Audit of the School-Based Behavioral Health Program

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

Report No. 02-11
June 2002

THE AUDITOR
STATE OF HAWAII

Office of the Auditor

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

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

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds are existing funds meet legislative criteria.

7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.

8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.

9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

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

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OVERVIEW

Audit of the School-Based Behavioral Health Program

Report No. 02-11, June 2002

Summary

The Office of the Auditor conducted an audit of the School-Based Behavioral Health Program of the Department of Education (DOE) pursuant to Section 23-4, Hawaii Revised Statutes, which requires the office to conduct post-audits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

The School-Based Behavioral Health (SBBH) Program serves all students who have, or may develop, behavioral issues. The program offers prevention, early intervention, and intensive services closely tied to educational activities. The program began on July 1, 2001 when the DOE assumed responsibility for approximately 9,000 students previously receiving outpatient mental health services through the Department of Health's Child and Adolescent Mental Health Division. The DOE's educational model focuses on behaviors that impair a student's ability to learn, as opposed to a clinical model of diagnosis and treatment.

We found that the DOE has not ensured the efficient and effective delivery of mental health services under its SBBH Program. The program has deficiencies in the areas of personnel, management information systems, procurement, and quality assurance. The department had identified these concerns prior to the implementation of the program, but proceeded anyway.

In the area of personnel management, we found that some employees received significantly higher salaries than others with the same job titles and responsibilities. These differences appeared across districts and across complexes within districts. For example, a doctoral-level psychologist or a similar position providing clinical supervision could earn $70,000 a year in the Honolulu District or up to $123,000 in the Central District. In the Hawaii District, the same position could pay $70,000 to $80,000 in Hilo or $100,000 in Ka'u. As a result, districts and complexes competed with each other for qualified candidates.

The long-delayed management information system for special education, called ISPED, continues to vex the SBBH Program. Problems with inputting data at the school level mean that the system, although nominally operational, does not produce reliable and valid reports.

In assuming responsibility from the Department of Health for contracting with private providers for the SBBH population, the Department of Education has contracted with providers that do not meet DOE criteria. Hiring providers that cling to the clinical model means hiring contractors that could work at cross purposes against DOE's educational model. We found the department hired contractors over whom the department's evaluators expressed concerns.

We also found that the DOE fails to accurately account for the cost of its program. The department has been reporting only additional funding requests—$27.2 million and 405 positions for FY2001-02. It has not been reporting the funding in the base budget—another $14 million and 293 positions—for a total of $41.2 million and 698 positions for school-based behavioral health.

Finally, we found that the impact of anticipated autism services on the school-based behavioral health infrastructure and staff is unclear. The department intends to take on additional responsibilities (on July 1, 2002) for the delivery of even more complicated mental health services while still correcting SBBH program deficiencies. The department has no autism plan, the structure of contracts remains unresolved, and who is responsible to oversee contracted providers to curtail fraud is uncertain.

Recommendations and Response

We recommended that the DOE expedite its: a) development of minimum qualifications for staff and resolution of issues regarding probation and performance appraisals; b) integration of fragmented information systems by ensuring that ISPED is functional and accessible to all school-based behavioral health staff; c) revision of its procurement process to ensure that all relevant criteria are taken into consideration before issuing of an RFP and that only qualified providers willing to comply with the school-based behavioral health model are utilized; d) implementation of controls to curtail potential billing fraud; e) creation of a quality assurance system to track progress and assess appropriateness and effectiveness of services provided.

We also recommended that the Board of Education and the Legislature compel the department to update its school-based behavioral health budget to accurately reflect all positions and funding.

Finally, we recommended that the Department of Education clearly identify the infrastructure for the School-Based Behavioral Health Program and autism services, starting by differentiating the responsibilities of school-based behavioral health staff and autism services staff.

The DOE responded that it welcomes the findings of the report, but said we failed to note that corrective actions were already underway before the audit began and that we misstated a finding of a prior audit report issued by our office. The department also felt that it provided the Legislature with accurate information regarding the budget for the SBBH Program. However, the department noted that it would provide the Board of Education and the Legislature with a budget for the program that clearly reflects relevant positions and funding. The DOE also stated that actions are already underway to provide appropriate controls over personnel management, information systems, procurement processes, and quality assurance.

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Audit of the School-Based Behavioral Health Program

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

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 02-11
June 2002

Foreword

This is a report of our audit of the school-based behavioral health program of the Department of Education. The audit was conducted pursuant to Section 23-4, Hawaii Revised Statutes, which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

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

Marion M. Higa
State Auditor

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Chapter 1
Introduction

This is a report of our audit of the School-Based Behavioral Health Program of the Department of Education. This audit was conducted pursuant to Section 23-4, Hawaii Revised Statutes (HRS), which requires the office to conduct post-audits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

Background of the School-Based Behavioral Health Program

The School-Based Behavioral Health Program is designed to serve all students through school-wide prevention, early intervention, and intensive services for students with significant emotional and/or behavioral needs. As much as possible, services are provided on campus by staff employed by the Department of Education. However, contracted private provider staff are also utilized as needed.

The program was implemented on July 1, 2001 when the Department of Education assumed responsibility for the oversight and provision of behavioral health services to approximately 9,000 students previously receiving outpatient mental health services procured and overseen by the Department of Health's Child and Adolescent Mental Health Division. These students were part of an estimated 11,000 statewide who qualified for services under the *Felix* consent decree. The decree, approved by the U. S. District Court, requires the State to create a system of care to provide necessary educational and mental health services to qualified handicapped children through the Departments of Education and Health.

Discussions between the Departments of Education and Health regarding the concept of school-based behavioral health services began in early 1999 and formal planning began in fall of that same year. The move to school-based behavioral health services was sanctioned by the federal court and became a formal part of the *Felix* consent decree after the State was found in contempt in May 2000. The School-Based Behavioral Health Program was an integral part of the Department of Education's response and remediation efforts. The department was required to meet specific court benchmarks related to funding and personnel issues. Although the court monitor supported the move to school-based behavioral health services, he emphasized that the move should be viewed as a means of more effective service delivery and not as a cost-cutting measure.

The State Auditor initiated this audit due to concerns regarding the Department of Education's difficulties in its recent implementation of

this program. These concerns were raised in Report No. 01-16, *Follow-Up and Management Audit of the* Felix *Consent Decree.* The audit concluded that the Department of Education was ill-prepared to handle its new responsibilities. In fact, the report predicted that the transition would be costly to the State. The Department of Education had no plans to pursue Medicaid reimbursements, which could result in a loss to the State of up to $2 million a year. Additionally, the report noted that the initial budget of $21.5 million in FY2000-01 would be exceeded by $14.9 million or 69 percent. The report attributed the projected increase to the failure of the Department of Education to adopt proper oversight and controls over provider billing.

Target population of the program

The target population of the School-Based Behavioral Health Program has been described as *low-end* as opposed to *high-end*. The terms *low-end* and *high-end* have historically been used by the Department of Health to distinguish between the wide ranges of individualized services required by *Felix*-class students. *Low-end* has served as a working term for that segment of the population requiring less intensive services. Out of the total 11,000 students estimated to comprise the *Felix* population, 9,000 were referred to as *low-end* or in need of less intensive services. These services include psychological assessments, individual counseling, psychiatric evaluations, medication monitoring, and case management.

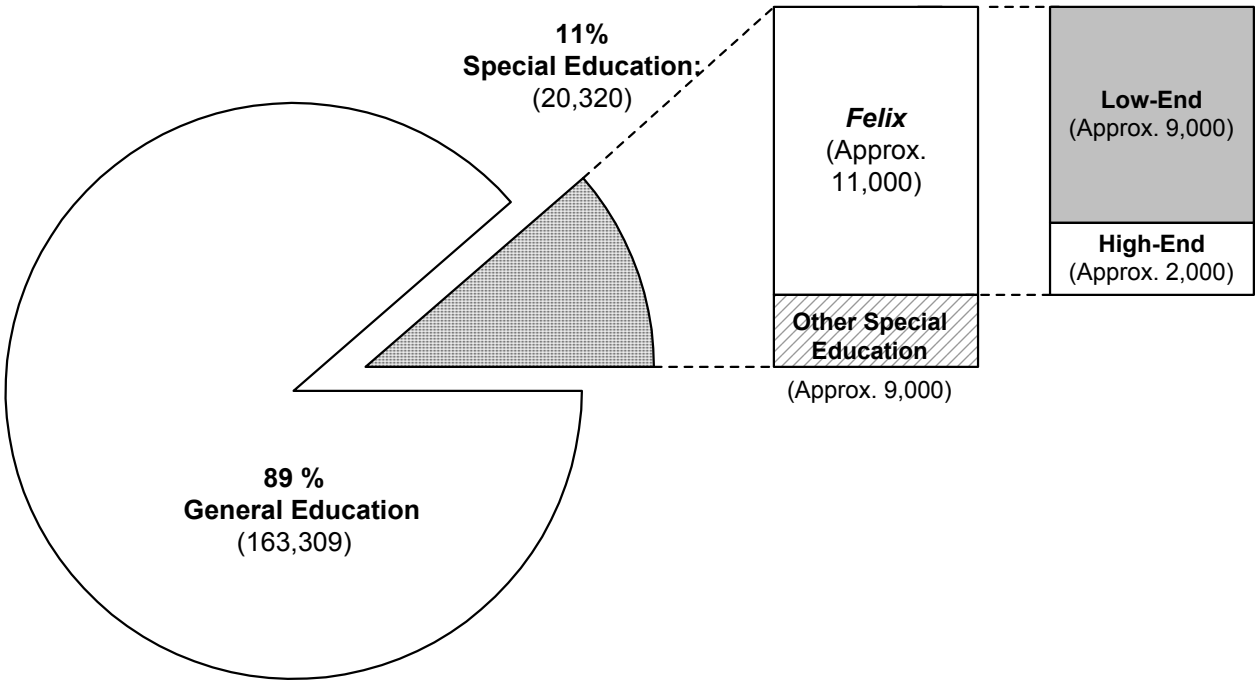
High-end students, such as those with Pervasive Developmental Disorders or autism, require more intensive services. These services include intensive in-home services and inpatient treatment services or hospitalization. Depending on their range of abilities, some of the students classified as *high-end* may simultaneously receive less intensive services, such as counseling, from the Department of Education. On July 1, 2002, a portion of the students in this high-end group, namely those with autism and developmental disabilities, will be transferred to the Department of Education.

Exhibit 1.1 provides a graphic representation of the current target population for the School-Based Behavioral Health Program.

School-based behavioral health is part of a larger educational reform initiative

The School-Based Behavioral Health Program is a part of the Department of Education's Comprehensive Student Support System (CSSS), which intends to provide a supportive learning environment for *all* students. CSSS consists of five levels of support, which range from basic support at the first level to specialized support at the fifth level. The School-Based Behavioral Health Program is the behavioral component for each of the five levels of CSSS.

Exhibit 1.1
Department of Education School Population and Sub-Populations



Total Population: 183,629

For CSSS, level one is comprised of basic support services for all students, including classroom instruction and career guidance. At this level, the classroom teacher plays an important role and is expected to work with both students and parents to address each student's needs. The corresponding component for the School-Based Behavioral Health Program is comprised of teaching students social and emotional skills, such as how to control anger, cooperate, and follow rules. Parents and school staff may be provided with information and training regarding children and adolescent mental health needs.

The classroom teacher also has an important role in the provision of level two services for CSSS, but collaborates with other school personnel, such as counselors and administrators. Supports at this level include counseling and health aide services. For the School-Based Behavioral Health Program component, recreation and friendship activities are available for students. At levels one and two, teachers might consult

school-based behavioral health staff informally regarding appropriate interventions – for example, asking them to lecture the entire class on conflict resolution.

At level three of CSSS, more individualized services are provided, which may include instruction outside the regular classroom. Such services may include alternative learning centers, the Comprehensive Student Alienation Program, and the Gifted and Talented Program. The School-Based Behavioral Health Program could provide consultation, assessment, and care coordination services in concert with such programs as the Comprehensive Student Alienation Program.

Levels four and five are essentially the same within CSSS and the School-Based Behavioral Health Program. At level four, students require specialized assessment(s) or assistance, which may include Section 504 accommodations, special education, and mental health services. Section 504 refers to a section of the Rehabilitation Act of 1973, which stipulates that a qualified person with a disability cannot be excluded from any program receiving federal financial assistance. Accommodations may include seating in the front row of the classroom, modifying homework requirements, and so on. Level five services are the most intensive and include multiple agency supports, which may include the Department of Health and Family Court. Students may be served in off-campus programs, such as community-based instruction (formerly known as day treatment facilities).

To date, the School-Based Behavioral Health Program has largely focused on levels four and five because of the urgency placed on the Department of Education by the federal court to meet compliance with the *Felix* consent decree.

Exhibit 1.2 graphically represents the alignment of the School-Based Behavioral Health Program with CSSS.

An educational model serves as the basis for school-based behavioral health

The Department of Education views its School-Based Behavioral Health Program as promoting an educational model, as opposed to the Department of Health's treatment or clinical model. Generally speaking, the clinical model requires diagnoses and attempts to treat a particular condition simply because it exists. In contrast, the educational model focuses on behaviors that impair a student's ability to learn. For example, a student who is experiencing anxiety in daily life would not be considered for individualized services unless the condition manifests itself in test anxiety.

Essentially, the educational model assumes that all behaviors are functional; that is, all behavior is learned and exhibited for a purpose—either to obtain a reward in the form of attention, or to avoid an

Exhibit 1.2
Alignment of School-Based Behavioral Health Program with the Comprehensive Student Support System

Levels, Functions and Populations Served	CSSS	SBBH
Level 1: Prevention Basic Support for All Students	• Classroom support • Positive relationships • Middle School Team • Career Pathways	• Classroom support • Positive relationships (Teacher and family)
Level 2: Risk Reduction Students with High-Risk Issues	• Walk-in counseling • Transition supports • Health aide services	• Walk-in counseling • Transition • Health issues
Level 3: Early Intervention Students with Mild Adjustment Problems	• Alternative Learning Centers • Comprehensive Student Alienation Program (CSAP) • Gifted and Talented Program	• Individualized school programs • Counseling sessions
Level 4: Treatment Students with Moderate Mental Health Problems	• Specialized Assessments or Assistance • Section 504 Accommodations • Special Education	
Level 5: Treatment Students with Severe Mental Health Problems	• Multiple agency supports • Off-campus programs such as community-based instruction	

Source: Department of Education

undesirable situation. Therefore, program supports and services focus on school and home-based interventions to help students meet their needs while replacing undesirable behaviors with more positive ones. For example, a disruptive student might whine, complain, and become verbally abusive to escape a demanding situation, such as completing a math problem in front of the class. The recommendation might be to restrict the student to desk work or pre-arranging a subtle signal with the teacher that the student needs a ten-minute pass to alleviate the stress of a situation.

The educational model is preventive in nature, stressing the promotion of positive behavior rather than the reduction of troublesome behavior and crisis management. This model involves a larger, more diverse group of "service providers" such as paraprofessionals, educators, parents, and mental health professionals that have a role and function in supporting students with behavioral health and other needs. Students may receive services from guidance counselors, social workers, school nurses, and psychologists within the school system.

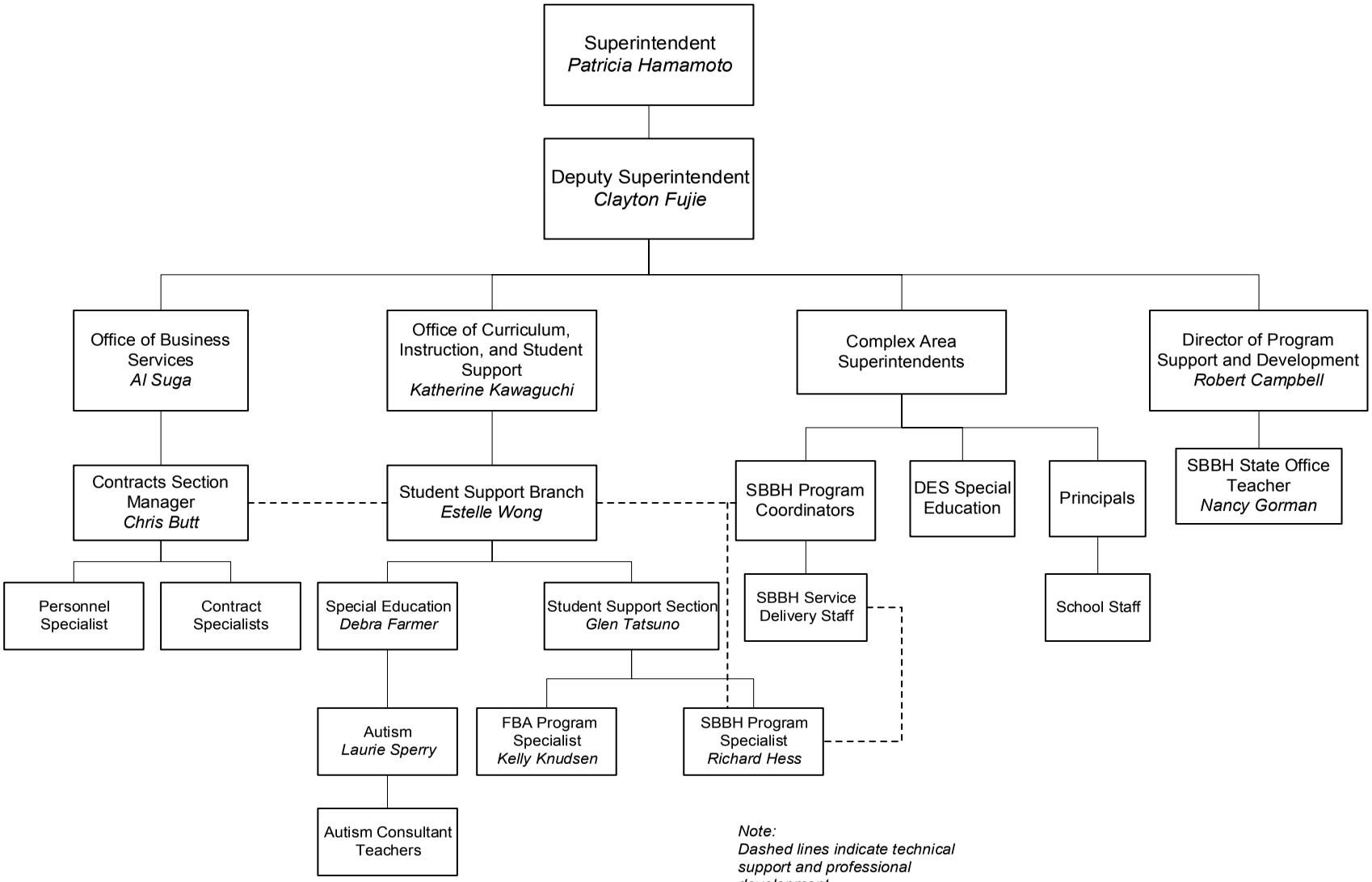
Another distinction from the clinical model is that the educational model does not rely on the judgment of a sole person to determine the services received by the student. The educational model uses school-based teams of parents, teachers, counselors or behavioral health personnel familiar with the student. The underlying rationale is that a group of people who know the child well and are familiar with the child's day-to-day behaviors are more likely to make effective recommendations.

Administration of the program

Despite a recent reorganization of the Department of Education that modified seven districts into 15 complex areas (a high school and its feeder elementary and intermediate/middle schools), the organizational structure for the School-Based Behavioral Health Program follows the traditional, seven-district model. Under the superintendent, the director of program support and development assists with oversight of the program, and the assistant superintendent for business services handles fiscal matters with the assistance of two support staff. Each district has its own program coordinator and contract specialist (who functions in an administrative officer-type capacity). At the school level, there are various mental health providers, which include behavioral specialists, social workers, and psychologists.

A graphic description of the organizational structure for the program describing the state-level administration was unavailable. However, upon our request, the department created the organizational chart in Exhibit 1.3.

Exhibit 1.3
Organization of the School-Based Behavioral Health Program



Source: Department of Education

Funding for the program

The majority of the department's funding for the School-Based Behavioral Health Program for FY2001-02 comes from the $21.5 million transferred from the Department of Health, which previously provided services under the Child and Adolescent Mental Health Division (CAMHD).

As indicated in Exhibit 1.4, the operating budget for school-based behavioral health services is $27.2 million and includes 405 positions. The majority of these funds – $25.8 million—covers costs for behavioral and therapeutic interventions. This includes 371 "in-house" staff who either provide services or supervise direct service providers such as behavioral specialists, school psychologists, and social workers, as well as funds for contracted services. The remaining $1.5 million was budgeted for infrastructure support at the state and district levels. This includes 34 positions consisting of a state-level contracts manager, fiscal specialist, contracts secretary, *Felix* personnel management specialist, and *Felix* personnel clerk. Infrastructure or administrative support positions also include contract specialists, program coordinators, and clerk typists deployed to the districts to oversee the program.

Objectives of the Audit

1. Determine whether the Department of Education has implemented adequate controls to ensure that its School-Based Behavioral Health Program provides mental health services in an efficient and effective manner.

2. Determine whether the department can accurately account for the cost of its program.

3. Make recommendations as appropriate.

Scope and Methodology

The audit examined the School-Based Behavioral Health Program statewide. The scope of our review is from the inception of the program, FY1998-99, to the present. We reviewed the Department of Education's compliance with laws, regulations, and other compliance requirements significant to the audit objectives.

At the state level, we conducted interviews with program, personnel, and fiscal staff involved with the School-Based Behavioral Health Program.

At each district, we reviewed contracts, district plans, and policies and procedures related to the School-Based Behavioral Health Program. In addition, we reviewed minutes from each district's monthly quality assurance meetings. We also reviewed interim interagency joint practice

Exhibit 1.4
FY2001-02 Operating Budget for the School-Based Behavioral Health Program

Behavioral Therapeutic Interventions	Number of Positions	Amount
SBBH Behavioral Specialists	250	$10,671,750
School Psychologists	45	3,093,165
Social Workers	76	2,138,240
Other personal services		175,000
Other current expenses		8,863,366
Equipment		821,000
Sub-total	*371*	*$25,762,521*
Infrastructure Support		
Contracts Manager	1	$55,641
Fiscal Specialist	1	55,641
Contracts Secretary	1	21,708
Contracts Specialists	7	389,487
Contract Clerks	8	173,664
Other current expenses		22,808
Felix Personnel Management Specialist	1	55,641
Felix Personnel Clerk	1	21,708
Program Coordinators	7	389,487
Clerk Typists	7	135,240
Other current expenses		28,584
Equipment		14,000
DOE share of Community Children's Councils' support		100,000
Sub-total	*34*	*$1,463,609*
GRAND TOTAL	**405**	**$27,226,130**

Source: Department of Education

guidelines developed by the Departments of Education and Health for the implementation of the School-Based Behavioral Health Program.

We conducted interviews with at least one complex area superintendent from each complex area, the district program coordinators, district contract specialists, and a sample of district-level educational specialists, resource teachers, and mental health professionals.

Our work was performed from February 2002 to April 2002 in accordance with generally accepted government auditing standards.

Chapter 2

The Department of Education Has Mishandled the Implementation of Yet Another Program

We have conducted a number of audits of the Department of Education and its programs. Consistently, our findings reflect the department's poor implementation of various initiatives, which has resulted in the need for corrective action. For example, in Report No. 96-2, *Audit of the Comprehensive School Alienation Program and the Pregnant and Parenting Teen Program of the Department of Education*, we found that these programs lacked a clear mission. Specifically, the department failed to provide districts and schools with clear objectives. As a result, program goals varied among sites and at times violated the department's and the Board of Education's policies on graduation and equal access to education. In our Report No. 97-14, *Audit of State Vocational Education Programs and Job Training Programs*, we found that the Department of Education had not consistently implemented adequate program evaluations to assess the effectiveness and needs of all of its vocational education programs.

Additionally, in Report No. 98-21, *Management Audit of Hawaii's School-to-Work Opportunities System*, we found that the system lacked a clear mission, goals, and outcome measures. The department and other entities involved with the initiative had failed to ensure that the target population was clearly identified and that adequate implementation strategies existed. Schools expressed frustration with the lack of guidance from state-level administrators.

The School-Based Behavioral Health Program is yet another example of mishandled program implementation by the Department of Education. Throughout our audit of the program, administrative staff informed us that the department's plan was to proceed quickly and take corrective action after implementation. However, despite the Department of Education's recognition of problems and its attempts at remediation, the School-Based Behavioral Health Program still lacks a basic infrastructure and accurate information on program costs. Furthermore, the department has not carefully assessed its plans to take on additional responsibilities related to school-based behavioral health services.

Summary of Findings

1. The Department of Education's infrastructure for school-based behavioral health services lacks adequate controls to ensure the efficient and effective delivery of mental health services. The program's infrastructure is incomplete and in need of improvement

in the areas of personnel, management information systems, procurement, and quality assurance.

2. The department is unable to accurately account for the cost of the program. The department has misrepresented the cost by reporting only additional funding requests and not the funding in the base budget as well.

3. The impact of autism services on the School-Based Behavioral Health Program's infrastructure and staff is unclear. The department intends to take on additional responsibilities for mental health services even though it is still grappling with correcting program deficiencies in school-based behavioral health services.

The School-Based Behavioral Health Program Lacks Adequate Controls Over Personnel, Management Information Systems, Procurement, and Quality Assurance

The Department of Education continues to struggle with establishing a basic infrastructure for the School-Based Behavioral Health Program. The lack of an overall structure was evident when the department could not readily produce an organizational chart that reflected how state-level staff interfaced with district-level staff and each other. Even after creating a graphic representation upon our request, the department was not completely clear about the lines of authority. For example, "district" contract specialists, who are physically based in district offices, are actually state-level staff and do not report directly to anyone in their respective districts. This has resulted in some confusion for district program coordinators who are responsible for school-based behavioral health staff in the districts.

Furthermore, creation of complex area superintendent positions has also complicated matters. Although the superintendent informed us that currently the School-Based Behavioral Health Program should be viewed in terms of the former district structure, future implications of the complex area divisions are unclear at this time. Given the lack of accountability within the current structure, we are concerned about the impact of further compartmentalization.

Concerns in the areas of personnel management, management information systems, procurement, and quality assurance were identified by the department prior to the implementation of the program, but are being dealt with only now. The department's lack of structure and guidance is evident in its transition plan, which noted that procedures and materials were developed on a "just enough and just-in-time basis." The department intended to limit what it termed "top-down interference" to allow for flexibility at the district level and to minimize the amount of "corrective action" needed due to what it termed "unforeseen circumstances." However, the Department of Education misidentified its approach. The lack of formal guidance from the state level actually created more problems for the districts and the program as a whole.

The department's state-level administration did not provide the districts with an adequate infrastructure

State-level administrators responsible for the implementation of the School-Based Behavioral Health Program failed to provide the districts with a basic infrastructure. Districts had to develop their own personnel guidelines, contractor oversight methods, and quality assurance measures. Because a functional, statewide management information system was lacking, districts had to develop and rely on their own systems. Some district-level staff noted a lack of space and equipment. One district administrator found it disconcerting that the department was attempting to create a structure for a program after it had been implemented.

Even more problematic is that some district and complex-level staff do not appear to have a common or basic understanding of the program's objectives. The districts were merely appropriated funds with the intent of allowing them to tailor the program to their own needs. However, state-level administrators had not ensured that each district knew its target population, or had a clear understanding of how to implement the program, before spending those funds.

The program was inconsistently implemented

Because of the lack of guidance, the districts were left to create their own versions of school-based behavioral health services. School personnel had the option of submitting a district plan or a complex plan to document their efforts to implement the program. The department asked districts/complexes to describe characteristics of the students each serves, the type of services provided, how school-based behavioral health services fit in with the Comprehensive Student Support System (CSSS), personnel and budget issues, data management, and quality assurance. As a result, there are a number of inconsistencies across the districts. For example, Honolulu, Central, and Maui Districts submitted overall district plans. Leeward had an overall district summary, but separate complex plans. Hawaii and Windward Districts did not have overall district plans, but submitted separate complex plans. Kauai District did not create an implementation plan and submitted its original Mokihana Project proposal.

In fact, the Mokihana Project has maintained many of the same elements, including level of staffing, since 1997. The project provides mental health services on school campuses, but staff have not fully embraced the School-Based Behavioral Health Program's educational model. Initially, the project was identified by state-level administrators as the closest example of the Department of Education's version of school-based mental health services. However, a state-level administrator noted that as the School-Based Behavioral Health Program evolved, it became clear that Mokihana is actually more clinical in nature. Furthermore, an attendee at a Mokihana Management Team meeting questioned why

changes to the project were needed when the State had yet to provide evidence that "what they've got" was any better.

Some flexibility is needed for district-specific concerns. However, there should be a basic standard or structure that districts can refer to as needed. Additionally, as long as Hawaii has a statewide educational system, accountability must be reflected on a statewide basis. With the wide variation in implementation of school-based behavioral health services, an overall assessment of the system as well as any comparative analyses across districts will be very difficult.

Some staff still unclear about the program's target population

Responses to our inquiry regarding the relationship between the School-Based Behavioral Health Program and the Comprehensive Student Support System (CSSS) varied greatly. We interviewed a number of district and complex-level staff who were directly involved with the program. Many respondents provided limited descriptions of the target population of school-based behavioral health, despite the fact that departmental documents and state-level staff emphasize that the program supports *all* students.

In April 2001, the current superintendent (then deputy superintendent) distributed a memo to district superintendents and district educational specialists regarding the Department of Education's framework for what was then termed school-based mental health services. Services were defined as "the broad spectrum of psychological and social supports and services along the five levels of the CSSS continuum. It requires the existence of a range and array of prevention, early intervention, and treatment services and activities."

However, approximately two-thirds of the over 30 district and complex-level staff we interviewed did not view the program in terms of the five levels of CSSS. For example, as expressed by one district-level administrator, school-based behavioral health ". . . covers more serious services such as those that fall under Chapter 56, 504 or special education – anything that requires an IEP (Individualized Education Program) or Modification Plan." When asked whether there was any instance when school-based behavioral health services could extend below Level 3 of CSSS, one administrator responded negatively and emphasized that the program directly relates to the provision of mental health services for special education and 504 students.

Only about one-third of the respondents provided explanations that were more in line with what state-level administrators have expressed. A school-based behavioral health resource teacher stated that school-based behavioral health ". . . goes across all levels of the support system, from the lowest, where students are taught about respect, social skills,

character education, to more intensive residential services. School-based behavioral health is part of that spectrum." Another district-level administrator noted that the program is "an enhancement of CSSS, and is blended with other services rather than standing on its own."

Lack of understanding of something as basic as the target population of a program should be a serious concern for the Department of Education. Such misunderstandings will make it difficult to implement future aspects of the program. Some staff who view school-based behavioral health services as strictly for *Felix* or special education students may feel that their responsibilities have been unfairly expanded once they realize that the program is intended to serve all students. Additionally, current staff with a limited understanding of the program may confuse newly hired staff by perpetuating misinformation.

Personnel issues are being addressed retroactively

The Department of Education failed to establish clear personnel guidelines for school-based behavioral health staff, leaving each district to languish in confusion. Position classifications and descriptions, minimum qualification requirements, salaries, recruitment and hiring issues were waived, with the rationale that employees would be exempt from civil service and compensation laws, and appointments would end in June 2002. The intent of this arrangement was to allow the districts flexibility to expedite the hiring process. However, in an attempt to address the resulting inequities across districts, the department is currently attempting to retrofit a statewide system by integrating the disparate elements of each district's structure.

A number of key personnel issues are pending. These include the development of position classes and descriptions with consistent minimum qualification requirements for each class of positions, such as behavioral health teachers, clinical psychologists, and social workers; salary determination; development of a hiring procedure for exempt school-based behavioral health positions; and clarification of roles and responsibilities. A key concern facing the department is the curious status of school-based behavioral health employees who are supposedly exempt from civil service, but are allowed union membership.

Although school-based behavioral health staff's status is designated exempt, unionized employees occupy some positions, resulting in massive confusion about appropriate personnel procedures. Under the premise that these were exempt employees, district program coordinators were not required to implement a probation period or conduct formal evaluations. However, school-based behavioral health staff's membership in the Hawaii Government Employees' Association Bargaining Unit 13 means that, after June 28, 2002 (the end of the current appointment period), former employees can file a grievance with the union alleging wrongful termination if their contracts are not

renewed. Districts without sufficient documentation of specific concerns about "problem employees" will be forced to retain these individuals after the end of their appointment periods to allow time for corrective action.

Union membership also means that these employees are subject to collective bargaining. Unfortunately, the program's first day of implementation coincided with that of the new government employees' contract, which contained a number of reforms. Those who accepted job offers based on benefits in the previous contract found their vacation and sick leave benefits reduced from 21 days to 12 days. Since then, the union has filed a grievance against the Department of Education to obtain benefits under the prior contract, with arbitration set for April 2002. One school-based behavioral health resource teacher remarked that morale was low among school-based behavioral health staff, particularly those who left higher-paying private sector positions in exchange for more vacation time. Another district-level staff member indicated that these employees are all threatening to leave their jobs and instead return as contracted providers, which could be more costly to the State.

The department's excuse for not setting up proper procedures was the urgency of program implementation. However, the Department of Education could have avoided the current turmoil if it had taken the time to utilize existing personnel guidelines common to all state agencies and provided more standards up front.

The lack of standardized position descriptions has resulted in the hiring of unqualified staff

Disparate position descriptions for similar responsibilities have resulted in uneven hiring practices. Out of approximately 100 behavioral health specialists, district staff estimated that between 20 to 30 percent do not have the master's degrees required for their positions. More than half of these are in neighbor island districts, reflecting what district-level staff call the difficulty of filling positions in remote rural areas. District-level staff justified hiring those without the master's degrees by pointing out that employees who had bachelor's degrees typically had years of experience in the area, or were working toward their master's degrees at the time of our fieldwork.

The minimum educational requirement itself was not clear. Most districts pointed out in their respective implementation plans that master's degrees were "preferred" rather than "required." However, this became a requirement about three weeks after the program was already implemented and staff were hired. To demonstrate the lack of an official communication, even the personnel specialist responsible for school-based behavioral staff was unaware of the policy.

When asked to confirm the master's degree requirement, state-level staff produced an informal e-mail from the superintendent to complex area superintendents that stated simply that only master's level applicants should be considered for school-based behavioral health positions, or the school will be liable for any mistakes made by the employee. As of April 2002, no official directive has been issued to reflect this change.

District-level staff also differed in their interpretation of the new requirement. Some stated that an advanced degree was required, but if no qualified applicant was available, then a waiver was allowed for remote areas. Others noted there was a waiver if the employee was pursuing a master's degree while on the job, or if the employee had years of experience. Still another district produced documentation of a specific request for a waiver of the educational requirement, which meant that those staff were not aware that such a waiver already existed. Another district ignored the requirement altogether, with staff saying that they "preferred to hire the best applicant rather than one who met the educational requirement." The lack of standardized position descriptions and informal communication regarding new requirements has created confusion among district-level staff who are responsible for hiring and supervising these employees.

Lack of standardization has also resulted in pay inequities

The State's decision to standardize pay scales has resulted in anxiety among some employees who had been receiving higher salaries than those in the same positions and job responsibilities in other districts, or even other complexes within their districts. Two districts acknowledged providing a pay differential to school-based behavioral health staff in their areas. In many cases, the inequities can be significant. For example, a doctoral-level psychologist or a similar position providing clinical supervision could either earn $70,000 a year in the Honolulu District, or up to $123,000 in the Central District. In Hawaii District, the same position could pay $70,000 to $80,000 in Hilo or $100,000 in Ka'u. As a result, districts were competing with each other to attract qualified candidates. For example, one program coordinator said there were 44 applicants for 18 therapist positions because that district initially paid between $45,000 to $50,000 per year. Another program coordinator said the pool of master's degree people was not large enough.

Standardization of pay scales across regions will create a more level playing field and give employees more mobility within the state system. However, facing potential salary differences, some employees may resign. Therefore, districts will once again fall short of the labor pool they need to provide effective services.

Staff report that more training is needed to properly implement educational model

The educational model has been inadequately implemented by staff who were trained in the clinical model of mental health delivery. In this model, they diagnosed patients one-on-one and attempted to cure them of their symptoms. Because school-based behavioral health is rooted in the educational model, wherein students receive embedded support services to enhance educational achievement rather than services to treat or "cure" a specific mental disorder, some staff have indicated that they need more training to make the transition. A district-level staff person reported having to remind these employees repeatedly that their orientation must change, and that therapy or counseling cannot be done in a vacuum or in isolation, since intervention plans are determined by teams and not just between provider and client. One staff member noted that peers had to be reminded that their services should be school-related, and services such as home visits should be minimized.

A district-level staff person explained that a contributing factor may be the lack of a local certification program in school psychology. Although there are a number of programs available for clinical psychologists, district staff noted that their training is not always conducive to addressing school issues. This compromises both the development of talent within the state, and the professional development of those who were hired from outside the state.

A district staff person believed that the Department of Education still has a stronger clinical orientation than an educational one. Districts typically conduct orientations regarding the department, as well as training sessions on such legal issues as the Individuals with Disabilities Education Act, Section 504 and Chapter 56 (which reflects the Department of Education's administrative rules governing special education programs). The department also trains on the Comprehensive Student Support System, how to write an Individualized Education Program (IEP), and how to use the department's management information system. The rest of the training might include information on such clinical diagnoses as attention deficit and hyperactivity disorder and autism. A district-level administrator noted that cognitive and behavioral interventions are not emphasized as much as clinical diagnoses. The staff person noted that once a student is diagnosed, there is a perception that formal treatment, such as therapy, must be initiated instead of investigating other alternatives to support the student in the classroom. In contrast, both state and district-level staff said that school staff must be educated about the appropriate use of clinical assessments. According to state-level staff, these training sessions are lacking a component that is estimated to address 90 to 95 percent of referrals: classroom management.

A state-level staff person cited research that only 5 to 10 percent of any school's population should qualify for Functional Behavioral Assessments and other such specialized services. The remaining percentages should "disappear" with effective classroom management. Any percentage over 5 percent was described as a burden on teachers. However, because teachers are insufficiently trained for classroom interventions and over-trained in using tools that are appropriate for only a small percentage of students, a much greater number of a school's population could potentially be identified as needing individualized support.

Training is also important for school-level staff who make decisions regarding their caseload, either administratively or through referrals for service. Since they are located at individual schools, school-based behavioral health staff are administratively supervised by the principal on a day-to-day basis – for administrative procedures such as signing in and out, obtaining permission to take leave, and so on. Some explained that because schools are short-handed, school-based behavioral health staff are sometimes called to address situations outside their intended responsibilities. To illustrate, one school-level staff member related that when a student was damaging property at a school, the school's staff called the school-based therapist. In the past, this would have necessitated disciplinary action by the vice-principal. Although therapists are at the school to serve students, the therapist should not have been called out of a session with another student in this case. State administrators stressed that school administrators need to re-examine their disciplinary procedures, to determine whether they are adequately communicated, fully understood, and consistently enforced.

A district-level staff person noted the abundance of training, but was unaware of whether staff were receiving any certification as a result, or if there was documentation of who attended training. One staff member commented on informal remarks by staff that training is "a waste of time." State-level staff reported that documentation of training is limited to hard copies of sign-in sheets. Additionally, other staff noted that they would like to add information regarding completed training to their resumes, but there was no other readily available evidence or any official documentation to serve as confirmation. Thus, although it is clear that there is no shortage of training, its usefulness and effectiveness is debatable.

Concerns with staff formerly employed by private provider agencies have been raised

Due to the absence of in-house expertise prior to the implementation of the School-Based Behavioral Health Program, the majority of staff in the program have been hired from former private provider agencies, according to district staff. Official figures were not available since the

department's state personnel office does not keep track of these statistics. While it might be argued that these new hires have the experience to perform their responsibilities, this practice has raised the question of how much improvement can occur when the service providers are largely the same individuals who were previously contracted by the Department of Health. As one district staff member noted, because the providers are essentially the same, the problems are the same.

One common concern among the districts is the extent to which employees who were trained in the clinical model can adjust to the educational model. In some districts, the shift in language and practice is troublesome. One district-level staff person noted that some former private provider employees appear to be resistant to the idea that they were no longer just responsible for providing one-on-one, individual therapy – but rather IEP-related services. As will be discussed in a section below, the department should have been better prepared to deal with the need for reorientation since the lack of understanding of the educational model was cited as one of the main concerns during the Department of Education's review of private provider agency proposals for contracts.

Staff maintaining their private practices has resulted in conflicts of interest

Another problem the department should have anticipated is the issue of conflicts of interest. Potential conflicts of interest have occurred as some school-based behavioral staff have maintained their private practices while employed by the Department of Education. One district staff member gave the example of a school-based behavioral health employee who billed for services rendered under the individual's private practice during school hours. Since then, the individual has been told to perform services related to private practice outside school hours.

According to a district staff person who was knowledgeable about similar questions previously raised at the Department of Health's Child and Adolescent Mental Health Division, the State Ethics Commission had issued the opinion that, as these employees had discretion over the selection of private providers, a conflict of interest occurs when they are simultaneously employed by the State and private agencies. The commission recommended that these providers practice as individuals or be disallowed from working as private providers. One district staff person noted that due to this opinion, some school-based behavioral staff with private practices have secured attorneys to support what they view as their right to maintain their businesses. The department needs to address these potential conflicts of interest issues as a substantial measure toward preventing provider fraud.

State management information system lacks features and reporting functions that are useful to school-based behavioral health staff

The Department of Education has not provided school-based behavioral health staff with adequate management information tools. The Integrated Special Education (ISPED) system has not provided school-based behavioral health staff with the seamless data collection and reporting mechanism that would aid in monitoring the effectiveness of school-based behavioral health services. ISPED was purchased by the education department and developed in 2000 to address concerns expressed in the *Felix* consent decree in 1994 regarding the lack of continuum of services, programs, and placement. The Department of Education's response was to develop an integrated data system to link those people involved with a student's care—service providers, teachers, parents and others—to a common database. The intent was to eliminate the duplication of work efforts, eliminate redundant system processing, eliminate processing bottlenecks, automate manual processes, provide timely and accurate information, and create flexible query and reporting capabilities. None of these goals have been met for the School-Based Behavioral Health Program.

Information system burdens rather than assists staff

Although ISPED was developed to promote efficiency, it has instead added to the staff's workload and requires them to take time to learn a system that is in constant flux while reducing the time they can spend on direct services. While some district staff expressed optimism at the eventual usefulness of the system, the current reality is that most staff are frustrated that they are required to use a system that is still in its developmental phases.

The coordinator of the system claimed that the lack of School-Based Behavioral Health Program-specific features was because the program was developed after ISPED was in place. However, the development and implementation of procedures regarding school-based behavioral health services was mandated by Act 91, Session Laws of Hawaii (SLH) 1999, prior to the Department of Education's ISPED purchase. This oversight in planning has resulted in a lack of coordination and frustration among the staff expected to implement the system.

At the most basic level, ISPED did not include school-based behavioral health categories until March 27, 2002 – eight months after these services were transferred from the Department of Health. Previously, there were no school-based behavioral health choices in the IEP or Modification Plan's (MP) services drop-down list. Staff were instructed to select either "Mental Health" and/or "School Counselor Services" and provide more details in the "Comments" field. Staff could also select "Other" and input more details. As a result, detailed reports regarding school-based behavioral health services and service providers were not readily available for tracking or monitoring purposes.

One program coordinator stated that at the time of our fieldwork ISPED did not produce state-mandated reports, such as the number of students exceeding the 60-day timeline for requesting and receiving services. The 60-day timeline report was added only on April 18, 2002. ISPED also did not create reports that would be useful for monitoring purposes, such as an overall view of contact logs—instead of a case-by-case inspection—or percentages of students in special education who were also receiving services under the *Felix* consent decree. As a result, the program coordinators call on school-level student services coordinators to submit these individual reports every month.

Another missing but significant feature is the financial module. Without this module, contract specialists have had to create district-level stand alone databases and/or spreadsheets, developed through commercial software, to monitor services provided by contractors. Kauai District staff continue to use their own database created for the Mokihana project—Psytrace—to monitor mental health services. In addition, the State is unable to readily gather timely information on expenses incurred or evaluate the cost-effectiveness of the program. The March 28, 2002 ISPED Bulletin indicated that a recently added function allows school-based behavioral health services to be assigned as a task to a specific provider. This is intended to serve as the foundation for eventual billing comparison, which includes ensuring that services provided were authorized. Meanwhile, district staff continue to use their own individual databases for this purpose.

Processing bottlenecks plague the system

Processing bottlenecks have undermined the availability of timely and accurate student records at the school and district levels. This was due to a feature that prevents school-based behavioral health staff from inputting student information until the special education teacher in-charge of the Individualized Education Program (IEP) marks the document "complete." At the school level, one program coordinator said, teachers did not want to mark the records complete because they were afraid that they would no longer be able to edit the document. Any significant alteration to an established IEP typically requires another team meeting, so rather than committing to a specific version of the IEP, teachers did not mark it complete even though the meeting had already taken place. Because of this, one service provider reported being locked out of students' records, and was unable to meet data inputting requirements.

According to a memo from the superintendent on February 20, 2002, the state office received numerous phone calls challenging the need for inputting visit logs if access was limited. The superintendent recommended keeping manual visit logs if IEPs were not in ISPED or if IEPs were scanned into ISPED, which made goals and objectives less

accessible. Only those with completed IEPs are required to input their visit logs into the system. Since paper and pencil logs have to be inputted into the system eventually, this does not eliminate the need for access to ISPED, but is only a temporary solution.

The actual source of the delays—the reluctance of teachers to mark an IEP "complete"—was not resolved. In response to this concern, the superintendent merely said that it was "critical that IEPs are marked complete." Indeed, on March 18, 2002, under the IEP section of Frequently Asked Questions (FAQs) in the ISPED website, this concern was defined as "a personnel management issue that the administrator at the school should be aware of and try to help resolve." However, in the March 28, 2002 ISPED Bulletin, a technological accommodation was made: the IEP/MP generation modules will enable users to create a "For Agency Use" document and/or an Event Log even after the IEP has been marked complete. Again, this series of responses constitutes band-aid solutions that do not directly address the staff's apprehension about using the system.

The bottlenecks at the school level have made it impossible for the database to contain timely and accurate information for monitoring at the complex and district levels. School-based behavioral health program coordinators and contract specialists have said that they use ISPED only to check on individual records rather than for aggregated reporting because the data is incomplete and therefore "questionable" for district-wide analysis.

Procurement process is marred with problems

The Department of Education was faced with a number of problems during its attempt to procure mental health services, including the lack of adequate criteria to evaluate proposals. Although the department indicated that it plans to follow the requirements of Chapter 103F, HRS, (*Purchases of Health and Human Services*) in the future, current contracts were awarded under a waiver granted by the federal court to the former superintendent under the *Felix* consent decree. Therefore, the contracts escaped the scrutiny of oversight bodies, such as the Board of Education and the Department of the Attorney General. Such scrutiny might have prevented some of the problems the department is currently facing.

The department utilized three types of contracts:

1. *Transition contracts* extended the effective date of Department of Health contracts that existed prior to the July 1, 2001 transition. The duration of these contracts was originally limited to three months to allow for the "transition" of services to the Department of Education. However, many of these contracts were extended an additional two

months and, in some instances, are still in existence. Transition contracts were not subject to the Request for Proposal (RFP) process.

2. *School-based behavioral health contracts* were initiated by the Department of Education through an RFP process and covers such services as assessment, individual counseling, group intervention, psychiatric evaluations, medication monitoring, and IEP participation.

3. *Community-based instruction contracts* for day treatment programs were also initiated by the education department and underwent an RFP process as well.

We reviewed the evaluation process for the school-based behavioral health and community-based instruction contracts. Transition contracts were not reviewed because they merely replicated the terms of the original Department of Health contracts and did not undergo a formal evaluation process. All of the districts, except for Kauai District, which had existing contracts under its Mokihana Project, participated in the evaluation process. State-level review teams, comprised of school-based behavioral health administrative staff, were provided with a checklist of review criteria and rating sheets.

For both kinds of contracts, the evaluation process was quite similar. A committee comprised of members who had experience in, knowledge of, and responsibility for program service conducted the programmatic assessment. The total possible points for this part of the evaluation was 70, consisting of the following categories: background and summary (10 points), experience and capability (20 points), personnel: project organization and staffing (10 points), and service delivery (30 points).

The second assessment was a fiscal review conducted by the district contract specialists. The total number of points for this assessment was 30. Ten points was the maximum number of points that could be awarded for each of three categories, which included competitiveness and reasonableness of the proposed group rate, reasonable budget proposal, and adequacy of accounting system.

Results of the contract review were categorized into three tiers, and the information was forwarded to the districts to assist them in the selection of private providers. A score of 70 points or higher indicated that the proposal passed review, and districts could contract with the provider. A score between 50 to 69 points meant that the proposal passed conditionally and that the district should contract with the provider only if there is sufficient justification (such as a unique geographic need). A score of 49 points or below was an indication that the proposal was inadequate and that the district should not contract with the provider.

RFP evaluation criteria were weak and poorly constructed

During our review of community-based instruction proposals, we noted several problems. We were able to review 13 of 15 program evaluation sheets completed by the reviewers. We noted that two sheets were missing and notified the Contracts Section Manager who could not locate them. Of the 13 proposals we were able to review, we noted that the reviewers had a number of concerns with the proposals, which included weak supervision (6 out of 13 proposals), unqualified staff (6 out of 13 proposals), and the failure to demonstrate an understanding of the educational model (7 out of 13 proposals). However, despite these concerns, the scores for 12 of the proposals were 70 and higher, indicating that they passed the review. All but three of the proposals received the full score of "30" for the financial score, with the other three proposals receiving a "25."

The scores of the financial analysis compiled by the department may not be completely reflective of the quality of the proposals submitted. The reviewers acknowledged that the department was at fault for not specifically asking applicants for information on transportation, facilities, employee costs, and lunches (meals) for students. Since these criteria were not explicitly stated or clearly explained in the RFP, the reviewers were instructed not to penalize the applicants for failing to include this information. Possible inflation of scores may have occurred because all applicants were automatically awarded 10 points for competitiveness and reasonableness of the group rate to reconcile the education department's error. Several proposals with scores barely over 70 might not have received passing scores if all of the necessary criteria were taken into consideration.

The department placed a heavier emphasis on cost than capability

The transition coordinator for school-based behavioral health services emphasized that the department placed a heavy emphasis on cost and those with the lowest rates had an advantage. This focus was evident for the school-based behavioral health services contract in particular, where the financial analysis component was 40 points or close to half of the total evaluation score. We agree that cost-efficiency is important; however, cost should not outweigh the capability of the provider to deliver services in an appropriate and effective manner. In fact, experience and capability made up only 10 percent of the total possible score.

The reviewers were clearly concerned with several of the 33 proposals that were submitted. Thirteen or 39 percent of the proposals were viewed as having a lack of knowledge of school-based behavioral health and/or the educational model. Several comments from evaluators

include: "Proposal did not display full grasp of SBBH and necessary theoretical understanding of a non-medical based system of care" and "Non-responsive to SBBH and CSSS. Delivery theory too clinical, not in conformance with SBBH." Sixteen of the proposals received scores below 70.

Reviewers also had an overall concern with the number of proposals that did not address the RFP. Concerns with vagueness, lack of clarity or specific details, and mere regurgitation of what was presented in the RFP were raised for half of the proposals (17 out of 33). Six of these proposals received passing scores even though it appeared the reviewers had rather substantive concerns. For example, one of the proposals received a score of 74 despite comments as follows: "vague on staffing pattern, vague in all sections, not clearly defined, confusing org chart, evaluation criteria a little weak." One proposal that received a score of 71 was referred to as having "no staff training; professional development – appear inadequate; vague. Sketchy plan. Unclear on scope of services, but adequate for limited number of services."

When the final scores were calculated for all of the proposals, only 17 out of the 33 proposals passed with scores of 70 and above, which eliminated nearly half of the potential providers. However, in an attempt to develop a large enough provider pool, the decision was to allow districts to contract with providers with scores of 50 to 69. Given these concerns, the department should have assisted the districts in developing a system to assess the quality of services rendered by private provider agency staff.

Because of staffing shortages, some districts have been forced to rely more heavily on contracted services than other districts. However, these districts do not have the proper controls in place to monitor contracts. The districts, as a whole, rely heavily on contractors to "police" their own employees/subcontractors. Most districts have largely conducted procedural/paper audits, merely ensuring that the hours billed for were properly authorized.

Only two of the seven districts (Maui and Windward) have demonstrated, through self-initiated projects, that they have actively attempted to scrutinize private provider billings to curtail potential fraud. These reviews have yielded evidence of potential overbilling and provision of inappropriate services. For example, after reviewing records for a particular private provider agency, one of the districts found instances of excessive amounts of individual and family counseling by the same individual and overlapping times for services provided on the same day. We were also informed of the district's termination of a contract as a result of poor performance.

The department's sloppy procurement procedures lead to concerns with potential litigation

The Department of Education took a lax approach to procurement for the School-Based Behavioral Health Program despite its familiarity with the state procurement process. The Department of the Attorney General commented on the department's sloppy procedures. On July 16, 2001, the attorney general's office returned 16 contracts after refusing to conduct a review requested by the education department and noted in a memo that the contracts had been executed, and in effect, there was no point in conducting the review. The memo concluded with the following statement: "In order for there to be a proper and meaningful review of the Agreements, our office must receive the Agreements prior to their execution and effective date. In the future, please have the Agreements sent to us prior to execution." Consequently, the Department of Education lost the opportunity to identify any potential legal issues that may arise in the future.

The department was also careless with other aspects of contract processing. During our onsite review of each district's contract files, we found that many of the contracts had been signed after the effective date of July 1, 2001. In one district, all ten school-based behavioral health contracts were signed late, with a range of over one month (August 10, 2001) to as long as four months late (November 13, 2001). In fact, all but two of the school-based behavioral health contracts were signed after the contract had taken effect, which puts the State at risk. Allowing contractors to begin work before a contract is properly executed can result in conflict between the two parties and possible legal problems for the State.

The Department of Education was also faced with other potential legal problems linked to private provider agencies' opposing the transition to school-based behavioral health services. A private provider agency, currently providing services in a number of districts, had distributed a memo in July 2001 to its subcontractors. The memo stated that workshops were available that were "geared towards empowering parents that may not be aware of the transitioning between DOH and DOE system." The agenda attached to the memo appears to bias parents toward opposing the transition by assuming that the Department of Education is unable or incapable of providing the same services as were provided under the Department of Health. For example, the first scenario states: "DOE/DOH tells you they are changing your child's service/provider to school-based services, even though that is not appropriate for your child." The recommended response is: "DO NOT AGREE. Say No, and explain why you are saying no."

Given that these are the same private provider agencies that have been utilized by the Department of Health, the Department of Education

should have anticipated such problems. At minimum, the department should have attempted to ensure that these entities were "on board" with the transition.

Existing litigation has resulted in higher than expected transition costs

In addition to concerns with potential litigation, there are existing legal matters affecting the School-Based Behavioral Health Program. Current litigation primarily relates to organizations that have refused to transition students from their care to the Department of Education. As a result, the program's transition costs were higher than anticipated. As noted earlier, transition contracts were originally intended for a three-month period (July 2001 to September 2001), but the department was forced to extend all but two of the 27 transition contracts until November 2001, with one extending to December 2001, for those students who still had not been transitioned.

As of January 2002 (as of October 2001 for Windward District), the department estimated that it spent approximately $3.4 million for transition contracts. However, this total may be even higher, given any overlapping costs incurred from having in-house or departmental staff on board and that several contracts have been extended beyond this date and may continue indefinitely. In one district, because of current litigation with a private provider agency, the monthly cost to the department has been approximately $59,000 and costs will continue to be incurred until the case is settled.

The majority of the private provider agencies that responded to the Department of Education's RFP had worked with the Department of Health's Child and Adolescent Mental Health Division for several years and had developed either positive or negative reputations. This should have been taken into consideration by Department of Education staff, so they would be better prepared to deal with potentially difficult private provider agencies. Furthermore, the department failed to capitalize on the backgrounds of former health department staff, now currently employed by the education department, who played integral roles in the procurement process. Yet, as stated earlier, the department downplayed the importance of experience and capability in its ratings.

Quality assurance measures are not in place

Evaluating the quality of mental health services, which involves reviewing the appropriate and effective delivery of services, was found to be one of the Department of Education's shortcomings. In Report No. 01-16, *Follow-Up and Management Audit of the* Felix *Consent Decree,* we raised concerns with the education department's ability to manage mental health services effectively and economically. We noted the department's lack of in-house expertise to administer clinical standards

for mental health services provided by private sector mental health professionals, which would likely place a heavy reliance on providers to determine appropriateness. These concerns were well-founded as the department still does not have a well-defined mechanism in place to ensure quality.

When we requested policies and procedures regarding quality control to determine effectiveness of mental health services, we were provided with a hard copy of a slide presentation on supervisory training for staff. Currently, the department relies primarily on a supervisory strategy using contact-by-contact reporting to track student progress. The department explained that for each student, each person involved in an intervention with that student must document when the intervention occurred, what occurred during the visit, and whether or not there has been any progress. Maintained by the supervisor, this information is documented manually, but there are plans to input the information directly into ISPED. Currently, this capability is still under development. As stated earlier, ISPED capabilities related to school-based behavioral health services were only implemented recently.

Districts have inconsistently attempted to develop quality assurance measures

Each district has made its own attempt to develop quality assurance measures. However, as with district implementation of the School-Based Behavioral Health Program as a whole, these efforts are quite diverse. The only common element in each district is regularly held quality assurance meetings that attempt to address school level and complex/ district level concerns. However, what is discussed at these meetings varies widely. We reviewed quality assurance meeting minutes in each district and found that the majority of the districts were still in the discussion phase and were still identifying potential outcome measures.

Most likely due to the pressures of meeting compliance with the *Felix* consent decree, many of the quality assurance efforts are focused on the individual student level and refer to service testing as a means to claim that services provided were effective and appropriate. Such an assumption is limited because service testing is not a scientific measure and only provides a snapshot of service provision for a select group of cases. Furthermore, in order to ensure that all students are receiving fair treatment, an assessment needs to be conducted systemically to identify common problems throughout the school-based behavioral health infrastructure from state to district/complex to school levels.

Clearly, districts and complexes need more guidance from state level administrators. If outcome measures are not standardized and are not collected uniformly, an overall assessment of the system cannot be made. The Department of Education should require certain standardized

measures to allow for a system-wide evaluation, but also encourage districts and complexes to collect any other data they perceive as useful for their specific needs.

System-wide assessment is lacking

According to the School Mental Health Project's May 2001 report, *Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations*, in addition to outcome measures of student progress, it is important to evaluate the system. Specific written policies and effective infrastructure, mechanisms, procedures, and personnel must be in place. The authors of the manual, whose work was used as the basis for the Department of Education's School-Based Behavioral Health Program, describe this system-wide review as a process evaluation. The department needs to conduct a process evaluation of its system to identify any deficiencies. Such an evaluation would allow decision-makers to assess program effectiveness, make informed decisions about the continuation of the program, and make necessary improvements. We have found in past audits that when programs have not been adequately evaluated, decision-makers cannot: (1) make sound decisions based on facts; (2) make the best use of public funds; and (3) be accountable to the general public.

The Department Does Not Accurately Account for the Program's Funding

The Department of Education has not accurately represented the budget for the School-Based Behavioral Health Program. According to the department, the budget for school-based behavioral health services for FY2001-02 is $27,226,130, which includes 405 positions. The program's budget is often referred to as *Felix* Response Plan Item 3, entitled *School-Based Services*. The plan is comprised of 12 items or budget requests that were created in response to the contempt order of May 2000. The department has repeatedly insisted throughout our inquiry that Item 3 is the only response plan item related to the School-Based Behavioral Health Program. However, based on further discussions with personnel and fiscal staff and analysis of budget documents, we found that the figures presented to us initially by the department are imprecise.

In an analysis conducted by the Department of Education's budget staff dated November 15, 2001, the FY2001-02 budget for the School-Based Behavioral Program is actually $41.1 million and consists of 698 positions. Apparently, the department failed to include an additional $14 million in related funding and another 293 positions. Most importantly, as presented in Exhibit 2.1, the document makes a distinction between current or base funding versus additional funding. Therefore, the department failed to emphasize that *Felix* Response Plan Item 3 is

representative of only additional funding requirements and not the total budget for the School-Based Behavioral Health Program.

Positions and funding already existed in the base budget

Without realizing that positions and funding already exist to support school-based behavioral health services, any analyses to determine the program's budget needs would be based on a faulty premise. For example, according to the budget document that delineates current and additional funding, there were 94 high risk counselors with related funding of $3,644,117 and 70 school social workers with related funding of $2,775,295 that already existed in the budget. These two categories alone represent 164 positions and $6,419,412 in funding that would not have been considered.

The failure to present an accurate picture of the budget for the School-Based Behavioral Health Program hampers the Board of Education's and the Legislature's ability to confirm the needs of the program. Therefore, these and other oversight bodies should be wary of the department's presentations. For example, as part of its estimated program costs, the department included $1,571,982 and $200,000 in "other support" for the School-Based Behavioral Health Services Director and the Student Support Section. The approximately $1.6 million was in reserve for unanticipated costs. However, we were informed that except for approximately $193,000 allocated to Hawaii District to cover contract costs, the department did not foresee any need to use the remaining funds. The department reached this conclusion despite the fact that there is a reported $1.5 million shortfall in the program's budget.

Regarding the $200,000 for "other support," over half of the funds are for three school-based behavioral health mentors ($90,000) who reportedly provide "ongoing mentoring for district/school plus crisis support" and airfare for complex mentors ($18,000) who provide "local complex leadership development." To date, the department reports that funds have not been used and no one has been hired. Therefore, we question whether such a budget item is truly necessary.

The *Felix* Response Plan does not represent the complete budget

Fiscal and personnel staff of the Department of Education emphasized that school-based behavioral health is limited to *Felix* Response Plan Item 3. A memo from the assistant superintendent of business services to district and school-level staffs, dated December 2001, stated that School-Based Behavioral Health Program positions are funded by *Felix* Response Plan Item 3 and that positions not funded by Item 3 are not School-Based Behavioral Health Program positions. However, based upon our analyses we determined that this program is represented under

Exhibit 2.1
FY2001-02 School-Based Behavioral Health Program Operating Budget (Including Base and Additional Funds)

SBBH Services	Current FTE	Current $	Additonal FTE	Additional $ (Felix Response Plan Item #3)	Total FTE	Total $
High Risk Counselors	94	$3,547,117	41	$1,287,564	135	$4,834,681
Other current expenses		97,000		51,250		148,250
SBBH Behavioral Specialists			250	10,671,750	250	10,671,750
Other current expenses				658,000		658,000
Equipment				250,000		250,000
School Social Workers	70	2,775,295	76	2,138,240	146	4,913,535
Other current expenses				8,098,777		8,098,777
Equipment				76,000		76,000
School Psychologists	24	937,810	69	4,173,165	93	5,110,975
Other current expenses				299,134		299,134
Equipment				564,072		564,072
Nurse Practitioners						0
Other current expenses				119,085		119,085
Transition Services -- SPED Teachers	40	1,610,785			40	1,610,785
Other current expenses		15,400				15,400
Summer Recall Services		1,373,364				1,373,364
Contracted SPED Services		969,816				969,816
Infrastructure Support (for SBBH) Program						
Program Coordinators			7	389,487	7	389,487
Clerk Typists			7	135,240	7	135,240
Other current expenses				28,584		28,584
Equipment				14,000		14,000
Contracts Manager			1	55,641	1	55,641
Fiscal Specialist			1	55,641	1	55,641
Secretary			1	21,708	1	21,708
Contracts Specialists			7	389,487	7	389,487
Contracts Clerks			8	173,664	8	173,664
Other current expenses				22,808		22,808
Personnel Management Specialist			1	55,641	1	55,641
Personnel Clerk			1	21,708	1	21,708
SBBH TOTAL	228	$11,326,587	470	$29,750,646	698	$41,077,233

Source: Director of Program Support & Development, Office of the Superintendent, Department of Education Analysis as of 11/15/01.

at least two of the other categories in the plan. For example, there are two program specialist positions, paid $100,000 and $125,000, that are located in *Felix* Response Plan Item 10.

Item 10, referred to as "Academy," consists of positions and funds to provide training for school complexes to assist them in addressing general need areas in autism, functional behavioral assessment, program planning, reading, and coordinated school-based mental health services. One specialist has been identified as the program specialist for school based services and has been referred to as the key contact for the School-Based Behavioral Health Program. The other program specialist, responsible for functional behavioral assessment training, is also viewed as important to the program since the training is integral to school-based behavioral health. Therefore, it can be argued that they should be considered school-based behavioral health staff.

Felix Response Plan Item 12, entitled "Related Services Support," is comprised of positions such as high-risk counselors and complex school psychologists who are clearly involved with school-based behavioral health services. In fact, these positions were reflected in the analysis conducted by the department's budget office that revealed additional positions and funding that have not been linked to the School-Based Behavioral Health Program in its official operating budget, see Exhibit 2.1. However, there are a number of other positions that are involved with the program as well, but may arguably have other duties outside the program. These include student service coordinator and educational assistant positions. Student services coordinators under Item 12 are described as assisting the schools' delivery of school-based services and programs to provide students with a system of support to enable them to become successful learners. Educational assistant positions were described as providing coordinated services, including mental health services, for all students with special needs.

Budget details vary depending on the source

Using official documents presented to the Department of Budget and Finance and the Legislature as a reference point, we have been unable to reconcile differences in position counts and funding for the School-Based Behavioral Health Program. In an attempt to definitively determine the program's budget, we have made several inquiries to personnel and fiscal staff to no avail. When we contacted the personnel specialist responsible for school-based behavioral health positions we were informed that there were 383 positions and were provided with documentation reflecting such. However, since the official budget reflects 405 positions, we inquired about the other 22 positions. The personnel specialist indicated that he did not have any knowledge of the 22 positions and would have to question program staff. To add to the

confusion, when providing an update on school-based behavioral health services cost, the department indicated on a document representing "estimated program costs" for FY2001-02, a position count of 366.75.

In fact, we were informed that if we desired any information outside *Felix* Response Plan Item 3, we must contact district staff directly because the information was not compiled at the state level. When we inquired about School-Based Behavioral Health Program funding in addition to Item 3, the fiscal specialist for the program said it was outside his jurisdiction. Essentially, we encountered the same difficulty as the Department of Education's internal auditor when he conducted his audit of the *Felix* Response Plan in March 2001. The final report noted that program managers had insufficient tools to fiscally manage operations and that data was seriously fragmented among several sections of the department – budget, personnel, accounting, programs, districts, and schools. Close to a year later, after the report's issuance in June 2001, we found no evidence of corrective action despite the internal auditor's recommendation that the department create a comprehensive *Felix* financial report that extracts and compiles data from all levels in an understandable format.

The department makes an arbitrary distinction between school-based services and school-based behavioral health services

The misrepresentation of funding and positions is partially due to the fact that the department makes an arbitrary distinction between school-based services and school-based behavioral health services. The overriding perception appears to be that school-based behavioral health services is limited to the provision of mental health services, such as therapy and treatment. In some cases, there are perceptions that the program is even more limited to the *Felix* population.

Many staff failed to realize that school-based behavioral health is meant to provide assistance to all students and is aligned with the larger framework of school-based services (sometimes referred to as the Comprehensive Student Support System or CSSS). Notably, the underlying basis for determining the number of positions and the amount of funding required for program implementation was not derived in a standardized manner. Some districts considered school-based services in general, while others attempted to focus more closely on mental or behavioral health. Such variation makes it difficult for state administrators to accurately determine the budgetary or personnel needs of the program. In fact, one district administrator noted that comparisons between districts could be likened to identifying similarities between apples and oranges.

Therefore, a more accurate way of categorizing school-based behavioral health positions would be to determine whether a position provides mental health or behavioral health services to any student, regardless of whether they are special education students and regardless of whether

they are members of the *Felix* population. Taking this definition into account, we reviewed each district's implementation plan for school-based behavioral health services and documented what each district identified as "existing" school-based services positions versus "additional" school-based behavioral health positions.

Despite the inclusion of similar positions, such as clerks and psychologists, there are a wide variety of positions under the school-based services category. For example, four of the districts classified psychological examiners as school-based services positions, while others did not. To allow for some degree of consistency, we attempted to categorize positions in as standardized a format as possible and then asked each district to confirm whether the information we obtained from their district plans was correct.

Our review confirmed that there are a number of additional positions, labeled under school-based services, which are closely linked to the School-Based Behavioral Health Program. For example, we found that in addition to 19.8 school-based behavioral health positions, there are 176 school-based services positions in the Central District. Many of these positions have responsibilities that overlap. Therefore, as stated earlier, the Board of Education and the Legislature might consider requesting the Department of Education to more clearly define the relationship between school-based services and school-based behavioral health services.

For districts that have provided confirmation, we have included information in Appendix A regarding the total number of positions involved in school-based services and school-based behavioral health services. Some districts offered additional comments to explain their understanding of the relationship between school-based services and school-based behavioral health services, which we included.

The Impact of Autism Services on School-Based Behavioral Health Staff Is Unclear

The failure to develop an infrastructure prior to program implementation resulted in a number of problems for the School-Based Behavioral Health Program. Rather than proceed with caution, the Department of Education is forging the same troubled course with the transfer of autism services from the Department of Health on July 1, 2002. As of late March 2002, the department still had not finalized its infrastructure for autism services, even though it was in the process of reviewing RFPs and was scheduled to award the contracts at the end of the month. In the meantime, school-level staff have been conducting IEP meetings and starting to plan resource needs for the following school year. Without knowledge of the expected interplay between current employees and contracted providers, department staff are inadequately prepared for the upcoming transfer.

Distinction between school-based behavioral health and autism services is artificial

Autism services are not totally separate from school-based behavioral health services because there will be overlaps in infrastructure, and possibly staff. The department distinguishes autism as a special education category and therefore separate from school-based behavioral health. However, the autism RFP pointed out that "services to be provided are to be integrated with the comprehensive student support system and school-based behavioral health supports and services in order to ensure timely and appropriate access to a full array of educational resources."

The State's autism specialist stated that autism falls under the Office of Curriculum, Instruction, and Student Support, specifically as part of Special Services. Therefore she did not foresee school-based behavioral health staff being involved with this population. She acknowledged that autism services might use some of the School-Based Behavioral Health Program's infrastructure, such as procurement. One resource teacher pointed out, however, that school-based behavioral health staff are not precluded from providing services to special education students. In addition, Functional Behavioral Assessment—a method of documenting behavioral triggers, consequences and possible interventions, and one of the building blocks of the School-Based Behavioral Health Program—will be used for autistic students if there are behavioral concerns. The artificial separation of autism from school-based behavioral health leads to clouded lines of responsibility, leading to widespread confusion among the staff.

The role of current staff in the provision of autism services has not been adequately assessed by the department

District staff have complained that discussions for the autism plan have not addressed school-level responsibilities. One district administrator noted that a number of his peers were concerned that the plan was weak. Some district staff expressed concern that the procurement of services for autism would be added on to the responsibilities of the school-level student services coordinators who already feel overburdened. Another concern was that there would be only one clerk per complex to assist with procurement. Additionally, concerns were raised regarding who would be responsible for informing the clerk about procurement requirements – the mental health therapist, student services coordinator, school psychologist, or some other person. Some staff were concerned that the behavioral health specialists might be called to assist teachers in therapeutic classrooms, compromising their intended role as providers of preventative care for a wider range of students with less intensive needs.

The State's autism specialist noted that the Department of Education's immediate role is to take over the procurement of services, not provide them. This appears to be the focus of current planning efforts. However, the procurement of services does not mean that school-based behavioral health staff will not be called upon for additional duties. The sooner the

department acknowledges this, the more effectively it can make appropriate plans and communicate them to staff.

The department underestimates the difficulty of providing autism services

Details regarding components of the infrastructure for autism services are still very much under discussion. The absence of a definitive plan three months before the transfer ignores the fact that taking responsibility for autism services means an exponential increase in the total number of students, the types of services, and the number of contracted services per student. Autism is a complex developmental disability resulting from a neurological disorder that affects the functioning of the brain in the areas of social interaction and communication skills. This is a spectrum disorder, meaning that symptoms and characteristics of autism can present themselves in a wide variety of combinations, from mild to severe.

Currently, the Department of Education is the sole provider of services for 139 students, addressing their instructional needs during the school day. After July 1, 2002, that number is expected to increase five-fold, with an estimated total of 692 autistic children eligible for educational support. Aside from the larger volume of students, the range of services will also include such additional services as assessment, parent training, parent counseling, autism/mental retardation counseling, skills training, extended school year services, therapeutic recreation, special schools and medication monitoring. In addition, the number of services per child is expected to increase. One contract specialist said that a typical student might receive one to two contracted services under school-based behavioral health, but an autistic student might require the services of as many as ten contracted providers.

The plan unveiled in February 2002 showed that autism services appear inadequate in light of the increased volume and complexity of contracts to come. At the state level, the Department of Education has hired an autism specialist functioning as the program head, who will oversee one state-level Autism Consulting Teacher (ACT) at a training site on Maui, three autism speech-language pathologists and ten ACTs to be deployed to the different districts. The transition plan also pointed out that on July 1, 2002 the autism specialist from the Department of Health will be transferred to the Department of Education. Joining her will be ten Autism/Mental Retardation Family Consultants and 15 account clerks for contract monitoring purposes. One program coordinator criticized this infrastructure as inadequate, because it consists mostly of resource-teacher types of positions. In light of the additional contracting responsibilities, a district staff person was worried that the transfer would turn into a "care coordination nightmare," with no assistance given to student services coordinators who already feel overburdened.

One district staff member pointed out that the Department of Health's Children and Adolescent Mental Health Division had a much larger infrastructure for managing contracts. One question posted on the autism RFP website revealed that there are currently 15 care coordinators handling more than 40 children on Maui, but after the transfer there will be only two. Specifically, the query was how two people would have the ability to adequately provide services. The response was that a plan for the appropriate infrastructure is still under consideration by the Department of Education. While not advocating the wholesale adoption of the Department of Health's structure, a district-level staff person suggested that the Department of Education can adapt the ways in which it deals with third-party insurers, healthcare finances, and quality assurance. Just as the School-Based Behavioral Health Program was reportedly blindsided by the fact that both "low-end" and "high-end" students could be eligible for "low-end" services, the autism program appears headed for lack of capacity and other similar problems that were foreseeable but not planned for.

A small number of staff will have responsibility for autism contracts

Giving responsibility for contract monitoring to one account clerk per complex area would be insufficient for preventing contract abuse. According to the transition plan presented in February 2002, 15 account clerks – one per complex area – will be given responsibilities for procurement, billing and contract monitoring, with supervision from the district-based contract specialists. This means that district-based contract specialists will be called upon for fiscal and contract management for School-Based Behavioral Health, serving as the only line of defense against contract abuse or fraud. As one district-level staff noted, "We're barely avoiding this now." This was a significant cause for concern because there could conceivably be hundreds of contracts within a single district. Most staff agreed that having one contract specialist potentially handling hundreds of contracts would leave the door wide open for contract abuse.

Current staff predict problems with potential provider fraud due to lack of adequate oversight

Staff we interviewed from two districts said they were concerned about the lack of supervision and accountability among private providers. One district program head said that therapeutic aides (who will be transferred to the Department of Education as skills trainers) have been providing services on a standalone basis, with very little supervision up to this point. Currently, regular reviews are done by contract specialists largely through paper compliance, which is an inadequate control against provider fraud.

Head of autism transition acknowledges that there are many unanswered questions

Three months before the transfer of autism services, state, district and school staff remain unclear about fundamental issues. The Department of Education's autism specialist acknowledged that there are unresolved issues with respect to autism, mirroring many of the concerns expressed prior to the implementation of the School-Based Behavioral Health Program. Some unresolved issues include: the structure of transition contracts, how the school-based behavioral health's infrastructure can be used to support autism services, and how autism will be accommodated within the CSSS process in the schools. The autism specialist also indicated that there will be transition contracts for autism similar to those school-based behavioral health services, but how it will be done – prior to or after the transfer in July 2002—was still under consideration by state-level administrators as of mid-March.

The State's total budget for autism contracts is $11.7 million. There is reportedly no ceiling on the amounts spent on individual contracts because this would depend on what they were providing; providers could provide services in pieces or on an overall basis. These significant structural gaps and piecemeal decision-making show that the department is continually reinforcing its pattern of inadequate planning and subsequent failure.

Conclusion

The School-Based Behavioral Health Program is representative of the Department of Education's myopic attempts at program implementation. Most surprising was the fact that staff were fully cognizant of problems that would inevitably arise from the program's lack of a basic infrastructure. Yet, the department elected to proceed and is only now dealing with such issues as personnel inequities, a fragmented management information system, a flawed procurement process, and the inability to determine whether services provided have been appropriate and effective. The department cannot make claims that the program is a cost savings to the State when it has consistently failed to accurately represent its budget.

The provision of behavioral health services is a serious responsibility that the Department of Education should not take lightly. Because the program is designed to assist all students, any negative impact derived from any missteps by the department will have far-reaching effects. However, the department apparently has not learned from this experience. Once again, it is implementing an initiative – in this case, autism services – without a basic infrastructure in place. Time wasted on correcting preventable mistakes means less time spent assisting students.

Recommendations

1. The Department of Education must expedite its:

   a. development of minimum qualifications for staff and resolution of issues regarding probation and performance appraisals;

   b. integration of fragmented information systems by ensuring that ISPED is functional and accessible to all school-based behavioral health staff;

   c. revision of its procurement process to ensure that all relevant criteria are taken into consideration prior to issuance of an RFP and that only qualified providers who are willing to comply with the school-based behavioral health model are utilized;

   d. implementation of controls to curtail potential billing fraud;

   e. creation of a quality assurance system to track progress and assess appropriateness and effectiveness of services provided.

2. The Board of Education and the Legislature should compel the department to update its School-Based Behavioral Health Program budget so that it accurately reflects all positions and funding.

3. The Department of Education must clearly identify the infrastructure for the School-Based Behavioral Health Program and autism services, starting with the differentiation of responsibilities of school-based behavioral health staff and autism services staff.

Appendix A
School-Based Services and School-Based Behavioral Health Positions

Honolulu District

(Budget was based on the delivery of School-Based Behavioral Health Services to 504/IDEA Identified Students)

Position	Existing	SBBH	Comments added by district
Administrative	0	0	Was not an allowable expense
Clerical	0	1	Clerk
Coordinator	0	1	SBBH Program Coordinator
Counselor	119	0	Regular school counseling positions to provide services for all students. They can provide SBBH services, but are also responsible for other school functions as well – testing, guidance, career and post high school, etc.
Educational Assistants	0	0	May be utilized to provide support services for SPED students, but are generally used for classroom and teacher support rather than student support.
Nurses	0	0	Will be needed for day treatment services to begin 6/02
PSAP/CSAP	0	0	110 Educational Assistant positions; 55 (1.0 FTE) and 55 (.5 FTE) provide early intervention/preventative services
Psychological Examiners	0	0	These are not SBBH support positions. They provide intellectual assessment as part of IDEA, but no direct intervention services to students.
Psychologist, M.A.	6	0	State Funded M.A. School Psychologist positions
Psychologist, Ph.D.	0	9	5 Full-time Ph.D. 2 Half-time Licensed Ph.D. 1 (.8 FTE) Ph.D. 1 (.2 FTE) Ph.D.
Social Worker	11	0	
Specialists	0	0	
Speech Pathologists	0	0	Allocated positions for speech therapy
Student/Family Support Worker (Behavioral Support Worker)	0	37	Four of the 37 current positions are .5 FTE
SSC	59	0	
Teachers (Resource)	0	0	
TOTAL	195	48	

Central District

Position	Existing	SBBH
Administrative (Business Manager, Educational Officer for SBMH)	0	0
Clerical	0	1

Counselor	111	0
Educational Assistant	0	3
Nurses	0	0
PSAP/CSAP	0	0
Psychological Examiners	0	0
Psychologist	6	1.8
Social Worker	15	0
Specialist	0	0
Speech Pathologist	0	0
Student/Family Support Worker (Mental Health Therapists)	0	12
SSC	44	0
Teachers (Resource)	0	2
TOTAL	176	19.8

Kauai District (Mokihana Project)

Position	Existing	SBBH
Administrative (Mental Health Supervisor)	1	0
Clerical	0	0
Coordinator (DES – Project)	1	1
Counselor	37	0
Educational Assistant	0	15
Nurses	0	0
PSAP/CSAP	0	0
Psychological Examiner	0	0
Psychologist	12	12
Social Worker	2	0
Specialist	0	0
Speech Pathologist	0	0
Student/Family Support Worker	11	14
SSC	0	0
Teachers (Resource)	0	0
TOTAL	64	42

***** 34 school counselors and 3 *Felix* High Risk Counselors not funded through SBBH.

Maui District

Position	Existing	SBBH
Administrative (District Director of Student Support Services, DES for Student Services)	4	0
Clerical	11.25	0
Coordinator (Preschool 619)	2	0
Counselor (SBBH)	0	41
Educational Assistant	0	0
Nurses	0	0
PSAP/CSAP	0	0
Psychological Examiner	5	0
Psychologist	9	8

Social Worker	7	13
Specialists	0	0
Speech Pathologists	25.5	0
Student/Family Support Worker (Mental Health Therapist)	0	0
SSC	33	0
Teachers (Resource)	10	0
TOTAL	106.75	62

Hawaii District

Position	Existing	SBBH
Administrative	45	0
Clerical	11	0
Coordinator	0	0
Counselor	107.5	0
Educational Assistant	0	0
Nurses	0	0
PSAP/CSAP	1	0
Psychological Examiner	6	0
Psychologist	9	10.75
Social Worker	11	0
Specialists	3	0
Speech Pathologist	27	0
Student/Family Support Worker (School-Based Services Therapist, Mental Health Therapist, School-Based Services Behavioral Assistants)	0	63
SSC	50	0
Teachers (Resource)	9	0
TOTAL	279.5	73.75

Leeward District

Position	Existing	SBBH	Comments added by district
Administrative (SBBH District Coordinator, School Assessment Liaison)	2	1	Paid through another funding source (not SBBH funds)
Clerical	2	1	1 clerk is in a state-funded position
Coordinator (Complex-Based Care)	0	0	
Counselor	136	0	
Educational Assistant	0	0	
Nurses	0	0	
PSAP/CSAP	1	0	
Psychological Examiner	6	0	
Psychologist	2	15	2 complex school psychologists are in state-funded positions
Social Worker	12	0	

Speech Pathologists	0	0	
Student/Family Support Worker (Behavioral Health Therapist)	0	28	
SSC	48	0	
Teachers (Resource)	0	1	
TOTAL	209	46	

Windward District

Position	Existing	SBBH	Comments added by district
Administrative (DES – Mental Health, Business Manager, Business Services Supervisor, Complex Services Manager, Project Manager, Lokahi Director)	1	4	
Clerical	1	4	Two half-time clerical positions
Coordinator (Intensive Care, Mental Health, Interval Resource, Therapeutic Classroom)	0	1	
Counselor	74	0	Includes 18 high-risk counselors
Educational Assistant	10	0	For therapeutic classrooms
Nurses	0	0	
PSAP/CSAP	52.5	0	Includes 36.5 educational assistants and 16 certificated teachers and counselors
Psychological Examiner	6	0	
Psychologist	5	2	
Social Worker	10	3	
Specialists	0	0	
Speech Pathologist	34.5	0	
Student/Family Support Worker (Mental Health Therapist)	0	36	
SSC	69	0	Includes 31 educational assistants and 38 certificated positions
Teachers (Resource, Therapeutic Classroom)	0	8	All positions are for therapeutic classroom
TOTAL	263	58	

Source: Original data obtained from district and complex-level school-based behavioral health implementation plans. Verification of data provided by district contract specialists and/or district program coordinator staff.

Legend:
Existing = School-based services positions in the district's budget prior to implementation of school-based behavioral health
SBBH = Actual number of current school-based behavioral health positions (only represents additional positions and does not include positions from the "existing" category)

Responses of the Affected Agencies

Comments on Agency Responses

We transmitted drafts of this report to the Department of Education, the Board of Education, and the Department of the Attorney General. A copy of the transmittal letter to the Department of Education is included as Attachment 1. Similar letters were sent to the Board of Education and the Department of the Attorney General. A copy of the Department of Education's response is included as Attachment 2. The Board of Education and the Department of the Attorney General did not submit written responses.

The Department of Education responded that it welcomes the findings of the report, but said we failed to note that corrective actions were already underway before the audit began and that we misstated a finding of a prior audit report issued by our office. The department also felt that it provided the Legislature with accurate information regarding the budget for the School-Based Behavioral Health Program. However, the department noted that it would provide the Board of Education and the Legislature with a budget for the program that clearly reflects relevant positions and funding. The Department of Education also stated that actions are already underway to provide appropriate controls over personnel management, information systems, procurement processes, and quality assurance.

We disagree with the department's assertion that we did not include information on corrective actions in the draft report. We provided a number of details on the department's attempts to remedy deficiencies in personnel management, information systems, and quality assurance. However, the department clearly missed the point of our finding: these efforts came *after* the School-Based Behavioral Health Program was implemented. Moreover, the efforts have fallen short, since these problems continue to exist.

We also disagree with the department's comment that we misstated a finding in our report, *Follow-Up and Management Audit of the* Felix *Consent Decree*, Report No. 01-16. The department claims that this prior report cited only fiscal concerns with its ability to manage the School-Based Behavioral Health Program and not overall management concerns, as cited in our current report. We note that in addition to numerous fiscal management concerns, the prior report spoke to management deficiencies in general. For example, we quote from page 14 of the report: "Inadequately planned efforts of the Departments of Education and Health will be costly and services may not be appropriate. The departments' implemented efforts will burden taxpayers

unnecessarily and may result in ineffective or overly costly programs that are difficult to change once established."

Finally, we stand by our finding regarding the department's inability to accurately account for the cost of the program. Only after repeated requests did we receive information that more closely reflected the true cost of the program. And even after giving us this information, departmental staff themselves could not completely agree on which numbers were correct. We reemphasize that the department did not clearly present the total budget of the School-Based Behavioral Health Program. Instead, it cited only funds designated under *Felix* Response Plan Item 3, which reflects just additional funding.

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

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

June 17, 2002

COPY

The Honorable Patricia Hamamoto
Superintendent of Education
Department of Education
Queen Liliuokalani Building
1390 Miller Street
Honolulu, Hawaii 96813

Dear Ms. Hamamoto:

Enclosed for your information are three copies, numbered 6 to 8 of our confidential draft report, *Audit of the School-Based Behavioral Health Program*. We ask that you telephone us by Tuesday, June 18, 2002, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Friday, June 21, 2002.

The Board of Education, Department of the Attorney General, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this confidential draft report.

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

Sincerely,

Marion M. Higa
State Auditor

Enclosures

ATTACHMENT 2

BENJAMIN J. CAYETANO
GOVERNOR

PATRICIA HAMAMOTO
SUPERINTENDENT

STATE OF HAWAII
DEPARTMENT OF EDUCATION
P.O. BOX 2360
HONOLULU, HAWAII 96804

OFFICE OF THE SUPERINTENDENT

RECEIVED
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OFC. OF THE AUDITOR
STATE OF HAWAII

June 21, 2002

Ms. Marion Higa, State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, HI 96813

RE: Audit of the School-Based Behavioral Health Program

Dear Ms. Higa:

Thank you for the opportunity to respond to Report to the Governor and the Legislature of the State of Hawaii regarding the **Audit of the School-Based Behavioral Health Program** (SBBH). As you report, SBBH is a proactive approach to assist all students to develop the positive behaviors necessary for success in school. The Comprehensive Student Support System is an educational model for quality student support that relies upon teams of individuals knowledgeable about the student and the school environment.

While I recognize the audit is limited with regards to scope and duration, it is unfortunate that it failed to comment on the recognizable widespread positive impact of the program:

- Significant new resources at the school level, to include social workers, school psychologists, and mental health therapists, for direct services to students.
- Parent satisfaction as noted through service testing results.

Furthermore, while the report states that the Department was "fully cognizant of problems that would eventually arise" it fails to report that corrective actions were already underway before this audit began. The report also misstates the **Follow-Up and Management Audit of the Felix Consent Decree** that at the time of the audit found "the Department of Education is ill prepared to assume the *fiscal* management of mental health services (*italics added*)."

As accurately reported, the Departments of Education and Health, as well as the Felix Court Monitor, have endorsed SBBH as being a more effective delivery system. The Department has accurately represented to the Legislature the cost of providing behavioral health services to those "low end" students previously served through Department of

Health "out patient" services. Budget discussions for FY 02 clearly represented the Department's requirement of $27.2 million was to meet the transferred responsibilities and presumed the continued related funding in both the base budget and other FRP Priorities. As reported, the cost of those services in FY 01 was projected to cost $36.4M.

The Department of Education fully recognizes the seriousness of the responsibility involved in providing behavioral health and autism services to students in need of such services, and strives to do so in an ever-changing environment shaped by numerous forces including court mandates and Legislative expectations. Thus, the Department frequently must cope with limited time for planning, stressed infrastructure, and unclearly defined external expectations. Lessons learned in the implementation of SBBH are being applied to the transition of services to students with Autism.

Nonetheless, the Department welcomes the findings of this report. As noted in the report, actions are already underway to provide appropriate controls over personnel management, information systems, procurement processes, and quality assurance. The Board of Education and the Legislature will be provided an SBBH budget that clearly reflects relevant positions and funding.

Please feel free to contact Robert Campbell, Ph.D., Office of Program Support and Development, at 586-3447 if there are any questions regarding these comments. Otherwise, I look forward to the issuance of your final report.

Very truly yours,

Patricia Hamamoto
Superintendent

PH:RC:sn

cc: Board of Education
Assistant Superintendents
Complex Area Superintendents
Directors in the Office of the Superintendent
The Honorable Benjamin J. Cayetano
Attorney General
Court Monitor
Senator Colleen Hanabusa
Senator Norman Sakamoto
Representative Ken Ito
Department of Health