Study of the Memorandum of Agreement for Coordinating Mental Health Services to Children

A Report to the Governor and the Legislature of the State of Hawai'i

Report No. 93-1
January 1993

THE AUDITOR
STATE OF HAWAI'I

The Office of the Auditor

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OVERVIEW

THE AUDITOR
STATE OF HAWAII

A Study of the Memorandum of Agreement for Coordinating Mental Health Services to Children

Summary

Adequate mental health services for public school children has been a continuing legislative concern. To better coordinate these services, the Legislature in 1980 required the Department of Health (DOH) and the Department of Education (DOE) to develop a memorandum of agreement. In reviewing the memorandum of agreement, we found that it has not served the purpose intended by the Legislature because the two departments have no ongoing collaborative process for keeping the agreement current and for resolving issues.

The 1985 memorandum between the two departments has not been updated to incorporate new statutory requirements enacted in 1988. The departments have not met regularly to monitor the memorandum and resolve systemwide problems. DOH and DOE personnel at the local level find it difficult to work together effectively because they lack the authority to resolve departmental policies that are unclear, contradictory, or simply nonexistent.

Among issues that need to be resolved is agreement on who is to be served. The memorandum does not set priorities that clearly define the target clientele. The departments also have not agreed on what financial information should be required on each client's ability to pay for mental health services. Nor have they collaborated on collecting statistical data on mental health services or the needs of public school children. Policies on confidentiality of students' psychological reports are another source of conflict between the two departments. The DOH children's teams are also concerned that DOE has not given them adequate space for treatment services.

We believe that the requirement for a memorandum of agreement should be retained but the agreement must be made meaningful and useful. For collaboration to work, the departments must first define their respective responsibilities for mental health services for public school students. The DOE is accountable under federal law to provide or to purchase mental health services for special education students. Some special education students have not received mental health services because of funding limitations at DOH. To avoid federal lawsuits, the DOE needs to ensure more predictable mental health services.

State law requires the DOH children's mental health program to provide a wide range of services for eligible children under age 18. The DOH has not developed a manageable mission or priorities for the program, and the children's mental health teams are unsure about their roles. The DOH needs to decide how it can best serve the mental health needs of children, establish priorities, and organize a program to carry out these priorities.

The Legislature could encourage departmental action by pressing them for more specific information on expenditures for mental health services including information on how much money and how many positions each department used for mental health services. The Legislature could also amend the statutes to establish clearer missions and priorities.

Recommendations and Responses

We recommended that the Department of Education and the Department of Health strengthen their commitment to collaboration by developing a mechanism such as an interagency task force to implement, monitor, and update the memorandum of agreement. The Department of Education should ensure predictable mental health services for special education students; it may wish to contract with DOH for some of these services, and to seek federal Medicaid funds to help pay for the services. The Department of Health should define the primary mission and priorities of the children's mental health program, clarify the role of the children's mental health teams, and issue rules to formalize the mission and priorities. The Legislature should consider requiring each department to submit information on mental health expenditures and services, and it should consider working with them to amend Chapter 301 and Chapter 321, HRS, to clarify their respective missions, priorities, and responsibilities.

The Department of Health did not respond to our recommendations that the director of health clarify the role of the children's mental health teams and issue rules to formalize the mission and priorities of the children's mental health program. The department did acknowledge the need for greater collaboration and reported that it recently began meeting with the Department of Education to map out a functional agreement based on our report. The Department of Education also did not respond to our recommendations. It stresses that no amount of collaboration can overcome the problem of inadequate funding.

The Department of Education should recognize that limitations in funding do not mean the memorandum of agreement will be a futile exercise. Instead, limited funding makes it even more important that the two departments define their respective missions, responsibilities, and priorities in terms of what can feasibly be carried out with available resources and work collaboratively to maximize the services that can be offered with limited funding.

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Submitted by

THE AUDITOR
STATE OF HAWAII

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Foreword

State law requires the Department of Health and the Department of Education to describe in a memorandum of agreement how they will coordinate mental health services to public school children. In 1992, the Legislature passed two resolutions asking the State Auditor to examine the effectiveness of the memorandum of agreement between the departments. This report responds to the legislative requests.

We reviewed the memorandum to determine if it is serving the purpose for which it was developed, and if there is a collaborative process for implementing, monitoring, and updating the agreement. We also reviewed key state statutes to determine if they support interagency collaboration, promote an efficient use of resources, and encourage the departments to maximize federal Medicaid funds.

We wish to express our appreciation for the cooperation extended to us by the staff of the Department of Health and the Department of Education during the course of this study.

Marion M. Higa
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Chapter 1
Introduction

Several thousand children in Hawaii are reported to have emotional problems requiring professional help. For many years the Legislature has been concerned that the Department of Health (DOH) and the Department of Education (DOE) have not been working together to meet the mental health needs of these young people. In 1992, the Legislature passed House Concurrent Resolution No. 433, House Draft 2, and Senate Concurrent Resolution No. 251, Senate Draft 1, requesting the State Auditor to assess the effectiveness of a memorandum of agreement between the departments for coordinating mental health services. This report responds to the legislative requests.

Background on the Memorandum of Agreement

The Legislature in 1974 established a program of mental health services for children. Act 211, which became Chapter 321, Part XV, Hawaii Revised Statutes, required DOH to give preventative and diagnostic mental health services, treatment and rehabilitation to all eligible children under age 18. The law established within DOH a children's mental health branch to be responsible for implementing centralized and highly specialized programs. It also established children's mental health teams within community mental health centers to work with public and private agencies to develop a network of mental health services.

Section 321-174 of the law required the children's teams to: (1) cooperate with public schools in identifying and referring for treatment students needing mental health services, (2) accept referrals from school counselors and diagnostic teams for evaluation and direct treatment of students whose emotional problems interfere with learning, and (3) help teachers and other school personnel identify and screen students needing professional services. In 1977, the DOH and the DOE developed an interagency agreement to describe how they would coordinate these activities.

The Legislature amended Section 321-174 in 1980 to require DOH and DOE to develop a memorandum of agreement describing how they would share responsibilities for a broader range of mental health activities, including educating parents and school personnel about the emotional disturbances of children and helping DOE with mental health services for students in its special education program.[1]

The departments issued the memorandum of agreement in 1985. It is a 13-page document describing each agency's programs and responsibilities for coordinating mental health services. It contains procedures for referring students, providing direct and indirect mental health services, and training personnel in both departments. The memorandum incorporates many of the procedures from the 1977 interagency agreement and from DOH administrative rules adopted in 1984 to guide the delivery of mental health services for special education students under Section 301-27, HRS. The memorandum of agreement has not been revised since 1985.

Request for the Study

Concern about emotionally disturbed students "falling through the cracks" with their needs ignored and services not provided prompted the Legislature to adopt two resolutions calling for this study. Both resolutions note that mental health services are needed to help children with serious emotional problems. They call for more effective coordination and cooperation among agencies providing these services and express concern about obtaining available federal funds to help pay for them.

The resolutions were supported by several community organizations. The Hawaii Advocates for Children and Youth testified that systemic problems in coordinating mental health services under the memorandum of agreement had created an impasse. The Mental Health Association in Hawaii reported that the departments were confused about their responsibilities under the memorandum in light of varying laws governing the DOE special education program. The State Advisory Council on Mental Health and Substance Abuse noted that the departments were not assessing, documenting, and reporting on unmet student mental health needs as required by the law that governs the memorandum. The Hawaii Public Health Association observed that much needs to be done to provide integrated help for children with emotional problems and their families.

Objectives of the Study

Our study sought to determine whether the memorandum of agreement complies with the law, whether personnel in both departments can work together effectively under the agreement, and whether the statutes support the coordination of mental health services for children attending public schools.

The specific objectives were to:

1. Determine if the memorandum of agreement is serving the purpose for which it was developed, and if there is a collaborative process for implementing, monitoring, and updating the memorandum.

2. Determine if state statutes support interagency collaboration, promote efficient use of resources, and encourage the departments to maximize federal Medicaid funds.

3. Recommend improvements so the departments can collaborate more effectively in providing mental health services for public school students.

Scope and Methodology

We obtained background information on child mental health, special education, and Medicaid financing by reviewing the literature and by interviewing community mental health advocates, national experts, federal officials, and persons responsible for collaborative mental health programs in other states.

We examined the memorandum of agreement to determine if it complies with statutory requirements and includes elements necessary for an effective interagency agreement. We reviewed the key Hawaii statutes (including Chapter 321, Part XV, and Section 301-27, HRS) to identify barriers to interagency collaboration and obtaining federal Medicaid funds.

We collected information on the coordination of mental health services by interviewing state-level personnel in DOH and DOE, members of the DOH children's mental health teams, school district personnel who work with the children's teams, and members of various mental health committees in both departments. We also reviewed files at the DOH Children and Adolescent Mental Health Division; the DOE Special Education Section; and the children's mental health teams and school district offices on Oahu, Kauai, Maui, and the Big Island (Hilo).

Our work was performed from May 1992 through December 1992 in accordance with generally accepted government auditing standards.

Chapter 2

Coordination of Mental Health Services

In this chapter we examine whether the 1985 memorandum of agreement between the Department of Health (DOH) and the Department of Education (DOE) establishes a viable framework for collaboration.

Summary of Findings

We find that the memorandum of agreement is inadequate and has not served the purpose intended by the Legislature. Specifically, we find that:

1. The Department of Health and the Department of Education have not demonstrated sufficient commitment to a collaborative process that would keep the memorandum of agreement up to date and help resolve operational issues.

2. Before an effective memorandum can be drawn, the two departments need to define what their respective responsibilities are to children with mental health needs and how they intend to meet these responsibilities.

3. The Legislature can encourage collaboration and the efficient use of resources by pressing the departments for needed information and improving the statutes.

Commitment to Collaboration Is Weak

The two departments have shown little commitment to the collaborative process. To improve the delivery of mental health services, the departments need to make collaboration a priority. The memorandum of agreement was to be an ongoing working agreement between the two parties that would delineate their respective responsibilities and would result in cooperative efforts in delivering mental health services to students. We find that the memorandum has not resulted in this type of collaborative effort.

The National Conference of State Legislatures reports that the delivery and funding of mental health services for children are often fragmented and uncoordinated.[1] But some states use formal interagency agreements to bring together education, mental health, social services, and other agencies serving the mental health needs of

children. The agreements can serve as "the cornerstone of all collaborative efforts"[2] and help maintain continuity as key players in the agencies change. For example, Vermont reports that it used a memorandum of agreement among the departments of mental health, education, and child welfare to set up an integrated program for mental health services for special needs children. The agreement led to a state law spelling out in detail each agency's responsibilities.

Kentucky has an agreement that several state agencies will cooperate to improve the organization, financing, and delivery of services to children with severe emotional disabilities. Reportedly more than 800 children received case management and coordination benefits during the program's first two years.

To succeed, interagency agreements should be formalized only after sufficient discussion about the purpose of collaboration, what each party hopes to accomplish, potential conflicts and barriers, and how the agreement will be implemented. Once executed, interagency agreements should be reviewed and updated at regular intervals "to reflect new realities."[3]

The Education and Human Services Consortium—a coalition of national organizations including the National Conference of State Legislatures, the National Governors' Association, and the Children's Defense Fund—has been concerned with interagency efforts to connect children and families with comprehensive services. The consortium calls for a communication and problem-solving process and says this is essential for interagency efforts to succeed and to "deflect turf and control issues, reconcile differences in institutional mandates and professional perspectives, and make critical mid-course corrections in strategy and implementation."[4]

The current memorandum has not resulted in this type of collaboration. There is no ongoing process for keeping the agreement current and for resolving issues.

No process for collaboration

A collaborative process was not used either in developing the memorandum or in implementing it. The current memorandum was produced very quickly. In November 1984 the superintendent of education informed the director of health that it had come to his attention that Act 59 of 1980 required a memorandum.[5] Drawing on language from previous documents, a memorandum was quickly drafted, circulated for comment, and signed by the department heads on March 1, 1985. There is no indication that issues relating to goals, potential problems, and implementation were sufficiently explored, discussed, and resolved.

Furthermore, the departments have no mechanism to regularly review, improve, and update the agreement to reflect changing circumstances. The memorandum permits DOE to convene an interagency task force to help resolve gaps in services and variances from established agreements and procedures. However, the task force has not met since 1986.

A 1988 plan issued by the DOH children's branch says that the memorandum needs reworking.[6] Independent of each other, staff of each department have developed issues and proposals for updating the memorandum, but the departments have not collaborated. The departments have not resolved systemwide issues that have plagued personnel at the local level in recent years.

Memorandum out of date

The statute for a memorandum of agreement, Section 321-174, HRS, requires the two departments to share responsibilities in a number of areas including accepting referrals from the schools and assisting school personnel in identifying children in need of services. An additional responsibility was established by Act 257 of 1988—developing an ongoing mechanism to assess, document, and report to the Legislature and the governor unmet needs for mental health services for students in each geographic region.

The Legislature considered this issue sufficiently important to add this requirement in Act 257. But the memorandum still quotes the 1980 version of the law. If the memorandum had been updated to incorporate the new provision and if the departments had implemented the requirement, the legislative and executive branches could have received important information on whether collaboration was working and what gaps in services existed.

Many unresolved issues

The departments have not developed interagency plans, policies, and procedures to guide mental health activities at the local level because there is no state-level process to monitor and oversee the program. Many issues that could have been resolved through collaboration plague both departments. They include questions about whom they are to serve, referrals, financial assessments, data collection and monitoring, confidentiality, and treatment facilities.

School district personnel and children's team members lack sufficient authority to resolve these issues. They have been stymied in their attempts to clarify departmental policies and forced to develop makeshift arrangements for working together.

Target group unclear

Agreement on who is to be served is obviously the most important issue. Currently, the memorandum does not set priorities for who will be served first among all public school students. This has led to differing expectations. The literature on collaboration emphasizes the importance of clearly defining a target population.

Section 321-174 covers public school students needing mental health services including, but not limited to, those for whom the DOE must provide special education. But many staff in both departments believe that the memorandum addresses special education students only.

This may be because the memorandum was drafted by a DOE-DOH task force that had been working on special education issues. The task force incorporated many special education procedures into the document, leading to confusion about the target population. In addition, the DOE special education section was designated as liaison for implementing the memorandum.

The lack of a defined target group makes it difficult for the DOE to know whom to refer to the children's teams and for the children's teams to know whom they must serve. The memorandum merely says that the DOH is responsible for informing referral sources of the criteria for appropriate referrals, determining the appropriateness of referrals, accepting appropriate referrals, and informing referral sources regarding the disposition of referrals. DOE personnel are uncertain whom the children's teams will accept because the individual children's teams use different or changing criteria.

Financial assessments problematic

The DOH recently began requiring the children's teams to collect financial information on each client's ability to pay for mental health services. The families of some special education students refused to provide the information because federal law entitles them to free services. This problem could have been avoided if the departments had worked together in developing the financial assessment procedure.

Data collection and monitoring weak

The memorandum makes the DOE responsible for monitoring the effectiveness and uniform delivery of mental health services, providing DOH with semi-annual statistical information on students and schools that may be underserved, and convening an interagency

task force to recommend resolution of any service gaps. These activities have not been carried out in recent years.

Each department recently began collecting information on the mental health needs of special education students. The DOE revised its forms to collect statistical data, and DOH instructed the children's teams to notify the children's program when they cannot provide mental health services for the students. These initiatives are being carried out independently and the departments have not developed a plan for consolidating and reporting the data.

Confidentiality conflicts

The school districts follow rules that permit wider access to student educational records—including psychological reports—than the children's teams are allowed under their policies. The children's teams have responded by releasing the reports to the school districts with a statement restricting the use of the reports by school personnel and other parties, by refusing to release the reports without the informed consent of parents, or by preparing shorter reports.

School district personnel are concerned that the reports have been delayed or never released because of the informed consent process for parents, or that the reports no longer contain enough information to help students.

Treatment space unsatisfactory

The memorandum of agreement requires the DOE to give the children's teams space for treatment services that is private, easily accessible, properly ventilated, lighted, and furnished. But the schools are overcrowded, and the children's teams have been providing therapy in bathrooms, broom closets, and other locations that do not afford privacy. Children's team members are concerned that these arrangements may have a negative impact on students who already have emotional problems.

Department-level commitment needed

To get things moving, the superintendent of education and the director of health need to demonstrate a commitment to collaboration and to establish a mechanism for implementing, monitoring, and updating a memorandum of agreement. Currently, the department heads appear to see the problem only as one of funding and not one of inadequate collaboration.

In testimony on the request for this study, the superintendent of education contended that inadequate funding had stymied full

implementation of the memorandum. The director of health also testified that inadequate funding was a major obstacle to meeting the mental health needs of children. Both opposed having the State Auditor study the effectiveness of the memorandum. Instead they testified that the two agencies, with DOE as the lead, should develop an action plan, including funding, to facilitate the delivery of services.[7]

The National Conference of State Legislatures reports that "many states cite that insufficient funding is the major obstacle to developing and coordinating needed services for youth who have severe emotional disturbances."[8] In Hawaii's case, however, additional funding alone, without improving collaboration and vastly strengthening the memorandum, is not the solution. An action plan may be useful in implementing a memorandum of agreement but it is not a substitute for the memorandum nor should it precede some high-level attention to the basis of the problem. We believe that the memorandum should be retained and made meaningful and useful.

Departments' Responsibilities Are Not Clearly Defined

As a first step, each department needs to define its responsibilities for providing mental health services for public school students. The DOE must determine how it can meet its responsibility for special education students. The DOH must clarify its mission so that it can best use its limited resources to serve Hawaii's children. Currently, both departments are under the gun to provide services to different target groups. Unless this is recognized and accommodated, collaboration will falter and the memorandum of agreement will not realize its potential.

Services required for DOE special education students

The status of mental health services for special education students is uncertain. The DOE is legally responsible for furnishing these services. The DOH provides some free services to these students, but only when it has the resources. Resolving this issue is critical.

DOE responsible for services

Federal law requires the DOE to assure all children with disabilities the right to a free appropriate public education, including special education and related services.

In 1990 the U.S. Department of Education clarified that the DOE must provide or purchase mental health services for special education students when DOH cannot provide these services. The federal special education law was also amended to permit interested parties to file suit

in federal court when states or local school districts fail to provide the required services.

In a 1991 site visit, the U.S. Department of Education found that the DOE was not complying with the federal law because mental health services were not always provided to meet the needs of special education students. The DOE reported that mental health services were simply not available in some schools, and that some teachers had stopped trying to obtain such services because DOH would not provide them. The federal agency again instructed the DOE to provide or purchase the mental health services that the DOH cannot provide.

DOH does not feel compelled to provide all of the mental health services that special education students need. In Act 269 of 1982 the Legislature amended Section 301-27, HRS, to require DOH *within the funds available* to provide related *health* services for special education students. The DOH administrative rules interpret the statute as requiring the department to provide these services "only so long as sufficient appropriations by the State legislature for such purposes are available to, and have not been exhausted by the department."[9] The DOH has unlimited discretion in deciding when appropriations for related *mental health* services are exhausted.

DOH policy changing

For many years the DOH made special education students a top priority. But the children's branch began questioning this policy in 1988 because the children's teams did not have enough resources to develop community-based programs for other children. Finding that DOE was ultimately accountable under federal law to provide or purchase mental health services for special education students, DOH began curtailing these services so the children's teams could focus on other priorities.

The DOH wanted the children's teams to focus on the most seriously emotionally disturbed children. It believed it could not continue committing most of the children's teams' resources to special education students and also expand services for children with serious emotional disturbances. As a result, the children's teams no longer provide many of the services traditionally offered to special education students under the memorandum of agreement.

The director of health recently issued procedures for documenting when the department cannot provide the services with available funds. The children's teams have been notifying the school districts when they cannot provide services so that other arrangements can be made.

Predictable services needed

The DOE acknowledges its legal responsibility to provide or purchase mental health services for special education students. But it no longer feels that it can rely on DOH to provide the required services in a predictable manner. The DOE needs more consistent services to meet the mental health needs of special education students and satisfy federal requirements.

One approach would be for DOE to contract with DOH for a specified type and quantity of services that DOE cannot provide or purchase elsewhere. Since money is an issue, the DOE might want to explore Medicaid. The U.S. Department of Health and Human Services recently clarified that state and local educational agencies can use federal Medicaid funds to help pay for special education related services—including mental health services. Hawaii statutes do not appear to present any obstacles to DOE's seeking federal Medicaid funds or contracting with DOH.

Another approach would be for the DOE to work with the DOH to define target groups of special education students—for example those who are severely disturbed and those who are not—for which each agency would be responsible.

Clarification of DOH program needed

The DOH has yet to decide on the mission of its Children and Adolescent Mental Health Division. Section 321-171 of the state law on mental health services for children requires DOH to provide preventative and diagnostic services, and treatment and rehabilitation for all those eligible under age 18. The Children and Adolescent Mental Health Division is responsible for carrying out this broad mandate. But there is no consensus within the department about whom the program should serve and what the role of the children's teams should be.

It is unlikely that DOH can treat all children who might benefit from mental health services. It needs to establish priorities and develop a program with the organizational capacity to carry out those priorities. Most experts agree that 12 percent of children under age 18 have emotional problems requiring professional mental health treatment and that anywhere from 3 to 8 percent experience severe emotional disturbances that disrupt their functioning for an extended period of time.[10] If the experts are correct, about 33,600 of Hawaii's children require mental health treatment, and from 8,400 to 22,400 of them are severely disturbed.

No DOH consensus on mission

The DOH children's mental health branch attempted to clarify the program's mission in 1988 when it issued a plan calling for a system of care to coordinate mental health services for children and adolescents. The plan prioritized services for two target groups: (1) children and adolescents who have severe emotional disturbances or risk developing them, and (2) children, adolescents, and families who can benefit from primary prevention and early intervention services. The branch proposed amending Chapter 321 so the program could focus on these target groups. But the statute was not amended, and the plan was never fully funded.

The director of health has seen services for the most seriously disturbed children and adolescents as the program's top priority. In 1990 he notified the superintendent of education that the children's teams would be narrowing their target group to focus on children and adolescents with serious emotional disturbances. The children's teams soon began disengaging from their longstanding associations with the public school system in order to develop community-based services for the new target group. But staff turnover, a difficult reorganization process, and funding limitations apparently have prevented the department from achieving the new priorities.

The new children's mental health chief would like to expand the program to include prevention services and programs for children and adolescents who risk developing serious emotional disturbances. This approach is similar to that proposed in the 1988 plan. But the plan has expired and there is no new plan. Administrative rules defining a mission would be helpful but the director has not issued such rules, although he has the authority to do so.

Role of children's teams unclear

The department needs to clarify the role of the children's teams. Functional statements developed for the reorganization do not clearly define the role of the teams. They merely state that each team will provide "several" of nine mental health services ranging from crisis intervention to helping clients get entitlement benefits.

The children's teams consist of mental health professionals such as psychiatrists, psychologists, and social workers. The department administers eight children's teams—five on Oahu, and one each on Kauai, Maui, and the Big Island. The administration of a ninth team, in Waianae on Oahu, is contracted out.

The teams are struggling to determine what is expected of them and to meet the expectations. They are trying to develop new community-based and prevention programs but do not know if their future roles will emphasize clinical services, consultation services, case management services, prevention programs, or some combination of these and other activities.

Resources required by federal mandate

The U.S. Department of Justice recently clarified that child and adolescent residential treatment programs operated by the DOH must meet the requirements of the U.S. Civil Rights of Institutionalized Persons Act. The justice department is monitoring the state's progress in carrying out a settlement agreement covering these programs.

After a recent site visit, the justice department reported that the conditions of confinement in one of the state's residential treatment programs (at Castle Hospital) do not comply with the federal law, and that the facilities housing another program (at Leahi Hospital) need to be upgraded. The first program was closed. DOH hopes to renovate facilities at Hawaii State Hospital to provide services for adolescents in 1993; in the meantime it is paying a private hospital for the services. It is also planning to upgrade the second program's facilities.

Legislature Can Encourage Departmental Action

Problems surrounding mental health services for children go back many years. Recommendations the Legislature made in 1976 remain valid today. More positive legislative action may encourage the departments to improve collaboration. The Legislature could press the departments for more specific information on their respective expenditures for mental health services and it could amend the statutes to establish clearer missions and priorities.

Recommendations from 1976 still valid

In reviewing implementation of the program for children's mental health services, the House health committee found in 1976 that close coordination was needed between the DOH and the DOE; that DOE and DOH needed to move with urgency to define their respective responsibilities; and that DOH needed to establish statewide and local priorities and design a program to meet these priorities.[11] These recommendations are still valid today.

Specific information on funding

The Legislature should consider requiring the departments to submit specific information on their expenditures for mental health services for public school students. Available budget documents do not clearly identify how these services are funded, how the money is being spent, or how many students are being served. This makes it difficult to hold either department accountable.

Funding for the services at DOE falls primarily into the program categories EDN 107, Special Education, and EDN 208, Educational Assessment and Prescriptive Services. For FY1992-93, the Legislature appropriated about $61 million and 2,000 positions for EDN 107 and $14.4 million and 290 positions for EDN 208. It would be useful for the Legislature to know how much of these funds and how many of the positions were used for mental health services. In addition, information on the number and characteristics of students served should be made available.

Funding for mental health services at DOH falls mostly into the HTH 460 program category, Child and Adolescent Mental Health. For FY1992-93, the Legislature appropriated about $14 million and 191 positions to HTH 460. The DOH should be asked to submit information about what kinds of services it provided or purchased and how many and what kinds of children were served. We understand that DOH plans to request an increase in its budget for mental health services to children. The Legislature should request detailed information on the purpose of the increase, what additional services will result, and how these services will be integrated into the existing system.

Statutory amendments

The Legislature should consider amending the statutes to provide direction. This could strengthen collaboration and encourage efficiency in providing mental health services to children.

Two key statutes are involved. Chapter 321, Part XV, requires the DOH to provide mental health services for eligible children under age 18. Chapter 301, Part II, requires the DOE to provide special services (including psychological evaluations) and corrective therapy for students with disabilities through age 19; it also requires the DOH within available funds to provide mental health services for these children.

These statutes do not establish a clear mission and priorities for addressing student mental health needs. In particular, Chapter 321, Part XV, does not establish a manageable mission or priorities for the DOH children's mental health program. It requires DOH to provide a full range of preventative, diagnostic, treatment, and rehabilitative

services for children. The department must (1) provide centralized and highly specialized services, (2) foster a network of public and private services, and (3) offer an array of services in the public schools. But there are no priorities setting out which children should be served or what services among all those listed are essential. Chapter 301, Part II, does not address the mental health mission and priorities of the DOE special education program, and Section 301-27 leaves open the DOH's responsibility for serving special education students.

These statutes could be amended to reflect the Legislature's priorities, pin down the departments' responsibilities, and specify where the funds would go. This would contribute to more effective collaboration and more efficient use of resources. It would also help to establish accountability for mental health services.

Recommendations

1. The Department of Education and the Department of Health should strengthen their commitment to collaboration by developing a mechanism such as an interagency task force to implement, monitor, and update the memorandum of agreement.

2. Before pursuing the memorandum of agreement, the departments should clearly define their respective responsibilities:

    a. The Department of Education should ensure predictable mental health services for special education students. The department may wish to contract with DOH for some of these services and to seek Medicaid support to increase funding.

    b. The Department of Health should define its primary mission and establish priorities for mental health services to children. The director should clarify the role of the children's mental health teams and issue rules to formalize the mission and priorities of the children's mental health program.

3. The Legislature should consider:

    a. Requiring the departments to submit specific information on their expenditures for mental health services for public school students, including the source of funds, the services provided, and the number and type of students served. Similar information should be requested for their budget requests.

    b. Working with the departments to amend Chapter 301 and Chapter 321, HRS, and to clarify the departments' missions, priorities, and responsibilities for mental health services for children.

Notes

Chapter 1

1. Act 59, Section 3, SLH 1980. The act required memoranda of agreement but according to the committee reports a single memorandum was intended. See House Special Committee Report No. 16, Regular Session of 1980. See also Senate Standing Committee Report No. 864-80, Senate Standing Committee Report No. 775-80, and House Standing Committee Report No. 371-80 on House Bill No. 584, Regular Session of 1980. Act 55, SLH 1985, clarified the matter by amending Section 321-174 to require a memorandum.

Chapter 2

1. Rebecca Tarkington Craig, *What Legislators Need To Know About Children's Mental Health,* National Conference of State Legislatures, Denver, Colorado, April 1990, p. 4.

2. National Association of Public Child Welfare Administrators and State Mental Health Representatives for Children and Youth, *The Child Welfare/Children's Mental Health Partnership: A Collaborative Agenda for Strengthening Families,* June 1991, p. 19.

3. Ibid.

4. Education and Human Services Consortium, *What It Takes: Structuring Interagency Partnerships to Connect Children and Families With Comprehensive Services,* Washington D.C., August 1991, p. 21.

5. Memorandum to Leslie Matsubara, Director of Health, from Francis M. Hatanaka, Acting Superintendent of Education, Subject: Coordination of Mental Health Division (MHD) Services with the Department of Education (DOE), November 26, 1984.

6. Hawaii, Department of Health, *Window of Opportunity: Children's Mental Health Services Plan, State of Hawaii, 1988-1991,* Honolulu, undated, p. 22.

7. Testimony on House Concurrent Resolution No. 433, House Draft 1, submitted by Charles T. Toguchi, Superintendent of Education, to the House Legislative Management Committee, April 14, 1992; and Testimony on House Concurrent Resolution No. 433, submitted by John C. Lewin, M.D., Director of Health, to the House Committee on Legislative Management, April 14, 1992.

8. Craig,*What Legislators Need to Know,* p. 4.

9. Section 11-147-12, Hawaii Administrative Rules.

10. Craig,*What Legislators Need to Know,* p. 1.

11. House Special Committee Report No. 14, Regular Session of 1976.

Responses of the Affected Agencies

Comments on Agency Responses

We transmitted a draft of this report to the Department of Health and the Department of Education on December 21, 1992. A copy of the transmittal letter to the Department of Health is included as Attachment 1. A similar letter was sent to the Department of Education. The response from the Department of Health is included as Attachment 2, and the response from the Department of Education is included as Attachment 3.

The Department of Health did not respond to our recommendations that the director of health clarify the role of the children's mental health teams and issue rules to formalize the mission and priorities of the children's mental health program. It did acknowledge the need for greater collaboration and reported that it began meeting recently with the Department of Education to identify problem areas and map out a functional agreement based on our report. It noted that Castle Hospital voluntarily closed the residential program for adolescents and we have revised our report to reflect this.

The Department of Education also did not respond to our recommendations that it consider contracting with the Department of Health to ensure more predictable mental health services for special education students and seek federal Medicaid funding to help pay for the services. It said instead that no amount of collaborative spirit can overcome inadequate funding. It reports that an interagency task force is currently meeting to forge a vision for child and adolescent mental health services in Hawaii but it is the inescapable conclusion of this group that additional resources will be necessary to implement this vision.

We wish to emphasize that funding will always be limited and the two departments must define their respective missions, responsibilities, and priorities in terms of what can feasibly be carried out with available resources. The memorandum of agreement is a means to maximize the services that can be offered by the two departments if they were to work collaboratively.

ATTACHMENT 1

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

December 21, 1992

The Honorable John C. Lewin, M.D.
Director of Health
Department of Health
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Lewin:

Enclosed are three copies, numbered 6 through 8, of our draft report, *A Study of the Memorandum of Agreement for Coordinating Mental Health Services to Children.* We ask that you telephone us by December 24, 1992, on whether you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than December 31, 1992.

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

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

Sincerely,

Marion M. Higa
State Auditor

Enclosures

JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

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

In reply, please refer to:
File:

January 4, 1993

CAMHD-D69

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STATE OF HAWAII

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

Dear Ms. Higa: Marion -

Thank you for the opportunity to review the draft report entitled, "A Study of the Memorandum of Agreement for Coordinating Mental Health Services to Children."

Since many of the personnel involved in the drafting of the agreement are no longer available, we are unable to comment on the historical development compiled by your staff. We would like to correct a sentence on page 14 (paragraph 3) where it states that, "DOH closed the first program." This is incorrect. The Castle residential program was closed at the discretion of Castle Medical Center Administration and not as a result of any urging from Department of Health (DOH). Secondly, it is the intention of the Child and Adolescent Mental Health Division (CAMHD) to utilize the Hawaii State Hospital facility for high end psychiatrically compromised adolescent patients. This had not been the function of the Castle residential program. It is CAMHD position, after reviewing the patients placed at Castle, that greater utility would come from a program that emphasized a combination of experiential programming combined with residential care. To this end, CAMHD has requested RFP bids for this type of programming as an ongoing resource for the children of the State of Hawaii and not a stop gap measure, which the end of the paragraph seem to imply.

The need for greater collaboration between DOH and the Department of Education (DOE) is of great concern to us. The renewed process for facilitating an improved working relationship between these two departments started on December 15, 1992. A meeting was held between the Children's Team leaders, Division personnel, and representatives from DOE. This meeting was held to identify problem areas and begin the task of mapping out a functional agreement between the Departments. The next meeting is scheduled for January 12, 1993 at which time your report will be thoroughly reviewed and steps for rectifying the memorandum will be taken.

There remains, however, an inescapable difficulty with the report placing most of the implementation difficulties at the feet of a lack of commitment and collaboration between the two Departments. We know that a number of meetings were held between the Departments to forge an acceptable means of providing services. In most cases, no matter how well defined a service is, the necessary funding stream is still required to make it a reality. If the stream is limited to a puddle, then services must reflect the reality of that puddle. On this point, we strongly concur with DOE that adequate resources are critical to the delivery of services. Governor John Waihee's commitment to increase CAMHD's budget by $6.6 million demonstrates the Executive Branch's priority for children's mental health. With Legislature's support, we believe significant progress can be expected in our services to children.

Thank you for the thoroughness of your study and the opportunity to comment on the various components of the report. We appreciated the professional manner in which Ms. Nancy Millard of your office conducted the study. The findings and recommendations will prove to be a valuable tool in implementing the necessary changes required to serve the youth of Hawaii.

Sincerely,

JOHN C. LEWIN, M.D.
Director of Health

JOHN WAIHEE
GOVERNOR

CHARLES T. TOGUCHI
SUPERINTENDENT

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

OFFICE OF THE SUPERINTENDENT

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STATE OF HAWAII

December 30, 1992

MEMO TO: Ms. Marion Higa
State Auditor

F R O M: Charles T. Toguchi
Superintendent of Education

Charles T Toguchi

SUBJECT: Response to Draft Report, "A Study of the Memorandum of Agreement for Coordinating Mental Health Services to Children"

Thank you for sharing with us your draft report, "A Study of the Memorandum of Agreement for Coordinating Mental Health Services to Children." We also appreciate the opportunity to comment on your findings and recommendations. Commentary included here will be limited to the relative accuracy of the findings on which the recommendations are predicated.

The 1978 "Working Agreement between the Department of Health and Department of Education, Mental Health Division" was revised in 1985 as the result of a great deal of interagency collaboration. At least eight two-hour meetings were held during a span of about five months in which eight drafts of the agreement were developed. These meetings were attended by most of the DOH Child and Adolescent Mental Health (CAMH) Team Heads, CAMH Branch personnel, and several DOE administrators of special education and special services. Review and commentary were solicited on each draft from a minimum of sixty stakeholders in the two departments. Drafts were distributed for review and commentary throughout the CAMH Teams and to a wide variety of DOE personnel at the school and district levels.

The most frequent input from the field to the task force working on the various drafts was that resources were too limited to implement the agreement as drafted. This concern notwithstanding, the interagency task force agreed to continue to develop the agreement wholly in response to the needs of the children and adolescents to be served, rather than attempt to frame the agreement by working backward from a vague estimate of the amount of resources that might become available for its implementation. Consequently, the memorandum of agreement (MOA) is child-focused and was formulated to respond directly and comprehensively to each point of the legislative mandate for the interagency MOA outlined in §321-174, HRS. The revised agreement was judged by all to represent a significant improvement over the 1978 MOA. There was unanimous agreement that it would improve CAMH services if it were to receive the required funding support.

Those task force members who felt uncomfortable in developing a MOA for which it was clear that there were insufficient resources were comforted by the fact that the 1982 Legislature had provided a caveat in §301-27, HRS, that CAMH services for special education students, who comprise the majority of those requiring those services, need to be provided only "within the funds available." Since funds for a service can be made unavailable in a budget so easily, it was clear that this MOA could never be truly binding in the absence of resources. It would also not be binding should the resources, otherwise sufficient to provide the required CAMH services, be allocated for purposes other than those required by the MOA.

Numerous interagency task force meetings have been held since the signing of the MOA by the then Director of Health and the then Superintendent of Education to attempt to resolve problems in the implementation of the MOA. Many of the issues brought to the interagency task force were able to be resolved to the satisfaction of all. However, many more were not resolved as a result of the inevitable impasse created when Department of Health personnel invoked the caveat -- that funds were not available to provide the CAMH service requested. The draft study, however, seems to imply that additional interagency meetings could somehow alleviate the problems caused by the chronic shortfall in CAMH services resulting from unavailable funds.

Two statewide surveys on the delivery of mental health services in the public schools have demonstrated the following facts which are contrary to the summary of findings in your report:

1. It is not due to the agreement itself being somehow inadequate that the MOA has not been fully implemented. The respective responsibilities of the two departments have been defined and delineated in sufficient detail.

2. It is not due to a lack of commitment to interagency collaboration that the MOA has not been fully implemented. Where resources have been sufficient, the MOA has been implemented very effectively with a high level of collaboration and commitment.

Since this proposes to be a study of the MOA itself, rather than on the reasons the MOA cannot be fully implemented, a few specifics on the additional content suggested to improve the MOA would be helpful. The study refers to strengthening the MOA and making it meaningful and useful, yet very little in the way of details as to what is weak or of limited utility is mentioned.

The MOA is merely a vehicle through which stakeholders gain an understanding about the division of labor required to see that children and adolescents in the public schools who require mental health services actually receive the help that they need to become contributing members of our communities. Without the necessary resources to fuel this vehicle, one cannot expect top performance from this vehicle.

No amount of collaborative spirit will be enough to offset the increasing needs for CAMH services for over 13,000 unserved children and adolescents in Hawaii who have "relatively severe and chronic [mental health] problems" ("Second Biennial Review of Progress," Hawaii Department of Health, 1987).

An interagency task force is currently meeting regularly to forge a vision for CAMH services in Hawaii. As a result of the study conducted on the MOA, this group would welcome any significant input regarding components of the MOA which need to be improved or how the MOA might be implemented more efficiently with existing resources. Thus far, it remains the inescapable conclusion of this group that a major infusion of additional resources will be necessary to implement this vision. Without this, the ongoing crisis in children's mental health will continue to worsen.

CTT:pm

cc: Office of Instructional Services