acute inpatient confinements should be used sparingly and only when that degree of care is appropriate, and not just because alternative services are unavailable.

The final value is that available money be targeted to the specific needs of the child, rather than having needs be defined by availability of program dollars:[69]

> Too often the disturbed child is forced to follow available service dollars, which are locked into specific programs, institutions, or narrow definitions of benefits, rather than having the resources follow the child's specific needs.[70]

One emphasis of the Robert Wood Johnson project has been exploration of new sources of funding. One source being explored is a new provision of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program which entitles children across five different service systems to be compensated for mental health services.[71]

One Robert Wood Johnson Foundation program, San Francisco's "Family Mosaic" project, has the most diverse population of all of the Robert Wood Johnson sites.[72] The project builds upon Ventura County's model program by stressing interagency collaboration and a flexible approach designed to avoid unnecessary out-of-home and out-of-county placement of youth. Some of its key components are integrated, multiagency case management by family advocates, neighborhood-based intervention, individualized services to families and children under an organized "culturally competent" delivery system; and working with parents. One of the key project objectives is to change the way services for the target population are reimbursed. One method being considered is pooling general fund dollars across such county-level categorical programs as child welfare, education, and juvenile justice in order to maximize federal financing.[73]

Oregon's "Partners Project"[74] also features capitated funding through the Medicaid 1915(a) option -- a Medicaid option which allows states to finance services to a defined population through rate capitation rather than on a fee-for-service, open-ended basis. Through this option, agencies pool general fund dollars contributed from budgets for child welfare, mental health, education, and juvenile justice agencies. Most of these funds were previously unmatched by federal entitlements. This pool of local funds is held by the Medicaid agency and matched with federal Medicaid dollars. As the program enrolls clients, it receives a monthly capitated fee and the freedom to fit the benefit to the needs of the particular child and family. Differential rates are developed to meet the individual needs of highly impaired children.

Each of the Robert Wood Johnson program's eight sites are providing services by uniting their child-service systems in a cooperative, integrated effort. Financial strategies have been developed to maximize funds available and ensure that the funds are used to provide individualized treatment approaches. These programs should be monitored closely, and the evaluations of each program, when available, should be scrutinized.

When asked during an interview to suggest specific recommendations for Hawaii, the Deputy Director of the Mental Health Services Program for Youth said that Hawaii should look to the multi-agency service approach developed through the Robert Wood Johnson Mental Health Services Program for Youth in redesigning its mental health system for children and adolescents.[75]

Conclusion

The evolution of public mental health services in the five states discussed in this chapter has been, in each case, distinctly related to particular problems and circumstances of the states involved. Nonetheless, it is apparent that when appropriate political and legislative action is combined with committed professional and community initiatives, meaningful reforms are possible.

Endnotes

1. Comment, Malina Kaulukukui, M.S.W., B.C.D., AMHD Social Worker, AMHD Reorganization Subcommittee Meeting, October 6, 1993.

2. David Mechanic and Richard C. Surles, "Challenges in State Mental Health Policy and Administration," Health Affairs, vol. 11, no. 3, Fall 1992, p. 48.

3. Georgia, Report of the State Commission on Mental Health, Mental Retardation and Substance Abuse Delivery, "A Call for Change: Empowering Consumers, Families and Communities" (hereafter "A Call for Change"), December 1992, p. 3.

4. "Equity" refers to the quality and quantity of resources and services existing across the state.

5. "A Call for Change," p. 7.

6. Ibid., p. 5.

7. Ibid., pp. 17-20.

8. House Bill 100, amending chapter 3, title 31, Official Code of Georgia Annotated, 1993.

9. Ibid., pp. 3-4.

10. Georgia, Briefing Paper, Transition Implementation Unit, "A New Way of Doing Business in Georgia; Reforming Mental Health, Mental Retardation and Substance Abuse Services," October 12, 1993, p. 5.

11. Ibid., p. 6.

12. Telephone interview with Lawrence Walker, Acting Co-Director for Mental Health Services, Division of Mental Health, Mental Retardation and Substance Abuse, Georgia Department of Human Resources, October 7, 1993.

13. Ibid.

14. Washington Mental Health Reform Act of 1989, 2SSB 5400, 1989.

15. E. Fuller Torrey, M.D., Karen Erdman, Sidney M. Wolfe, M.D., Laurie M. Flynn, Care of the Seriously Mentally Ill; A Rating of State Programs (hereafter "Torrey, M.D., et al., "Care of the Seriously Mentally Ill - 1990), (Washington, D.C.: Public Citizen Health Research Group and the National Alliance for the Mentally Ill, 1990), p. 120.

16. Lewayne Gilchrist, Ph.D., and David Allen, Ph.D., "A Proposal for an Evaluation of the Impact of SSB5400 on Mental Health Consumers," submitted to the Legislative Budget Committee, Washington State, Draft: November 1991, p. I-1.

17. Ibid.

18. Washington (state) Legislature, Legislative Budget Committee, Mental Health Evaluation Working Paper, Preliminary Report, November 20, 1992, p. vi.

19. Ibid., see also, RCW section 71.05 [Washington's Involuntary Treatment Act].

20. Washington (state), Mental Health Evaluation Working Paper, pp. 6-11.

21. Ibid., p. vii.

22. Ibid., pp. 107-111.

23. Ibid., p. 111.

24. E. Fuller Torrey, M.D. and Sidney M. Wolfe, M.D., Care of the Seriously Mentally Ill; A Rating of State Programs (Washington D.C.: Public Citizen Health Research Group, 1986), p. 59.

25. Torrey, et al., Care of the Seriously Mentally Ill - 1990, p. 120.

26. Gail K. Robinson, Ph.D., "Journal to Passage: The Ohio Mental Health Act," Mental Health Policy Resource Center, U.S. Department of Health and Human Service, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, February, 1991, p. 5.

27. Gail K. Robinson, Ph.D., "Changing the System: The Ohio Experience," Policy in Perspective, Mental Health Policy Resource Center, March, 1991, pp. 3-5.

28. Michael F. Hogan, "New Futures for Mental Health Care: The Case of Ohio," Health Affairs, vol. 11, no. 3, Fall 1992, vol. 11, no. 3, p. 72, citing, Ohio Department of Mental Health, Annual Report (Columbus, Ohio: ODMH, 1987).

29. Ibid., p. 73.

30. Kathryn Haller, "Analysis of Amended Substitute Senate Bill 156," Mental Health Policy Resource Center, 1991, pp. 79-91.

31. If a dispute arises regarding the content of the plan, there is a mediation to assist in resolving that dispute.

32. Hogan, p. 77.

33. Maine, Final Report to the State of Maine Systems Assessment Commission, "Mental Health Systems Reform in Selected States," January, 1991, p. 28.

34. Due to its weak children's services, New Hampshire's overall rating in the Torrey study was a tie for second place.

35. E. Fuller Torrey, M.D., et al., Care of the Seriously Mentally Ill - 1990, p. 58.

36. New Hampshire, Office of Legislative Budget Assistant, Mental Health Services System, Performance Audit, 1990, (hereafter "New Hampshire Performance Audit"), p. 2.

37. New Hampshire Revised Statutes Annotated (RSA), section 135-C:1.

38. Ibid.

39. Non-contracted services receive no funding from the Division of Mental Health and Developmental Services, although they may receive funds from other state agencies.

40. New Hampshire Performance Audit, p. 3.

41. Ibid., p. 61.

42. Maine Final Report, p. 64.

43. E. Fulller Torrey, M.D., et al., Care of the Seriously Mentally Ill - 1990, pp. 70-73.

44. Ibid., p. 42.

45. Colorado, Report of the State Auditor, Division of Mental Health Performance Audit, May 1991, p. 12.

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47. Ibid.

48. Ibid., p. 4.

49. The corporation was created under section 501(c)3 of the Internal Revenue Code.

50. Mental Health Corporation of Denver, informational sheet, July 21, 1993, p. 2.

51. Telephone interview with Skip Hibbard, Assistant City Attorney, Denver, Colorado, October 29, 1993.

52. Miles F. Shore and Martin D. Cohen, "Grant Watch: Observations from the Program on Chronic Mental Illness," Health Affairs, vol. 11, no. 3, Fall 1992, p. 230.

53. Ibid.

54. Hibbard interview.

55. Howard H. Goldman, Joseph P. Morrissey, M. Susan Ridgely, Richard G. Frank, Sandra J. Newman, and Cille Kennedy, "Lessons from the Program on Chronic Mental Illness," Health Affairs, vol. 11, no. 3, Fall 1992, p. 58.

56. Telephone interview with Howard H. Goldman, M.D., Ph.D., October 29, 1993.

57. Hawaii, Neal Mazer, M.D., M.P.H., and Mark J. O'Donnell, M.P.H., The Future of the Child and Adolescent Mental Health System in Hawai'i, written in response to S.C. R. No. 123 and H.C.R. No. 245, 1992.

58. Torrey, et al., M.D., Karen Erdman, Sidney M. Wolfe, M.D., Laurie M. Flynn, The Rating of State Programs for People with Mental Illness, Published by Public Citizen Health Research Group and the National Alliance for the Mentally Ill, 1990 Edition, p. 132.

59. Daniel J. Jordan, Ph.D., and Mario Hernandez, "The Ventura Planning Model: A Proposal for Mental Health Reform," The Journal of Mental Health Administration, vol 17, no. 7, Spring, 1990, pp. 28-31.

60. Mazer and O'Donnell, p. 32.

61. "Developing Community-Based Systems of Care," Family Matters, Mental Health Services Program for Youth, National Program of the Robert Wood Johnson Foundation (hereafter "Family Matters"), Fall, 1991, p. 1.

62. These sites are in California, Kentucky, North Carolina, Ohio, Oregon, Pennsylvania, Vermont and Wisconsin.

63. Family Matters, p. 3.

64. Mary Jane England, M.D., and Robert F. Cole, Ph.D., "Building Systems of Care for Youth with Serious Mental Illness," Hospital and Community Psychiatry, vol. 43, no. 6, June 1992, pp. 630-631.

65. Ibid., p. 633.

66. Family Matters, p. 3.

67. England and Cole, p. 633.

68. Family Matters, p. 3.

69. Ibid.

70. England and Cole, p. 633.

71. Family Matters, p. 4.

72. Telephone interview with Charles Morimoto, Assistant Director, San Francisco, "Family Mosaic" project, October 22, 1993.

73. Family Matters, pp. 4-5.

74. Ibid., pp. 10-11.

75. Telephone interview with Robert F. Cole, Ph.D., Deputy Director, Mental Health Services Program for Youth at the Washington Business Group on Health, October 9, 1993.

Chapter 8

PUBLIC AUTHORITIES/CORPORATIONS: CONSIDERATIONS

Senate Resolution No. 137, S.D. 1, asks the Legislative Reference Bureau to consider the formation of a public corporation or public mental health authority as a means of "providing increased operational autonomy while maintaining accountability for fiscal decisions and quality of services."

This chapter first discusses the basic organization and design of public corporations or public authorities[1] and their relationship to state government. Second, it includes brief descriptions of several authorities and corporations which presently exist in Hawaii, including the Aloha Tower Development Corporation, Hawaii Housing Authority, the Research Corporation of the University of Hawaii and the Hawaii Housing Finance and Development Corporation. Third, it describes the experience of the state Department of Health Division of Community Hospitals' effort to form an autonomous authority to operate the community hospitals. Finally, it discusses the organizational structure of Wai'anae Coast Community Mental Health Center, Inc. -- the only private community mental health center presently operating in Hawaii.

As noted in Chapter 6, the fundamental premise of the Robert Wood Johnson Program for the Chronically Mentally Ill was that that each major urban region should have a unified mental health authority with "combined administrative, fiscal and service responsibility."[2]

In order to assist cities to develop proposals to be considered for funding by this Robert Wood Johnson Foundation Program, the Institute of Public Administration published a report[3] setting out the organizational framework of a mental health "public authority." In this report, a "public authority" is defined as a non-stock government corporation, established by state statute (or municipal ordinance) under state enabling legislation, with legal powers and legal personality separate from that of its sponsoring government and without the power to tax.[4] The Institute of Public Administration report presents basic considerations concerning organizational alternatives, management structure and typical dimensions for oversight for public mental health authorities. Some central conclusions from the report are presented below.[5]

The usefulness of any organizational form varies with the functions it is to serve, the way in which it is led and operated, and its economic and political environment. To assess the public authority's usefulness and how it should be designed, one must make some decisions about what powers and activities would be assigned to it, the characteristics of the services it will provide, the patterns of financing, and the distribution of political, legal and economic support on which it will depend. Therefore, consideration must begin with the aims and conditions of reorganization of mental health services.

Organizational Alternatives

The common denominator for reorganization of mental health services is one organization which is the primary point of contact, information, assignment, monitoring, and evaluation for each client case. Among other things, it must be able to interact with state and private agencies and be able to assure provision of, and to monitor, crisis services, hospital care, clinic and outpatient services, residential treatment, and special housing.

A mental health authority might be designed to have a broad range of financial capabilities, including: use of federal and state grants-in-aid and appropriations; receipt and processing of medicare, medicaid and private insurance payments for patient care; participation in guaranteed loans and mortgage pools; issuance of tax-exempt bonds; lease rental and contract payments from the State; and receipt of tax-exempt gifts.

The intimate mix of private and public financial forces that are involved means that effective methods of audit and of assuring public accountability are crucial. This should remain a state responsibility.

Public authorities differ from line agencies of the executive branch of government in the following ways:

- They have separate legal identity (corporate personality) for purposes of revenue retention, contracting, property ownership, financial obligations and litigation;

- They may be (depending upon statutory law) exempt from many of the administrative procedures and regulations that apply to line agencies, such as civil service and other personnel regulations, procurement and other administrative procedures, rules and controls by central executive staff agencies;

- Their powers and structure can usually be changed only by statutory amendment (not by executive order), and such changes may be limited by legal covenants entered into by the corporation for borrowing and other contracts;

- They are generally permitted business-type budgets without line item or expenditure period limitations, and may be permitted to retain their own earnings, rather than channeling them through treasury and appropriations processes;

- They usually have independent borrowing capacities and credit ratings.

Because they are independent legal entities, authorities act almost as if they are not "governmental" at all, and that is a concern. Defenders of the authority concept argue that they must have independence and flexibility to act in a "business-like" fashion, to finance, construct and often operate revenue- producing public enterprises.

Organization and Management of Authorities

The Board of Directors

Most public authorities are headed by boards of directors modeled after private sector boards. But unlike directors of a private firm, they do not answer to stockholders, and the company cannot be controlled through stock transactions.

Directors generally do not receive full-time pay but are entitled to costs and allowances for attending meetings and for other work on authority business. They are generally appointed for fixed and staggered terms. They are often reappointed and stay in office for longer periods of time than the elected officials who selected them.

Most authority directors are private persons not otherwise in government service. However, the board may be used to institutionalize intergovernmental and interfunctional coordination. For example, the mental health authority may be partially appointed by a governor and partially by a county executive, or include appointees of several municipalities in an urban region. In addition, several such appointments can be specified to be reserved for persons with professional qualifications or representatives of particular community groups or client constituencies. The design of such a board becomes part of the negotiations central to organizing powers.

Another alternative is to include *ex officio* appointments to the board; for example, social service officials, or housing and mental health commissioners might be named members of the board. But if one office or agency (e.g. the BHA or its divisions) is to be the main focus of oversight over the authority there is some experience to suggest that it should not be represented on the board. Effective oversight requires objective review from outside the organization, something not always compatible with an active role on the board.

Top Managers

Internally, the top managers of a public authority function much the same as private sector counterparts -- if and only if the corporation has been exempted from government budget, personnel and procurement systems, has not inherited labor contracts and civil service rules from a government forerunner, and is not subject to specific decision interventions by state mental health division elected officials. Top managers of public

authorities, then, may have as much control over operations as private sector managers, but without the involvement of the performance pressure put on the private sector manager by stock values and a board concerned with them. Quality of management is crucial in public authorities, and some type of performance/program audit should be required to stimulate it. Appointment of the chief operating officer or executive director by the board is the rule. Once appointed, the manager needs support -- but he or she should be permitted to manage freely and be held accountable for results.

Relationships with Government

Public authorities are independent governmental entities only in comparison with divisions, departments and agencies of the regular government bureaucracy. Public authorities -- by definition -- are subsidiaries of government, and are increasingly being treated that way. This treatment has paralleled the growth of public authorities in traditional government, as opposed to commercial activities. "Generally Accepted Accounting Principles," promulgated by the National Council of Government Accounting, require that "parent" governments include, in their financial reporting, data on all of their governmental subsidiaries.

The greatest challenge of drafting public authority charters is to build in effective oversight, performance incentives, and opportunities for state government financial and policy planning and influence, without undermining the management effectiveness of the corporation. Good oversight allows government to develop priorities on allocation of financial resources and basic public policies, including those service areas in which operational responsibilities are delegated to separate organizations. Good oversight promotes management skill, decentralized, task-oriented organization, accountability to customer and public, employee support and motivation. To do this, managers must be given management freedom with risk. Performance reviews are necessary but government should resist the temptation to substitute detailed administrative controls for effective oversight.

Typical dimensions of oversight for public authorities are:

1. Information gathering and distribution. Some parent governments have begun to gather and organize data on the operations of their corporate subsidiaries. Some data may be used to trigger intra-governmental financial or management audits. Reporting requirements and procedures for analyzing the information should be spelled out in charter legislation.

2. Powers to appoint and replace directors. Powers of appointment and dismissal represent in most cases the primary means of effective government oversight of authority operations. Those who exercise such oversight are increasingly careful about the impacts of such interventions. Dismissal is difficult and

controversial. More effective is designation of staff units to monitor authority operations, and alert government officials or departments of impending authority problems and to define directors' responsibilities in such a way as to make them responsive to program audits.

3. Laws regarding the duties of directors. The directors of every public authority are affected by laws covering the liability, indemnification, and exoneration of authority executives. In many states, for example, the liability of authority directors for decisions made "in good faith" has been legislated away. This is done in order to attract capable people to authority boards. However, other states have laws that make the liability of authority directors conform to "duty of care" provisions found in business codes. In other words, authority directors can be found guilty of "mismanagement," and liable for damages, if they do not maintain a reasonably careful awareness of their organization's operations -- no matter how much good faith was involved. Such directors may still be indemnified against personal financial loss resulting from such judgments. The point of the law is not to punish after mismanagement occurs, but to provide extra motivation for directors to perform responsibly. The possibility of being held liable for reasonable management capability usually suffices to keep directors well informed.

4. Special laws regarding business plans, open hearings, etc. Some parent governments have passed special laws to force authorities to draw up investment plans or "business plans," as a source of information about what the future course of the authority's operations may be. Provisions may be added to have such plans approved by the regular government chief executive, or planning office. Laws may require that such plans be discussed in open public meetings, or that they be signed and approved by each member of the authority's board of directors.

5. Relationships with government staff agencies. Many parent governments have regulations about regular intra-governmental audits of authorities, the policies and procedures used by authorities in investing surplus funds, financial reporting and budgeting formats, and the regular provision by authorities of financial and administrative data concerning their operations. Some parent governments have created special agencies to monitor or participate in the management of troubled authorities, and other agencies to review authority borrowing proposals. Many states and cities have set up special authorities to divide up the capital financing, construction, and ongoing management of particular kinds of governmental activities (health care, housing, etc.). In some instances, special units in the budget office review authority budgets and summarize them in executive budget documents.

6. Line departments, such as a mental health or social services department, may be designated as the major focus of oversight, with clearly defined standard setting and review responsibilities. Indeed, authorities can be administratively located within a department. Departmental review and coordination can only be effective, however, if it is based upon mutually agreed on program plans and standards. Without these, it can deteriorate into nit-picking.

7. The legislature, with its powers of investigation, hearing and legislative amendment, in addition to powers of appropriation of subsidies, has the ultimate oversight responsibility, but usually lacks information. Reporting and staffing mechanisms to overcome this weakness are needed.

Some Existing Authorities and Corporations in Hawaii

Aloha Tower Development Corporation

In 1981, the Legislature established the Aloha Tower Development Corporation, a public body corporate and politic and public instrumentality of the State, for the purpose of undertaking the redevelopment of the Aloha Tower. The corporation is placed within the Department of Business, Economic Development, and Tourism for administrative purposes and has a board of directors of seven voting and several ex officio voting members.[6]

Research Corporation of the University of Hawaii

In 1965, The Hawaii Legislature established the Research Corporation of the University of Hawaii.[7] This public corporation is part of the University of Hawaii for administrative purposes. The corporation is run by a nine member board of directors.

In order to promote cooperative research projects with private firms or persons, the Research Corporation is granted flexibility in hiring its personnel and in handling and disbursing moneys by being excepted from the state laws relating to special fund reimbursements to the state general fund, advertising for bids and purchases to be made in Hawaii whenever public moneys are expended, civil service, compensation, and public employment.[8]

The board of directors appoints an executive director and other employees who administer the affairs of the research corporation. It sets the employees' duties, responsibilities, salaries, holidays, vacations, leaves, hours of work, and working conditions, and benefits. Employees of the Research Corporation are not entitled to any benefits conferred under chapters 76 relating to civil service, 77 relating to compensation, 78 to 83

relating to public employment; and 88 relating to pension and retirement system for state and county employees, *Hawaii Revised Statutes*.[9]

Hawaii Housing Authority

The Hawaii Housing Authority, a public corporation with perpetual existence, is placed within the Department of Human Services for administrative purposes.[10] The Authority consists of eight members of whom six are public members appointed by the Governor. Not more than three of the public members may be members of the same political party. Two of the public members are appointed at large; the remaining public members are appointed from each of the counties of Honolulu, Hawaii, Maui, and Kauai. The Director of Human Services and the special assistant for Housing are ex-officio voting members.[11]

The Authority also employs, not subject to chapters 76, 77, and 89 and section 26-35(4), *Hawaii Revised Statutes*, an executive director, whose salary is statutorily set. The Authority employs, subject to chapters 76 and 77, various technical experts and officers, agents, and employees, permanent and temporary. When, in the determination of the Authority, services to be performed are unique and essential to the execution of the functions of the Authority, it may hire persons on a contractual basis not subject to chapters 76, 77, and 78; provided that no individual contract shall be for a period longer than two years per term. The Authority may call upon the Attorney General for such legal services as it may require or may employ its own counsel and legal staff. The Authority may delegate to one or more of its agents or employees such powers or duties as it deems proper.[12]

Housing Finance and Development Corporation

In 1987, the Legislature established the Housing Finance and Development Corporation, a public corporation with perpetual existence, which is now placed within the Department of Budget and Finance for administrative purposes.[13]

The rationale for creating this corporation was expressed by the Legislature as follows:[14]

> . . .[T]he problem of providing reasonably priced housing in Hawaii is so complex that existing institutions cannot solve it without a comprehensive overview and direction. The legislature has determined that the problem must be solved for the general well-being of the State and that the legislature has the duty to provide the overview and the direction.

The Corporation is headed by a board of directors consisting of nine members, of whom six are public members appointed by the governor. Two public members are appointed at large; the remaining public members are appointed from each of the counties of Honolulu,

Hawaii, Maui, and Kauai. The Director of Finance, the Director of Business, Economic Development, and Tourism, or their designated representatives, and the Special Assistant for Housing are ex officio voting members.[15]

The Corporation employs, not subject to chapters 76 and 77, an executive director. The Corporation may employ, subject to chapters 76 and 77, technical experts and officers, agents, and employees as required. The Corporation may also employ persons on a contractual basis not subject to chapters 76, 77, and 78 when in the determination of the Corporation the services to be performed are unique and essential to the execution of the functions of the Corporation, provided that no individual contract shall be for a period longer than two years per term. The Corporation may call upon the Attorney General for such legal services as it may require, or it may employ its own counsel and legal staff. The Corporation may delegate to one or more of its agents or employees such powers and duties as it deems proper.[16]

The Division of Community Hospitals, Department of Health

According to Senate Resolution No. 137, S.D. 1, "the plight of Hawaii's mental health service delivery system is similar to that of the community hospitals in that both attempt to deliver flexible, individualized, client-centered health care services to the general public while being hampered by ponderous, government fiscal controls and personnel and administrative policies." The community hospitals, which are administered by the Department of Health Division of Community Hospitals, are closely analogous to the community mental health centers administered by the Behavioral Health Administration.

Historically, the Division of Community Hospitals has experienced many of the same types of problems as those experienced by the BHA and described elsewhere in this report. In response to those problems, in 1992 the Auditor recommended that the governance of the community hospitals be carried out through a community hospitals public corporation attached to the Department of Health. Because of the similarity between the community hospitals and the community mental health centers, it is instructive to examine the history leading up to this recommendation by the Auditor.[17]

As long ago as 1986, the Department of Health has considered various possibilities for restructuring its community hospitals division.[18] In 1990, the Legislature enacted a pilot project to foster "autonomous operation"[19] of two of Hawaii's public hospitals -- Maui Memorial Hospital and Hilo Hospital. The Department of Health and other state agencies were directed to "initiate basic restructuring to foster hospital involvement and accountability in a pilot project to minimize administrative 'red tape', and encourage local health care

professional participation in service decision-making at the hospital level" involving those directly providing health care service structure.[20]

The rationale for this legislation was expressed by the Legislature[21] as follows:

> The legislature finds that efforts must be made to expedite and improve the delivery of health care services provided by Hawaii's public hospital system. Changes in the way the State's public hospital system is operated and managed, and the restructuring of the system to allow for more health care decision-making at the hospital level involving those directly providing health care services, will improve hospital accountability.

In 1992, the original pilot project was amended to include Kona Hospital and extended until 1993.[22]

In 1993, the Legislature again expanded the pilot project to include the one remaining acute care hospital and the four long-term care hospitals and extended the project for three additional years.[23] In doing so, the Legislature noted that "the pilot project to foster autonomous operation of Maui Memorial Hospital, Hilo Hospital, and Kona Hospital has contributed effectively to expediting and improving the delivery of health care services by Hawaii's public hospital system." The legislation also provides as follows:[24]

> In order to achieve the benefits of a decentralized and relatively unencumbered autonomous operation, the hospitals. . .shall be granted flexibility in the hiring of personnel and the collection and disbursement of funds by being exempt from sections 103-22 and 103-41 through 103-48, Hawaii Revised Statutes, relating to advertising for bids and purchases to be made in Hawaii whenever public moneys are expended for the duration of the pilot project.

In January, 1992, the Hawaii State Auditor conducted a management and financial study of the Division of Community Hospitals. The Auditor assessed the division's administrative structure, policies and procedures in the areas of financial management, personnel, program planning and budget planning, and concluded:[25]

(1) State laws and policies on budgeting and expenditures create financial problems. For the community hospitals, they have resulted in unrealistic budgets, cash flow problems, deficits, and poor financial management.

(2) State policies and practices on procuring and paying vendors are not suited to the community hospitals. They have resulted in delays that threaten hospital services.

(3) Many state policies and practices on personnel are not appropriate for community hospitals. They hamper timely recruitment and hiring of appropriately trained personnel.

The Auditor recommended that the Division of Community Hospitals create another form of governance for the community hospitals and proposed that the Legislature establish a community hospitals public corporation attached to the Department of Health.[26]

In 1992, a bill calling for "a total restructuring of the way community hospitals located in the counties of Hawaii and Maui are managed that ultimately result in the governance, operation, and management of these hospitals by nonprofit corporations"[27] was proposed, but did not pass. Similar legislation was proposed during the 1993 regular legislative session; this legislation also failed to pass.[28] It is expected that similar legislation will again be proposed as an administration bill by the Department of Health in the 1994 regular session.[29]

Wai'anae Coast Community Mental Health Center, Inc. a Private, Community-Based Mental Health Center

During the 1970s, the residents of the Wai'anae Coast became increasingly concerned about health and mental health care, and in 1972, a community board was established by Wai'anae residents, who planned, secured funding, and created a community-based, comprehensive health care center in Wai'anae. One of the critical elements to the success of the mission was the "community ownership" of both the creation and the implementation of this project. In a soon-to-be published chapter in a book, the "community ownership" involved is described as follows:[30]

> Community ownership is a well established principle in the Wai'anae community. In 1971, when the Wai'anae Coast Comprehensive Health and Hospital Board was formed to plan and build a primary health care clinic in Wai'anae, both the planning Board and eventually the operating Board were composed entirely of Wai'anae Coast residents with a majority being non-professional. The community-based Board had the authority to hire the initial planning staff and later, the medical staff. The design of the Health Center was offered to the community at large for its approval and hundreds of residents met in multiple community meetings to provide input. Policies and decisions, such as which medical services to provide, whether to have night clinic hours, etc. were voted on by the community residents. The highly participatory nature of Wai'anae's community-based planning tradition, flowed over into activities to renovate the community's mental health services and programs.

Several events sparked the establishment of Hawaii's first private mental health center. First, there was a strong community sentiment that the existing mental health services being provided in Wai'anae were inadequate and culturally inappropriate.[31] This consensus resulted in a decision by the Wai'anae Human Services Interagency Council, a coalition of state and private human service agencies, to request the Governor to either close the existing mental health clinic or permit the community to establish a new, culturally based, community-directed clinic.[32] Also, the State's Mental Health Division chief urged the State to privatize its mental health services.[33] Finally, the University of Hawaii Medical School's Department of Psychiatry needed community-based training site rotations for its psychiatric

residents. Since the Hawaii State Hospital was unaccredited, it seemed that a mutually beneficial partnership opportunity could be provided through the University's involvement with a clinic which would focus on interdisciplinary teamwork and culturally sensitive psychiatric practice.[34]

In 1986, the Wai'anae Coast Community Mental Health Center, Inc. was officially established. Presently, the center is run by a board of directors who appoint an executive director. The center receives reimbursement for services it provides from private and public health insurance programs. Unlike the other CMHCs, Wai'anae has "immense flexibility in hiring."[35] Employees can be hired and fired without the involvement of state personnel offices or civil service requirements.

While it is unclear whether the Waianae Coast Community Mental Health Center can or should serve as a model for all community mental health centers in Hawaii, the apparent success of this center does provide strong evidence that some form of privatization may well be the answer to the problems facing the present system.

Endnotes

1. The terms "public authority" and "public corporation" are essentially synonymous. A "public corporation" is defined as "an instrumentality created by the state, formed and owned in the public interest, supported in whole or part by public funds and governed by those who derive their authority from the state. 18 Am Jur2d Corporations, §30, p. 823.

2. Under the terms of the program, applicants must "present a plan to implement a community-wide mental health authority with operational and budgetary control for publicly financed mental health services within two years of the grant award."

3. Annmarie Hauck Walsh and James Leigland, "Public Authorities for Mental Health Programs," Institute of Public Administration, Division of Biometry and Applied Sciences, National Institute of Mental Health, 1986.

4. Generally, public authorities are also authorized to issue revenue bonds, on which the interest paid to investors is exempt from federal and other income taxes.

5. The material which follows is excerpted (near verbatim) and condensed from Annmarie Hauck Walsh and James Leigland, "Public Authorities for Mental Health Programs", Institute of Public Administration, Division of Biometry and Applied Sciences, National Institute of Mental Health, 1986.

6. Hawaii Rev. Stat., §206J-4.

7. Hawaii Rev. Stat., c. 307.

8. Hawaii Rev. Stat., §307-4; see also, Hawaii, Marion M. Higa, "Audit of the Research Corporation of the University of Hawaii, A Report to the Governor and the Legislature," Report No. 93-10, October 1993, finding that the Research Corporation of the University of Hawaii is "an independent organization that operates with little accountability and oversight by either the university or its Board of Directors."

9. Hawaii Rev. Stat., §307-5.

10. Hawaii Rev. Stat., §356-1.

11. Hawaii Rev. Stat., §356-5.

12. Ibid.

13. Hawaii Rev. Stat., c. 201E.

14. Hawaii Rev. Stat., §201E-1.

15. Hawaii Rev. Stat., §201E-3.

16. Ibid.

17. The Division of Community Hospitals consists of a central office located in Honolulu and thirteen medical facilities located primarily on the neighbor islands.

18. See e.g. Herman Smith Associates, Recommendations Concerning Restructuring of the Hawaii County/State Hospital System to Department of Health, County/State Hospitals Division, Honolulu Hawaii, November 1986.

19. For purposes of the Act, the term "autonomous operation" means a "method of hospital management that decentralizes health care decision-making and fosters local health care professional participation at the hospital level.

20. 1990 Haw. Sess. Laws, Act 223.

21. Ibid.

22. 1992 Haw. Sess. Laws, Act 187.

23. 1993 Haw. Sess. Laws, Act 211.

24. Ibid.

25. Hawaii, Marion M. Higa, Acting State Auditor, "Study of the Division of Community Hospitals", A Report to the Governor and the Legislature, Report No. 92-6, January, 1992, p. 13.

26. Ibid., p. 29.

27. House Bill No. 3801, H.D. 2, Sixteenth Legislature, Regular Session of 1992, State of Hawaii.

28. House Bill No. 766 and House Bill No. 1496, Seventeenth Legislature, Regular Session of 1993, State of Hawaii.

29. Telephone interview with Lori Higa, Community Hospitals Administrator, November 12, 1993, referring to administrative bills HTH-4 (1994) and HTH-19 (1994) proposed for introduction during 1994 Regular Session.

30. Susan Meyers Chandler, D.S.W. and Stephanie Bell, M.S.W., "Wai'anae, Hawaii: A Culturally Sensitive Model of Mental Health Care in an Ethnically Diverse, Rural Community," Implementing Change for Community Care for Persons with Severe Mental Illness, eds. Rockwell Schulz and James Greenley (expected publication date: 1994).

31. Ibid.

32. Ibid.

33. Ibid.

34. Ibid.

35. Interview with Billie Hauge, Executive Director, Wai'anae Coast Community Mental Health Center, Inc., November 12, 1993.

Chapter 9

BASIC CHARACTERISTICS OF EFFECTIVE PUBLIC MENTAL HEALTH SYSTEMS; FOUR FUNDAMENTAL PRINCIPLES

As previously discussed in Chapter 7, the mental health systems of other states vary widely in their approaches to governance. The various states' approaches reflect strategies and organizations which are appropriate within their own political, economic, and social or cultural contexts.[1] Clearly, it would not be possible or prudent to simply superimpose any of the systems described in previous chapters upon Hawaii. This is reflected in the previously noted comment by a mental health consultant that "once you've seen one state, you've seen one state."[2]

However, when the mental health systems of those states recognized as effective in this area are examined, certain fundamental principles of effective governance become apparent. The recurrence of these principles suggests fundamental "paradigms" of successful systems.

In this chapter, the four principle characteristics of successful implementation and operation of public mental health systems are identified and discussed. Whatever the specific structure to be developed in Hawaii, the success of that structure will clearly depend upon the realization of these principles.

Fundamental Principle #1: The Functions of Policy-making and Monitoring Must be Separated from the Direct Provision of Services

> The job of government is to steer, not to row the boat. Delivering services is rowing, and government is not very good at rowing.
>
> -- E.S. Savaas, cited in Reinventing Government[3]

Comprehensive and effective policy-making and planning of mental health services requires detachment from direct management responsibility. In recognition of this principle, a New York State Commission concluded over eight years ago that "[t]he local [mental health] management cannot be a direct service provider, but must be accountable solely for system management. . .the local management function [should] be organizationally separated from that of direct service delivery."[4] Similarly, one of the fundamental precepts shaping Georgia's recent mental health reform process is that service planning, coordinating and contracting must be separated from the function of service delivery.[5]

There are many reasons for separating needs assessment, policy-making, planning, and monitoring mental health services from the direct provision of those services. First, as

Georgia as well as other states have recognized, segregating these functions eliminates the inherent conflict of interest which exists when the same organization both coordinates, provides and monitors mental health services. For instance, as noted in the report of the Georgia State Commission on Mental Health, Mental Retardation, and Substance Abuse Service Delivery, "it is difficult for case managers to zealously advocate for their client when they are co-workers with service providers."[6]

Second, when these functions are separated, government has the time and resources to operate as a "skillful buyer, leveraging the various producers in ways that will accomplish its policy objectives."[7]

Third, separating these functions provides policy managers with maximum flexibility to respond to changing circumstances, and enables them to hold service providers accountable for quality performance.[8]

Finally, separating these functions provides government with the time and energy to be proactive as opposed to reactive. As Osborne and Gaebler note in *Reinventing Government*:[9]

> [O]rganizations that focus their best energies on rowing rarely do much steering. They develop tunnel vision. Because they are programmed to think of government as service delivery by professionals and bureaucrats, they wait until a problem becomes a crisis. . .

Fundamental Principle #2: The System Must Provide Decentralized, Community-based Control

Virtually every state has struggled with whether administration of public mental health services should be centralized or decentralized. The tension between these competing modes of organization is reflected in an Indiana report which notes that while "there is the need for a service system that is more flexible and capable of responding to local, individualized, specific needs" there is also "a need for economies of scale that can pool resources to achieve greater efficiency."[10]

Nonetheless, most states have resolved this question in favor of decentralization. This apparently reflects recognition of the fact, noted by the Maine Systems Assessment Commission, that when decision- and policy-making are removed from local control and design, it results in "stigma, loss of community participation and involvement, and excessive reliance on the state. . . .The state must reduce its centralized control over community-based programs and foster a locally controlled and designed mental health system, while fulfilling its responsibilities in quality assurance, public information, funding public programs. . ."[11]

In Vermont (widely viewed as one of the best mental health systems in the country), the state mental health division determines the outcomes it desires and encourages the

CMHCs, the state hospitals and the constituents to "creatively" determine what actions are necessary to achieve the outcome.[12]

Recent reforms in Georgia, Washington and Ohio, have been premised on an understanding that local communities are in the best position to know their own problems and to develop solutions for those problems. As discussed in Chapter 7, each of these states have recently enacted legislation designed to empower local communities with decision making and resource allocation authority.

The effect of these changes has been mental health systems which are intended to be far more flexible, effective, innovative, and to generate higher morale, commitment, and productivity.[13]

The importance of decentralization has also been recognized by the Robert Wood Johnson Foundation, when it structured its program on Chronic Mental Illness, as described as follows:[14]

> The idea behind the establishment of local mental health authorities (LMHAs) is to have a single local public authority that has responsibility for the clinical, administrative and financial aspects of public mental health care. Such an organizational structure involves state government delegating a great deal of managerial responsibility for mental health care to localities. Delegation of authority to LMHAs has been posited to reduce fragmentation of services for the severely mentally ill and increase flexibility for local mental health authorities in their use of public monies for the delivery of mental health services. This puts the budget for local mental health care in "one set of hands." The hope is that this arrangement should avoid the cost-shifting, bureaucratic duplication, and transaction costs associated with the current "fragmented" mental health system. At the same time that LMHAs increase local control and responsibility, they decrease the state's control and responsibility. Thus, states who choose more decentralized systems must simultaneously choose regulatory and financing mechanisms which will lead localities to maintain adequate and cost-effective services for the mentally ill.

Fundamental Principle #3: The Service Delivery Structure Must Promote Competition Between Service Providers

> [I]f the customers do not have a choice of providers. . . [t]he providers are in the driver's seat, and customers can only hope they drive where the customer wants to go.
>
> -- David Osborne and Ted Gaebler[15]

In considering how to design a system allowing consumers and families greater choice among service providers and the types of services they receive, Georgia's Commission on Mental Health noted:[16]

> . . .The current system is one in which monopolies predominate. Thus it is difficult for consumers and families to have a choice of providers and a choice in the types of services which are provided. . . .Over the past several years, there has been a

> shift in assumptions about the roles and responsibilities of people with disabilities. A person with a disability was once viewed as someone who must always be on the receiving end and who could not be trusted to make choices and decisions. The new assumption says: A person with a disability is someone who has the right to define his or her own needs, to have opportunities for growth and determination, and to define his or her own quality of life.
>
> . . .If there is only one provider of service available, and a limited number of service options, there is little opportunity for choice. Individual service plans should identify services and supports needed to translate consumer and family preferences into real opportunities for independence and productivity.

In *Reinventing Government*, Osborne and Gaebler assert that "customer-driven systems require head-to-head competition between service providers" since "[i]f there are few competing service providers and new competitors face significant barriers to entry, customers will encounter the problems of monopoly."[17] Competition between service providers does not necessarily require that those providers be private. Osborne and Gaebler note that in Arizona, public agencies and private service providers compete for service contracts in certain areas. This competition has encouraged greater efficiency among prospective service providers, both public and private:[18]

> The important distinction is not public versus private, it is monopoly versus competition: "where there's competition, you get better results, more cost-consciousness, and superior service delivery."

Clearly, competition between service providers, public and private, is essential if a public mental health system is to operate with maximum effectiveness:[19]

> . . .[W]hen service providers must compete, they keep their costs down, respond quickly to changing demands, and strive mightily to satisfy their customers. No institution welcomes competition. But while most of us would prefer a comfortable monopoly, competition drives us to embrace innovation and strive for excellence.

Fundamental Principle #4: Successful Mental Health Reform will Require Consensus from all Stakeholders in the System

The final principle does not relate to the characteristics of effective mental health systems, but rather to the character of systematic reform. The experience of the states whose public mental health systems have been reformed in recent years makes absolutely clear that effective reforms are not easily or quickly achieved.

If the public mental health system in Hawaii is to be transformed into one in which the three principles of effective systems identified above are realized, that transformation will require much more than legislation. Rather, it will require consensus among all the stakeholders in the system: the BHA staff, unions, professionals, elected officials, recipients of services, mental health advocates, etc. Arriving at this consensus will necessarily require a long-term effort, as all stakeholders must be involved in the "process of change."

In this context, meaningful consensus is not to be confused with "universal agreement." Rather, it implies that all stakeholders in the system have participated meaningfully in the reform process, so that they all have an investment in the system resulting from that process.

This kind of systematic reform clearly requires that all participants in the reform process be committed to meaningful reform of the present system. As one prominent Hawaii mental health advocate noted, "I used to think that the most important step in changing something was to get a bill passed. Now I think that that is maybe the third step in about fifteen steps. The real challenge is implementing the change."[20]

Conclusion

When Hawaii's present public mental health system is assessed objectively, it is clear that the system is not governed by the fundamental principles presented in this chapter. In Hawaii's system, the "steering" and "rowing" functions are not separated, they are combined; decision-making and budgetary authority is largely centralized; and the system does not promote meaningful competition among service providers. The experience of other states, as well as our own history, makes clear that effective reform will require us to come squarely to terms with these realities.

Endnotes

1. David Mechanic and Richard C. Surles, "Challenges in State Mental Health Policy and Administration," Health Affairs, vol. II, no. 3, Fall 1992, p. 48.

2. This remark was made to AMHD Social Worker, Malina Kaulukukui, M.S.W., B.C.D., and repeated at an AMHD Reorganization Subcommittee Meeting, October 6, 1993.

3. David Osborne and Ted Gaebler, Reinventing Government, p. 25, noting also that "[s]teering is very difficult if an organization's best energies and brains are devoted to rowing, ibid., p. 30.

4. The Governor's Select Commission on the Future of the State-Local Mental Health System in New York, p. vii, cited in Annmarie Hauck Walsh and James Leigland, "Public Authorities for Mental Health Programs," Institute of Public Administration, February 1986, p. 5.

5. Georgia, Report of the Georgia State Commission on Mental Health, Mental Retardation, and Substance Abuse Service Delivery, December 1, 1992, p. 20.

6. Ibid., p. 16.

7. Osborne and Gaebler, Reinventing Government, p. 35, citing Ted Kolderie.

8. Ibid.

9. Osborne and Gaebler, Reinventing Government, p. 220.

10. Indiana, Evaluation Audit, Indiana Legislative Services Agency, "Mental Health Needs and Local Service Delivery," September 1991, p. 90.

11. Maine, Final Report of the Maine Systems Assessment Commission, "Mental Health and a Healthy Society: Transforming Maine's Mental Health System by the Year 2000," January 25, 1991, p. 12.

12. Comment, David Goodrick, Ph.D., Hawaii PL 99-660 Implementation Initiative, Conference Proceedings, Honolulu, Hawaii, August 18-20, 1992.

13. Osborne and Gaebler, Reinventing Government, pp. 252-253.

14. Richard G. Frank and Martin Gaynor, "Fiscal Decentralization of Public Mental Health Care and the Robert Wood Johnson Program on Chronic Mental Illness," John Hopkins University, May 1993, pp. 1-2.

15. Osborne and Gaebler, Reinventing Government, p. 180.

16. Report of the State Commission on Mental Health, Mental Retardation, and Substance Abuse Service Delivery, "A Call for Change: Empowering Consumer, Families, and Communities," December 1, 1992, p. 13.

17. Osborne and Gaebler, Reinventing Government, p. 186.

18. Osborne and Gaebler, Reinventing Government, p. 79, citing Phoenix City Auditor Jim Flanagan.

19. Osborne and Gaebler, Reinventing Government, p. 79.

20. Interview with Professor Susan M. Chandler, D.S.W., November 16, 1993.

Chapter 10

FINDINGS AND RECOMMENDATIONS

Senate Resolution No. 137, S.D. 1 (1993), requests the Legislative Reference Bureau to study options for the governance of the State's public mental health service delivery system. Underlying this request is a recognition that the present structure may be inappropriate and inefficient.

The primary focus of this chapter is to summarize the findings of this study and to provide recommendations for changes in the present governance structure.

> . . .[C]entralized bureaucracies designed in the 1930s and 40s simply do not function well in the rapidly changing, information-rich, knowledge-intensive society and economy of the 1990s. They are like luxury ocean liners in an age of supersonic jets: big, cumbersome, expensive and extremely difficult to turn around. . . [Government should strive] to become more innovative and more entrepreneurial.
>
> -- David Osborne and Ted Gaebler[1]

Findings

1. Hawaii's mental health service delivery system has historically been considered "disgraceful" by certain national experts who have ranked it, for three consecutive reporting periods, the worst state in the country for the care of the seriously mentally ill in terms of: (1) the dollars expended per mentally ill person; (2) the number of staff and services available to work with the seriously mentally ill at the community level; and (3) the quality of hospital and other institutional care for the mentally ill.

2. Despite assurances that "a miracle" would escalate Hawaii into the top ten states for mental health care by 1993,[2] it does not appear that this miracle has yet occurred. By all accounts, Hawaii's mental health care system requires significant reform in order for such a "miracle" to occur in the future.

3. As perceived by Department of Health (DOH) Behavioral Health Administration (BHA) "stakeholders," Hawaii's public mental health service delivery system is significantly hindered by state policies and procedures that do not allow mental health services to be provided on a timely and efficient basis. This report identifies fifteen general problems widely perceived as significantly hindering efficient and effective mental health service delivery in Hawaii. These problems, each of which bears directly on different aspects of the governmental, fiscal and administrative components of the system, are as follows:

A. Unified "Steering" and "Rowing" Functions Within the BHA

Mental health policy-making, planning, contracting, coordinating, service providing and monitoring functions are all performed within the BHA. This creates an inherent conflict. The functions of policy-making, planning and monitoring should be separated from the function of service delivery.

B. Ineffectual Accountability

Lines of accountability are confused within the BHA, and many community mental health center (CMHC) staffs feel that they are held accountable for the consequences of decisions even though they lack decision-making and budgetary authority.

C. Insufficient Program Monitoring

Despite the fact that all mental health services provided by or under contract with the DOH are supposed to be monitored and evaluated at least annually, this does not appear to be occurring. Several CMHCs and private service providers report that their programs have not been evaluated by BHA for several years.

D. Inadequate Supervision

Many CMHC questionnaire respondents note that they are provided with inadequate supervision. One possible reason for this is that Adult Mental Health Division (AMHD) and CMHC staff spend a great amount of time handling various crises and have little time or energy to devote to hands-on supervision.

E. Budget Problems and Fiscal Policies

Budget problems and fiscal policies are a great source of frustration for most BHA stakeholders. Their foremost concern is insufficient funds and resources. Also, budgets are viewed as unpredictable, unrealistic and beyond the control of those who must work within them. Finally, the necessary participation of various governmental entities, such as the DOH administrative and personnel offices, and the departments of Personnel Services (DPS), Accounting and General Services (DAGS) and Budget and Finance (B & F) is perceived as intrusive and counter-productive. These problems make long-term planning quite difficult. In addition, the decision-making process is hampered by the necessity for decisions to go through multiple bureaucratic layers for review and approval.

F. Centralized Control

Because of the BHA's highly centralized structure, decision-making substantially occurs in the central offices. This centralized control inhibits the system's ability to deliver services quickly and effectively.

G. Hiring Delays and Budgetary Restrictions

The BHA's budgetary and bureaucratic problems seriously impede effective staffing at the various BHA divisions. Salary levels are often perceived as too low to attract and retain sufficient qualified staff. The bureaucratic "red-tape" required to create and fill needed staff positions leads to significant and sometimes crippling delays.

H. Lack of Coordination

Hawaii's delivery of mental health services is highly fragmented. The responsibility for various mental health services is widely scattered among a variety of governmental and private departments, divisions and agencies, many of whom operate with little or no coordination.

I. Planning Deficiencies

Meaningful planning is lacking at the BHA. Plans and resources tend to go where the pressure is greatest. Priorities are perceived as constantly in flux, depending upon external pressures (e.g. which division is presently engaged in a lawsuit). Consequently, much of the planning is viewed as "not meaningful" and therefore fails to generate genuine commitment by the stakeholders involved.

J. Lack of Continuity in Leadership

With the exception of the Alcohol and Drug Abuse Division, (ADAD), the BHA division chiefs have frequently changed over the years. The AMHD has changed chiefs four times within the past six years and there have been seven Child and Adolescent Mental Health Division (CAMHD) chiefs over the past six years. This turnover has caused significant change in the operational priorities within the divisions, leading to frustration among the staff.

K. Managerial Problems

Within the AMHD, the two most common "managerial" problems are: (1) a perception of secrecy, and (2) poor communication within the central office and between the central office and the CMHCs. These problems may arise, in part,

because management is simply too busy responding to the daily pressures of the job to engage in time-consuming "management by consensus." Further, there are presently no intermediate levels of management within the Division.

L. Poor Data Management

Because of limited data processing capabilities, staff at AMHD and the CMHCs spend inordinate amounts of time and energy handling raw data. This causes low efficiency and high frustration.

M. Inefficient Organizational Infrastructure

AMHD's present infrastructure is chaotic and therefore confusing to those who need to access it most -- the CMHCs. The function of the AMHD central office staff vis-a-vis the CMHCs does not appear to be clear to either CMHC or AMHD staff.

N. Delays in Vendor Payments

BHA's delays in paying its private service providers are a critical and constant source of irritation to those with whom it contracts for services.

O. Cost-inefficiency

BHA's present system of operating is patently inefficient. This inefficiency costs the State a significant amount of wasted money, which might otherwise be spent on direct services for the mentally ill. There are, in general, five basic reasons for the "cost-inefficiency" of the present system. First, present budgetary policies often encourage wasteful spending. Second, the system provides few incentives to deliver services in a cost-efficient manner. Third, there is a lack of continuity in BHA planning and policy which results in significant amounts of money being expended to develop and implement programs which are subsequently altered or abandoned. Fourth, the complicated rules and regulations of the present system has created what amounts to institutional "gridlock" within the system. Finally, BHA lacks sufficient infrastructure and resources to maximize the cost-efficiency of its operations.

4. A national mental health expert, hired to review the BHA's management structure, conducted extensive interviews and on-site visits with BHA staff and noted during an interview, "the BHA, as it is currently organized and staffed, does not have the capacity to adequately deal with its current internal workload or to cope effectively with its highly dynamic external environment."[3]

5. Failure to achieve meaningful mental health reform may lead to the following socially and financially detrimental results: (a) the State will pay for services that could be paid for by federal insurance reimbursements; (b) a satisfactory resolution of the present lawsuit against the State involving CAMHD will be difficult to achieve; and (c) even if the present lawsuits are resolved, future lawsuits are a distinct possibility.

6. A review of the "means employed by other states to organize and operate their mental health systems" demonstrates that each state has developed strategies and organizations which are appropriate within their respective political, economic, social and cultural contexts.[4] Nonetheless certain fundamental principles emerge when the systems of these states are examined. There are four fundamental principles which characterize these effective public mental health systems. These principles should be incorporated into any mental health reform in Hawaii. The principles are as follows:

A. The functions of policy-making and monitoring should be separated from directly providing mental health services.

B. The system should allow for decentralized, community-based control.

C. The service delivery structure should promote competition between service providers.

D. It should be recognized that successful mental health reform will not be easily or quickly achieved; it will not only require legislative action, but also consensus and long-term commitment and cooperation from the various leaders and stakeholders in Hawaii's mental health system.

7. The structural means by which other states have realized these basic principles vary considerably. Nonetheless, it is almost universally the case that in other states, the direct delivery of services, which is primarily achieved through community mental health centers, is either privatized or, in some states, administered at a local (county) level.

Recommendations for Reform

1. Hawaii's public mental health system, which is currently comprised of the BHA and its component subdivisions, should be substantially restructured. The general characteristics of the system achieved by this restructuring should provide for:

A. Clear separation of the policy-making and regulatory functions from those functions related to the management and administration of direct provision of services;

B. A substantial degree of decentralized, community-based control; and

C. A service delivery structure which promotes competition between service providers.

2. A task force should be formed, headed by the Director of Health, with members appointed by the Governor, consisting of representatives of the departments of Health, Attorney General, Budget and Finance, Labor and Industrial Relations, Personnel Services, Accounting and General Services and appropriate mental health advocates, labor union representatives, and community members. This task force should be charged with designing an appropriate mental health governance structure to realize the system described above. The task force should prepare proposed legislation necessary to create the new structure which should consist of one of the following proposed organizational models.

A. Mental Health Corporation (or Mental Health Authority) which assumes the following responsibilities:

(1) Receiving all funds, including state, Medicaid, charitable and federal block grants, etc.;

(2) Directly managing the provision of all services;

(3) Directly employing service providers and support staff;

(4) Contracting for provision of mental health services by private providers through purchases of service when appropriate or necessary;

(5) Screening, assessing, and developing service plans for clients.

Under this model, responsibility for policy-making and regulatory functions is retained by BHA, to be carried out by the existing AMHD, CAMHD and ADAD.

Advantages

- Separates "steering" and "rowing" functions.
- Enables flexibility in hiring of personnel.
- Fosters flexibility and accountability in fiscal management.
- Frees up BHA staff to effectively perform regulatory and policy-making functions.

- Enables substantial degree of local autonomy.

- Fosters competition between service providers thereby increasing quality and efficiency of mental health services.

- Increases freedom to innovate and deal on a timely basis with problems in the management of and delivery of mental health services.

Disadvantages

- Creates another "layer" of bureaucracy.

- Reduces state government's ability to ensure fiscal responsibility in the management of mental health services.

- Structural change will necessarily create difficulties associated with political realities, including civil service accommodations and the possibility that public jobs may be altered or lost.

B. Two separate mental health public corporations or authorities, one responsible for adult mental health services and a second responsible for child and adolescent services. Other than differences in staffing related to the distinct needs of the respective target populations, the essential structure of the two public corporations is the same, and each would resemble the structure of the single public corporation discussed above.

Advantages

- With regard to the Adult Public Mental Health Corporation, advantages and disadvantages noted above are applicable.

- A separate child and adolescent public mental health corporation can more effectively administer programs relating to a distinct target population whose needs differ markedly from the needs of adults.

- The separate corporation would have the flexibility which would enable it to utilize the innovative approaches such as the Robert Wood Johnson Program for Youth, described in Chapter 7.

- Integrated funds from multiple department budgets managed by inter-agency board of directors consisting of directors from agencies dealing with youth (e.g. departments of Health, Human Services and Education, as

well as directors from the Family Court and the Office of Youth Services and other community representatives).

- Integrated funding creates leverage for maximizing Medicaid reimbursements, presently not available.

- Fosters interagency coordination for necessary services by reducing "turf war" approach which often occurs when competing state agencies provide services (and compete for available funding) to emotionally disturbed youth.

Disadvantages

- Families requiring both adult and adolescent mental health services will be required to deal with two separate entities.

- May lead to unnecessary administrative costs.

C. Multiple mental health public corporations, which are either county, regionally or community-based.

Advantages

- Decentralizes mental health care decision-making.

- Maximizes local autonomy.

- Fosters local mental health care professional participation.

- Enables more community-based decision-making.

Disadvantages

- Creates multiple layers of bureaucracies and multiple boards of directors with associated costs.

- Neighbor island counties may lack the infrastructure necessary for effective operation of the corporations.

- Effective oversight becomes exponentially more difficult as the number of corporations increases.

D. Substantial maintenance of the status quo except for privatization of the eight public CMHCs. The process of privatization may be structured to occur gradually.

Advantages

- Fosters competition among service providers who compete by maximizing services while minimizing costs.
- Allows community-based decision making.

Disadvantages

- Privatization will necessarily create difficulties associated with political realities, including making civil service accommodations and the possibility that public jobs may be altered or lost.

Endnotes

1. David Osborne and Ted Gaebler, Reinventing Government (New York: Penguin Press, 1992), p. 12.
2. Comments by DOH Director Jack Lewin, The Honolulu Advertiser, September 13, 1988.
3. Interview with Wayne Kimmel, Public Policy and Management Consultant, October 8, 1993.
4. David Mechanic and Richard C. Surles, "Challenges in State Mental Health Policy and Administration," Health Affairs, vol. II, no. 3, Fall 1992, p. 48.

THE SENATE
SEVENTEENTH LEGISLATURE, 1993
STATE OF HAWAII

S.R. NO. 137 S.D. 1

SENATE RESOLUTION

REQUESTING A STUDY ON OPTIONS FOR GOVERNANCE OF THE STATE'S MENTAL HEALTH SERVICE DELIVERY SYSTEM.

WHEREAS, estimates indicate that there may be ten thousand or more persons in Hawaii with serious mental illness; and

WHEREAS, the mental health service delivery system operated by the Behavioral Health Administration of the Department of Health, which includes the Hawaii state hospital, the regional community mental health centers, and the Department's Courts and Corrections Branch, represents the only available source of comprehensive, community-based treatment and rehabilitative services for a large proportion of these persons; and

WHEREAS, the Robert Wood Johnson Foundation has established as the hallmarks of exemplary community mental health systems for the severely mentally ill, the following characteristics:

(1) A comprehensive range of settings and services, with varying levels of supervision, that provides realistic alternatives to institutional care;

(2) Assignment of clearly defined and continuing responsibility for each chronically mentally ill person in the community; and

(3) Budgetary control over the broad range of relevant services and settings, with fiscal incentives for providing appropriate and cost-effective care;

and

WHEREAS, in most states, community mental health service systems are operated by private agencies which, while supported by a variety of government and non-government funding streams, are autonomous with respect to budgetary, personnel, and administrative functions; and

WHEREAS, in 1992, the Auditor reported in a publication entitled Study of the Division of Community Hospitals, that "State laws and policies have resulted in unrealistic budgets, cash flow problems, recurrent deficits, and poor financial management . . . State policies on personnel also have hampered timely recruitment and hiring of appropriately trained personnel"; and

WHEREAS, the Auditor recommended that governance of the community hospitals be carried out through a community hospitals public corporation attached to the Department of Health; and

WHEREAS, the plight of Hawaii's mental health service delivery system is similar to that of the community hospitals in that both attempt to deliver flexible, individualized, client-centered health care services to the public while being hampered by ponderous government fiscal controls and personnel and administrative policies; and

WHEREAS, in 1988, a Governor's sub-cabinet task force was created to serve as a governing body for the mental health service delivery system and seek ways of enabling more efficient and authoritative operations; and

WHEREAS, although the sub-cabinet task force was responsive to all requests and issues presented to it, regulations and statewide policies at the lower levels of state departments involved in the delivery of mental health services prevented substantive changes from being made in a timely manner; and

WHEREAS, the ideal of "the money following the patient" is unlikely to be achieved by a purely government-run mental health system that has no fiscal or administrative autonomy; and

WHEREAS, government health agencies are best suited for the essential government functions of assessment, policy, and assurance, rather than for large-scale direct health care service delivery; now, therefore,

BE IT RESOLVED by the Senate of the Seventeenth Legislature of the State of Hawaii, Regular Session of 1993, that the Legislative Reference Bureau is requested to study the means employed by other states to organize and operate their mental

health systems, particularly those states that operate with significant autonomy and effectiveness, and those locales which received positive recommendations during the August 1992 conference "Hawaii Public Law 99-660 Implementation Initiative" sponsored by the Department of Health Adult Mental Health Division; and

BE IT FURTHER RESOLVED that the Bureau is requested to consider and suggest various options for governance, administration, and funding, including but not limited to formation of a public corporation or public mental health authority and other arrangements that would provide increased operational autonomy while maintaining accountability for fiscal decisions and quality of services; and

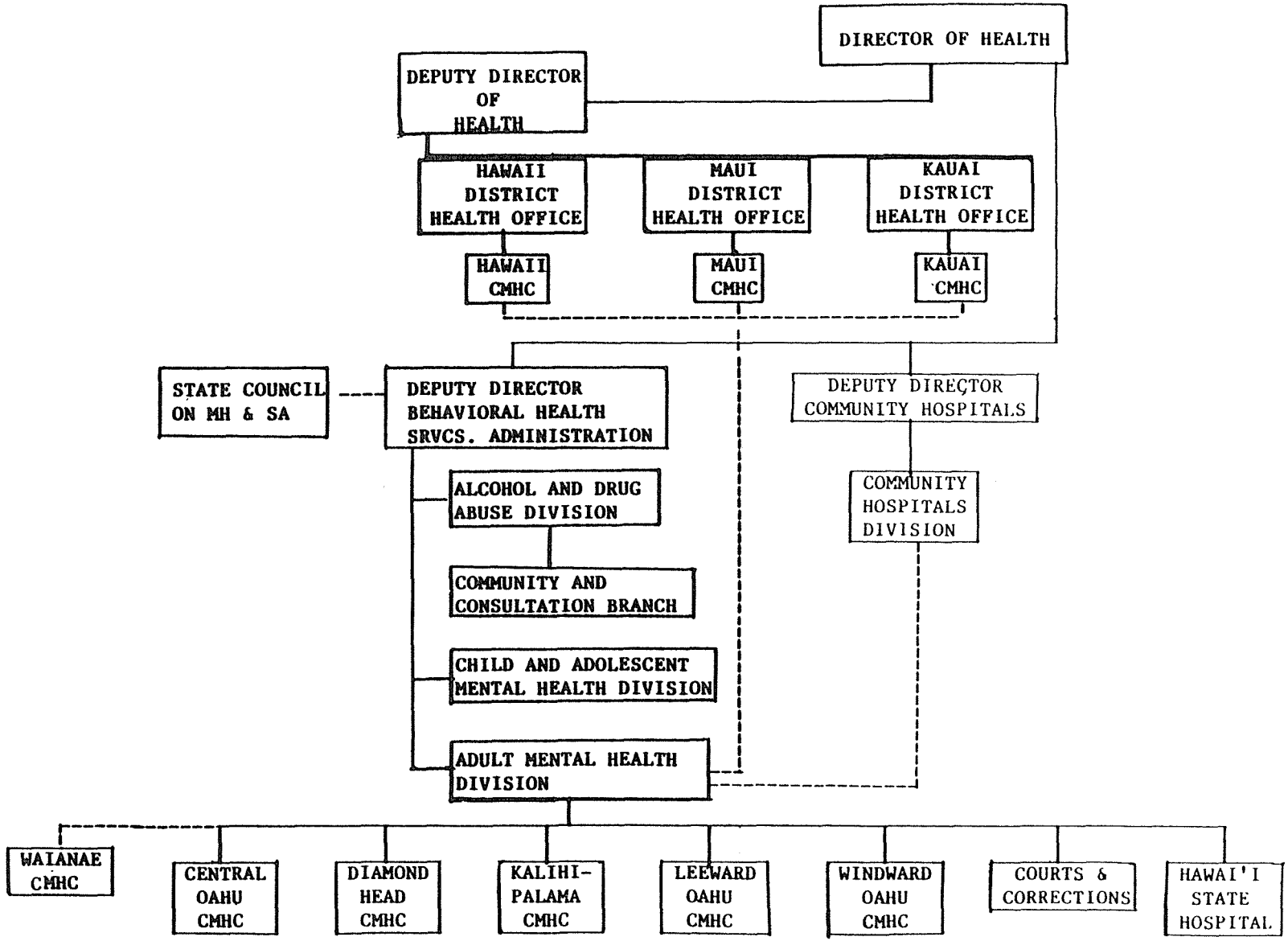
BE IT FURTHER RESOLVED that the Bureau is requested to include recommendations for any necessary proposed legislation, executive action, or fund allocation to support creation of a new governance mechanism; and

BE IT FURTHER RESOLVED that the Bureau is requested to report its findings and recommendations to the Legislature and the Department of Health no later than August 1, 1993; and

BE IT FURTHER RESOLVED that certified copies of this Resolution be transmitted to the Director of the Legislative Reference Bureau, the Governor, and the Director of Health.

TABLE I

ORGANIZATIONAL STRUCTURE OF BEHAVIORAL HEALTH SERVICES ADMINISTRATION*

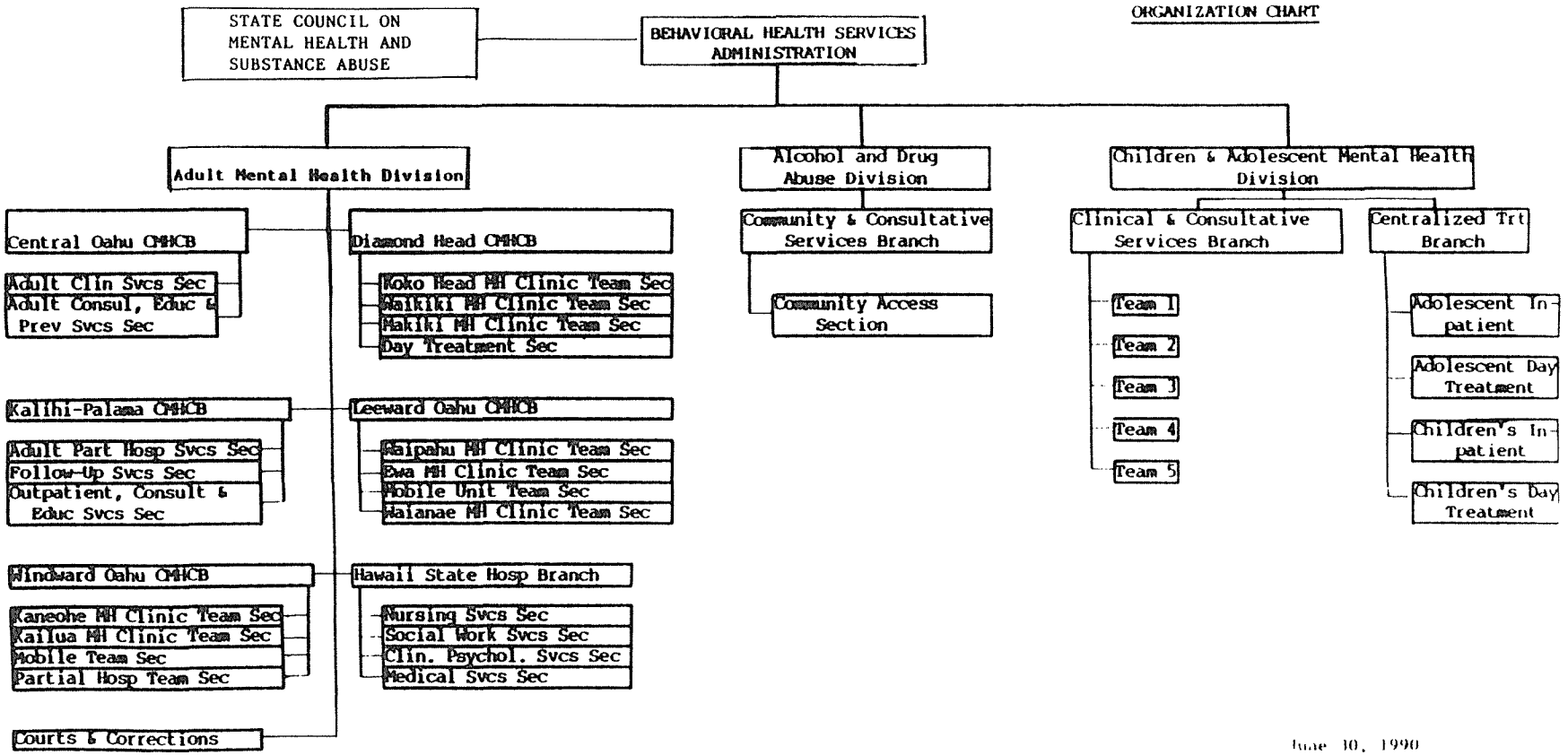


* Regionalized system in which the Adult Mental Health Division provides technical support to the Centers; Neighbor Island Centers administratively under the District Health Officer.

TABLE II

STATE OF HAWAII
DEPARTMENT OF HEALTH
BEHAVIORAL HEALTH SERVICES
ADMINISTRATION

ORGANIZATION CHART



June 30, 1990

Appendix C

QUESTIONNAIRE FOR COMMUNITY MENTAL HEALTH CARE CENTER PROFESSIONALS

Name: _____

Community Mental Health Center Name: _____

Note: No one in the department will see a completed questionnaire. Your individual responses will be kept confidential.

If applicable, please provide examples from your own experience. Additional pages may be attached where further explanation is appropriate.

* * *

1. What is your position?

2. What are your primary duties and responsibilities?

3. How long have you been employed in your present position?

4. What, if anything, prevents the Community Mental Health Center where you work from providing mental health services more efficiently and/or effectively?

* * *

For the next set of questions, please use the following scale and provide explanations and/or examples when appropriate.

Never Rarely Sometimes Often Always

5. Do you feel that state policies/bureaucracy constrain the efficient and effective provision of public mental health services?

Never Rarely Sometimes Often Always

If applicable, please provide examples from your own experience.

6. Do you feel that the provision of public mental health services is ever compromised by the state's purchasing and procurement regulations?

Never	Rarely	Sometimes	Often	Always

If applicable, please provide examples from your own experience.

7. Do you feel that the community mental health centers would benefit from an increase in autonomy? If so, how? If not, why not?

* * *

8. Do you feel that the provision of public mental health services is ever compromised based on any of the following?

For each identified "problem", please indicate on a scale of 1 to 5, your assessment of the severity of the problem.

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Also -- For each identified "problem", please provide insight as to whether you personally perceive this to be a problem in fact. If you have personal examples as to how the problem has manifested itself, and/or impacted upon you or your center's ability to provide meaningful services, please provide such examples.

(a) Lack of Resources

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(b) Too much rigidity within the system

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(c) Lack of accountability

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(d) Too much accountability/responsibility

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(e) Non-cost effective system

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(f) Too much time and energy spent in "finessing" the system

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(g) Failure of system to operate on a "timely" basis

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(h) Fragmented/Uncoordinated Service Delivery

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(i) Too little supervision

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(j) Too much supervision

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(k) Inability to be creative (eg. create experimental programs, preventative assistance, etc.)

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(l) Unrealistic or unpredictable budgets

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(m) Unrealistic/burdensome vendor payment and/or procurement requirements

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(n) Delays in vendor payments

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(o) Delays in hiring and/or personnel shortages

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(p) High turn-over of management positions

Never a Problem (1)	Rarely a Problem (2)	Sometimes a Problem (3)	Often a Problem (4)	Always Problem (5)

Explain:

(q) Other:

* * *

For the following questions, please use the following response scale.

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

If applicable, please elaborate on your answers.

9. The functions served by the central office of the Adult Mental Health Division ("AMHD") are clear to me

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

10. Previous reorganizations within AMHD have been appropriate and necessary

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

11. Previous reorganizations within AMHD have been effective

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

12. The present organization of AMHD makes sense to me

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

13. Work is generally distributed fairly among professionals within the community mental health center where I work

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

14. Work is generally distributed fairly among the various community mental health centers

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

15. I have a clear understanding of AMHD's mission

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

16. I have a clear understanding of the organizational structure of the AMHD

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

17. The State is often unable to deliver appropriate mental health services to the public because of constraints resulting from:

(a) State bureaucracy

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

(b) Lack of funding

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

(c) Inability to make and follow predictable, long-term budgets

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

(d) Timely recruitment and hiring of personnel

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

(e) No incentives within system to provide cost-effective services

Agree	Tend to Agree	Neutral	Tend to Disagree	Disagree
(1)	(2)	(3)	(4)	(5)

* * *

If you were "at the helm", how would you change the present governing structure of the state's mental health service delivery system? How would your changes benefit the system?

Please return to:

Legislative Reference Bureau
Attn: Ms. Susan Gochros
State Capitol
Honolulu, HI 96813

by October 22, 1993