

## ADULT MENTAL HEALTH STAKEHOLDERS RECOMMENDATIONS

**DT:** September 16, 2011

**TO:** Andrew Aoki, Assistant Chief of Staff, and Debbie Shimizu, Policy Liaison, for Governor Neil Abercrombie

**FR:** Chad Koyanagi, M.D., Assistant Professor of Psychiatry, John A. Burns School of Medicine, and Medical Director, Kekela Psychiatric Unit, Queens Hospital; Greg Payton, CEO, Mental Health Kokua; Scott Wall, Certified Peer Specialist; and Marya Grambs, Executive Director of Mental Health America of Hawai'i, on behalf of a group of 16 major adult mental health providers and advocates

The following are the most significant problems and suggested solutions facing the adult mental health (severely mentally ill) population:

**1. Already a Train Wreck:** Fractured system of numerous providers. There are nine mental health care providers/insurers for severely mentally ill, all with different coverage -- HMSA private insured, , HMSA Quest, Kaiser private insured, Kaiser Quest, AlohaCare (Quest), AMHD, QUEXA Ohana, QUEXA Evercare, and APS Healthcare/Community Care Services (see attached grid). The most vulnerable patients – those with the most severe mental illness – get bounced around from plan to plan and this, of course, has a very negative impact on their stability (they may be on Quest, fail to complete paperwork, are dropped, are then provided services by AMHD, which gets them back on Quest, etc etc etc. POS providers say that patients' insurance or provider suddenly changes for no explainable reason. Some fall through the net entirely. Many of these decompensate to the point of becoming **homeless**, being arrested, going to the E.R., or being hospitalized – but of course they are not tracked because they have fallen out of the so-called "system."

Recommendation (cost neutral): Move all severely mentally ill Quest patients back to AMHD. Or, bring all of the severely mentally ill into one umbrella managed care organization, which most states do. Or????

**2. Already a train wreck:** Inability of Quest patients to access psychiatrists i.e., for medication management; on Neighbor Islands utterly impossible. Physicians can't even break even on Medicaid.

Recommendation: a partial solution, telehealth, would be very helpful. One barrier to implementing this is that there has been little or no funding.

**3. Already a train wreck:** Insufficient community based case management services (inadequate hours allocated per client -- limited to 3.5 hours per month) and crisis support services. Patients can't reach case managers, inpatient psychiatric units have no case manager to contact upon admission or discharge, etc. This impacts multiple systems and increases the number of severely mentally ill without adequate services, **on the streets** or being hospitalized.

Recommendation: Expand hours (but this costs money). It's too late now, however, because the community based case management RFP has already gone out. This is a serious problem.

4. Lack of transparency: where does money come from and where does money go? Many stakeholders are confused and concerned; there has been a build up of suspicion on the part of stakeholders for the past few years.  
Recommendation (cost neutral): produce Annual Report containing pie chart showing where money is spent: how much goes to administration (and what aspects—UM, Planning, Contracting, etc.), and how much to direct services, and which specific services: how much to supported housing, to community based case management, to clubhouse, crisis support services, Access/crisis line, community mental health centers, etc. Include how many people are served so can calculate per person cost (number of people served versus number of contacts – need to figure out how to differentiate that in the calculation. Could be available online so not incur printing costs.
  
5. Costly fragmentation and redundancy of services, i.e., between ADAD and AMHD:  
Recommendation (cost saving): Combine Alcoholic and Drug Division (ADAD) with Adult Mental Health Division (AMHD): majority of people with serious mental illness also have substance abuse disorders, and majority of people with substance abuse disorders have mental illness; these are overlapping disorders so it makes no sense to have separate systems treating them. Combining will save money and result in economy of scale.
  
6. Costly fragmentation and redundancy, i.e., between AMHD and Child and Adult Mental Health (CAMHD):  
Recommendation (cost saving): Combine Adult Mental Health Division (AMHD) with Child & Adolescent Mental Health Division (CAMHD): children have mentally ill parents, mentally ill adults have children, children and adults with mental illness live in families, so why are treatment systems kept separate? Combining will save money/result in economy of scale. [This alone would eliminate 10 FTE's] *[Every other state has an office of mental health services with both adult and child services under one roof; no other state splits this up]*
  
- Summary: Reduce costly fragmentation and redundancy by combining Behavioral Health Divisions. Right now EACH DIVISION (ADAD, CAMHD, AMHD) has its own management, billing, budget office/financial management, Utilization Management, quality control, contracting, planning, etc. etc. This extremely expensive redundancy would be eliminated by consolidating any of the above-mentioned Divisions.**
  
7. **Train Wreck**: No access to Hawai`i State Hospital except from jail – more people with severe mental illness/psychoses **on streets**, untreated, some possibly suicidal, some of them possibly violent, because they can't be hospitalized until they commit a crime.  
Recommendation: Build new community based hospital (dream on). Examine process by which people arrested for misdemeanors stay in the Hospital for long periods of time; it is likely that many of them do not need hospital level of care.
  
8. **Train Wreck**: Callers to our Crisis/Suicide/Access line (i.e., who are suicidal or in a psychiatric emergency) often get answering machine or the ring time is too long– this is unconscionable for the state's suicide prevention hotline (and national suicide callers who live in Hawai`i are routed to this line). *Can you imagine being suicidal and getting voicemail?*  
Recommendation: The Access line is down 2 staff members – these positions should be freed up and hired.

9. **Train Wreck:** Our system of mental health care no longer serves those with the most severe mental illness – those who needed the services the most were sacrificed in the budget cuts of the past few years. These are the “gravely disabled,” many of whom who are unwilling to remain in treatment without close monitoring.
1. Result: more **homeless** mentally ill/psychotic/arrested/emergency room/hospitalized, cycle repeated over and over.
  2. If “mandatory outpatient treatment,” aka “assisted outpatient treatment” is pursued and actually implemented, it could help get many of these very psychotic people into treatment and therefore off the streets.
  3. Right now the only way that the most severely ill, “gravely disabled” people get help is after they are homeless, are arrested, and hospitalized. That is ridiculously too late, and the cycle keeps repeating. Family members are frantic and frustrated at this state of affairs.
  4. **We already have a law on the books** to allow the “gravely disabled” to be mandated for treatment, but judges have been unwilling to implement it.

Recommendation (ultimately cost saving): Implement use of mandatory outpatient treatment law (must educate judges, psychiatrists) but there have to be treatment services, housing, and monitoring if this is to work. [I know Marc Alexander is working on this -- don't know whether his efforts have been successful.]