Follow-Up and Management Audit of the *Felix* Consent Decree

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

Report No. 01-16
December 2001

THE AUDITOR
STATE OF HAWAII

Office of the Auditor

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

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

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

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

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

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

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

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

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

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

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

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

THE AUDITOR
STATE OF HAWAII
Kekuanao'a Building
465 S. King Street, Room 500
Honolulu, Hawaii 96813

OVERVIEW

Follow-Up and Management Audit of the Felix *Consent Decree*

Report No. 01-16, December 2001

Summary

The Office of the Auditor conducted a follow-up audit of recommendations from several prior audits related to 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. The Departments of Education and Health are the agencies responsible for implementing this system of care. In May 2000, the State was held in contempt for failing to implement the required system of care. This report also responds to a legislative request and concerns about fiscal issues related to the *Felix* consent decree, as well as a legislative mandate for assistance with assessments of new mental health programs.

We assessed selected aspects of the departments' capabilities for accounting, reporting, managing, and forecasting the cost of compliance with Felix requirements. We reviewed management controls intended to monitor compliance with the federal law. We also examined the responsible agencies' efforts to implement previous audit recommendations.

We found that the system of care created in response to the *Felix* consent decree has not achieved the expected results. The system of care focused more on procedural compliance rather than on a system to effectively help the children. In addition, the system is largely based on treatments that cannot demonstrate effectiveness. As a result, a major shift in school-based delivery of services was necessary. This involved the assumption of responsibility for mental health care for approximately 6,000 children by the Department of Education.

We also found that the Departments of Education and Health do not provide a full picture of the costs of complying with the consent decree. The departments lack an adequate financial management infrastructure to support the *Felix* compliance effort. Costs reported by the departments are intermingled with other programs, are inaccurate, and suffer from a lack of transparency.

Finally, we found the system for monitoring service delivery improvements to be inadequate and lacking assessment to ensure that mental health services are appropriate and effective. The Department of Education lacks objective, measurable goals in individual education programs (IEPs) and Department of Health treatment plans are not linked to educational goals.

Recommendations and Response

We recommended that the Departments of Education and Health develop and implement coordinated capabilities for detailed reporting and analysis of *Felix* costs. All involved agencies should consider employing cost accounting and

decision support systems. We also recommended that the Department of Education consider adding the requisite capabilities enabling it to maximize federal Medicaid reimbursements. In addition, we recommended that the Department of Education ensure the use of consistent measurements for children's progress and use these measures in coordination with the Department of Health to ensure that mental health services are effective and appropriate in meeting educational goals set by IEP teams. Finally, we recommended that the Departments of Education and Health submit interagency consolidated financial reports for federally mandated special education requirements.

The Department of Education responded that it generally agreed with the recommendations made in our report. The department reported that its own internal audit recognized the need for a comprehensive financial report. The department also noted that it will modify its integrated special education system to meet Medicaid requirements, but that additional changes are still needed.

The Department of Health agreed with the report's recommendations but faulted the report for not reflecting recent improvements. The department contends that the report's finding that the Child and Adolescent Mental Health Division "lacks the capability" to support evidence based practices is inaccurate. It further states that the failure to report employee-related benefit costs, as part of the *Felix*-related costs, was not intentional and would have been provided if requested. This response is indicative of the problems we encountered in attempting to identify costs.

In addition, the Department of Health responded that our assertion that the Family Health Services Division is unable to provide a separate accounting of *Felix* vs. non-*Felix* costs is inaccurate. It contends that all costs in this area are *Felix*-related. However this statement appears to contradict its explanation of mental health related excluded from costs its Child and Adolescent Mental Health Division's reports.

Finally, we are encouraged that the department acknowledged our finding that treatment plans are not linked to educational outcomes and has made establishing clear, measurable objectives and criteria reflecting achievement of educational goals, a priority.

Marion M. Higa
State Auditor
State of Hawaii

Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813
(808) 587-0800
FAX (808) 587-0830

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Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 01-16
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Foreword

This report was prepared as a follow-up to previous audits addressing issues related to the *Felix* v. *Cayetano* consent decree as authorized under Section 23-4, Hawaii Revised Statutes. In addition the report responds to legislative concerns regarding the cost of complying with the consent decree and to provisions of Section 6, Act 25 and Section 2.41, Act 281, Regular Session of 2000, requesting the State Auditor to assist with the assessment of process and outcome evaluation reports issued by the Department of Healthís Child and Adolescent Mental Health Division.

We wish to express our appreciation for the cooperation extended to us by the officials of the Departments of the Attorney General, Education, and Health. We would also like to thank the staff of other departments and entities who provided assistance during the course of the audit.

Marion M. Higa
State Auditor

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Chapter 1
Introduction

The State Auditor has conducted a number of audits addressing issues related to the *Felix* v. *Waihee* (now *Cayetano*) consent decree as authorized under Section 23-4, Hawaii Revised Statutes (HRS). This audit follows up with responsible agencies to determine the status of implementation of pertinent recommendations and concerns from prior audits. In addition, it responds to a legislative request regarding concerns about the cost of complying with the consent decree and the uncertainty about its fiscal impact in the coming years. Finally, it responds to a legislative mandate for assistance with assessments relating to process and outcome evaluations of new mental health programs.

Audit work to assess the Stateís fiscal management of compliance efforts with the *Felix* consent decree was performed pursuant to Section 23-4, HRS, which requires the State Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

Follow-up on the implementation of applicable recommendations from prior audits involved the following three reports*: Study on the Privatization of the Child and Adolescent Mental Health Program* (Report No. 99-12), *Assessment of the Stateís Efforts Related to the* Felix *Consent Decree* (Report No. 98-20), and *Audit of the Big Island Pilot Project on Mental Health Services* (Report No. 98-1).

Finally, Section 6 of Act 25 and Section 24.1 of Act 281, Regular Session of 2000, required the State Auditor to assist with assessing process and outcome evaluation reports required for new initiatives and programs as well as overseeing the effectiveness and efficiency of the Department of Healthís Child and Adolescent Mental Health Division. The required process and outcome evaluation reports are due to the Legislature no later than 20 days before the 2002 Regular Session.

Background on the Compliance Effort

The *Felix* consent decree was the outcome of a class-action suit filed in 1993 in the U.S. District Court, in which the State was found in violation of two federal laws, Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act (IDEA). Based on the Education for All Handicapped Children Act of 1975, IDEA has seen a number of amendments, the most recent in 1997. These laws prohibit the exclusion of disabled persons from federally funded programs and require states to provide a ìfree and appropriate public education to disabled children.î

The court found that the State had ìsystematically failed to provide required and necessary educational and mental health services to qualified handicapped children of the State of Hawaii.î

In the consent decree, issued in October 1994, the State agreed that the Department of Education would provide all educational services that members of the *Felix* class require, and the Department of Health would provide all mental health services that class members require in order to benefit from the educational services. This would be achieved through a system of care that provides a continuum of services, placements and programs, and identification of eligible children with emotional or behavioral difficulties in a school setting. The system would operate through partnerships between state agencies, individual service providers, and the families of *Felix* class members. A June 30, 2000 deadline was set for full implementation of this system of care.

The decree further provided for a special master, a court monitor and a technical assistance panel. The special master performs tasks assigned to the court such as receiving recommendations from the court monitor, determining the Stateís expenses for the court monitor and the technical assistance panel and staff, and resolving disagreements between the parties. The court monitor is to develop a monitoring plan to measure the Stateís progress with compliance efforts and the effectiveness of the new system of care. The monitor also issues periodic reports and makes recommendations to the court. The technical assistance panel is comprised of three experts named in the decree. The Departments of Education and Health are required to utilize the panel for formulating the implementation plan. The panel may also retain experts for assistance.

Recent developments

Despite the acknowledged efforts made by the State, on May 30, 2000, the U.S. District Court found the State in contempt for failing to design and implement both a seamless system of care and an infrastructure to support that system as stipulated in the consent decree. The resulting court order of August 3, 2000, accepts the court monitorís recommended stipulations outlining benchmarks that will be met through December 31, 2001. It further provides for an 18-month monitoring period beginning December 31, 2001, to ensure compliance will continue once the benchmarks are met. All parties agreed to these orders.

Organization

Apart from the Departments of Education and Health, numerous other agencies contribute to the Stateís compliance effort. These agencies include the Departments of the Attorney General, Human Services (through its Med-QUEST Division and Child Protective Services Branch), Accounting and General Services (Information and Communication Services Division and School Transportation Services Branch, the latter now transferred to the Department of Education), and

Exhibit 1.1
Chronology of the *Felix* Consent Decree

May 4, 1993	*Felix et al.* v. *Waihee*, complaint filed in U.S. District Court
May 24, 1994	U.S. District Court Judge Ezra finds that the State is liable, having failed to provide services to plaintiff class under the Individuals with Disabilities Education Act (IDEA) and the Rehabilitation Act of 1973, Section 504.
October 25, 1994	Judge Ezra approves a settlement and consent decree and appoints a special master and a court monitor to facilitate a continuing effort towards compliance with the decree. The terms of the decree include: • The parties stipulate to the jurisdiction of the federal court; • The State waives its right to appeal; • The Departments of Education and Health are named responsible agencies but are obliged to form partnerships with other state and private agencies; • The State is required to establish a system of care of programs, placements, services, and an organizational and managerial infrastructure to support it; • Full implementation by June 30, 2000; • The State is required to develop an implementation plan within seven months; and • The State is required to establish maintenance of service programs as measured by May 1994 appropriations.
October 31, 1995	Implementation plan approved by Court - the plan was subsequently amended in August 1996 and December 1998.
May 30, 2000	Judge Ezra finds the State in contempt for failing to design and implement a seamless system of care as stipulated in the consent decree.

Budget and Finance (employee benefits). In addition, the Judiciary is involved through its Family Courts. Finally, the consent decree mandates that the State pay all costs associated with the Office of the Court Monitor, the technical assistance panel, plaintiff counsel, and the special master.

Recommendations from Previous Audits Are Still Outstanding

Our office conducted three previous audits addressing *Felix*-related issues. Follow-up summaries and recommendations pertaining to *Felix* from these reports follow. Several significant cost items remain outstanding; specifically, overpayments are not pursued and information systems capabilities are weak.

The mental health care system lacks coordination but Medicaid reimbursements have increased

In Report No. 98-20, *Assessment of the Stateís Efforts Related to the Felix Consent Decree,* we determined that the Stateís system for providing mental health care continued to be inefficient and ineffective, as eligible students were not identified on a timely basis, paperwork burdens were excessive, case coordination was insufficient, and service quality was poorly monitored. We also found that inadequate efforts had been made to ensure that the State is reimbursed for eligible *Felix*-related expenditures through Medicaid. While Medicaid reimbursements have improved, inconsistent coordination between the Departments of Education and Health continues to exist. The recommendations and follow-up conclusions are summarized in Exhibit 1.2.

Contracted services affect staff services

In Report No. 98-1, *Audit of the Big Island Pilot Project on Mental Health Services,* we found that the Department of Healthís family guidance centers were underutilized. Family guidance center staff statewide perform case management and care coordination for *Felix* children. However, the Department of Health contracted with Kapiíolani HealthHawaii to manage the Big Island Pilot Project, dramatically changing the staff assignments at the family guidance centers on the Big Island. Some staff became occupied for only half of their work periods. Exhibit 1.3 summarizes the relevant recommendation for Report No. 98-1 and the conclusion from our follow-up audit work.

Payments for contracted services are not adequately documented

Subsequent to issuing Report No. 98-1, questions arose about the disposition of a large cash balance on the contractorís books after the second contract year. This cash balance resulted from advance payments made under the contract. In response to this concern, we reviewed supporting documentation for advance payments and the depositing balance made under the contract. We found that questions remain open

Exhibit 1.2
Follow-Up Conclusions and Recommendations of Report No. 98-20

Prior Audit Recommendations	Follow-Up Audit Conclusions
The governor should ensure that the *Felix* operational management team aggressively pursues clarification of (a) the working definition for the *Felix* class and (b) the maintenance of effort requirement. After clarification is obtained, this information should be disseminated to staff, including Department of Education staff.	The report, *Follow-Up Review of the State's Effort to Comply with the* Felix *Consent Decree*, prepared by the Center for the Study of Youth Policy at the University of Pennsylvania, and issued in January 2001 through our office, concluded that (a) a working definition of the *Felix* class still does not exist and (b) personnel problems continue to make maintenance efforts problematic.
The *Felix* operational manager should ensure that the Department of Health and the Department of Human Services' Med-QUEST Division work together to develop a plan for the Child and Adolescent Mental Health Division to access federal Medicaid/QUEST funding for services provided to eligible children.	The Department of Health and the Department of Human Services' Med-QUEST Division have cooperated in improving access to Medicaid funding. As a result, estimated reimbursement have increased by more than $6 million.
The Department of Health's Child and Adolescent Mental Health Division should establish uniform payment schedules for mental health services.	The division has established maximum allowable fees for use in establishing contracted fees for mental health services.

Exhibit 1.3
Follow-Up Conclusions on Recommendations of Report No. 98-1

Prior Audit Recommendations	Follow-Up Audit Conclusions
The director of health should look at the possibility of utilizing family guidance center staff as providers of services. (The recommendation refers only to centers located on the Big Island.)	The Big Island family guidance centers now operate like other centers and their staff perform case management and care coordination functions.

on some of the charges paid to Kapiíolani HealthHawaii. For example, Kapiíolani HealthHawaii has not provided satisfactory documentation supporting an amount of $81,200 for salaries, and the division has failed to seek a refund. These problems were identified in an internal audit, which also questioned the lack of documentation for $1.2 million charged for contracted services. Division management decided that these problems could be resolved only through an audit and possibly litigation. The cost of such an enterprise was judged by Child and Adolescent Mental Health Division management to be higher than the potential recovery. The division chose not to pursue the $81,200 overpayment and the lack of documentation for the $1.2 million in charges.

Evaluation, training and information systems are weak

In Report No. 99-12, *Study of the Privatization of the Child and Adolescent Mental Health Program,* we found that while the Department of Healthís Child and Adolescent Mental Health Division has a policy for monitoring and evaluating provider performance, it relied on provider-set standards. This policy was inadequate to ensure service quality. Further, family guidance center staff authorized services without proper documentation. This was attributed to a lack of training. Finally, we determined that the Child and Adolescent Mental Health Management Information System (CAMHMIS) suffered from:

- insufficient planning and control over the implementation, costs and results of CAMHMIS,
- lack of linking capability with the Department of Educationís computer system, and
- insufficient planning for inclusion and training of private providers, resulting in data errors.

The recommendations and follow-up conclusions for Report No. 99-12 are summarized in Exhibit 1.4.

Published reports and computer data do not agree

The scope of our audit did not include an evaluation of the Department of Healthís Child and Adolescent Mental Health Divisionís information system. We did, however, identify a discrepancy between the divisionís published reports and its internal computer generated reports on the number of youths referred to mainland facilities.

The information system produced a report dated July 31, 2000, showing a total of 46 clients at mainland facilities, while a report submitted to the Legislature indicated 54 clients for the same date. The latter number was based on manual records. According to division staff, duplicate manual

Exhibit 1.4
Follow-Up Conclusions on Recommendations of Report No. 99-12

Recommendations	Follow-Up Audit Conclusions
Integrate a comprehensive evaluation system for quality assurance in the division's contract monitoring manual.	The division has developed and is using a comprehensive quality assurance system, including a clinical standards manual and evaluations of provider services.
Provide additional training for staff to prepare for a smooth transition.	Additional training has been provided and a quality review implemented to monitor compliance with authorization requirements.
Prioritize the implementation of an interagency management information system.	The division has placed a high priority on developing the CAMHMIS system's capabilities. However, because the Department of Education's ISPED system is not fully functioning, interagency functionality will have to be assessed at a later time.

records are kept because some mainland referrals are not entered into the system in a timely manner, resulting in the discrepancy. If allowed to persist, such practices can affect confidence in the integrity of data for the entire information system.

Our follow-up conclusions identify outstanding issues of system coordination, costs recovery, professional training, and weak financial data reporting. These are repeating themes.

Objectives

1. Assess critical aspects of the Stateís fiscal management of compliance with *Felix*-related requirements, including its ability to account for and predict the financial impact of compliance.

2. Assess the Stateís system for monitoring, on an individual student basis, the achievement of targeted improvements through services provided to students.

3. Assess any Child and Adolescent Mental Health program process and outcome evaluation reports submitted to the Legislature in compliance with Section 24.1 of Act 281 and Section 6 of Act 25, Session Laws of Hawaii, 2000 (SLH).

4. Make recommendations as appropriate.

Scope and Methodology

The audit focused primarily on the Departments of Education and Health. However, other agencies involved in the *Felix* compliance efforts, including the Departments of the Attorney General, Human Services, and Budget and Finance, were contacted as well.

We assessed selected aspects of the departmentsí capabilities for accounting, reporting, managing, and forecasting the cost of compliance with *Felix* requirements. We also reviewed management controls for monitoring the results of mental health services to ensure that services meet the requirements of federal law. The audit work focused on program and fiscal operations between January 1, 1998 and December 2000.

The audit examined the responsible agenciesí efforts to address previous audit findings and implement previous audit recommendations for the following reports: Report No. 98-20, *Assessment of the Stateís Efforts Related to the Felix Consent Decree;* Report No. 98-1, *Audit of the Big Island Pilot Project on Mental Health Services*; and Report No. 99-12, *Study of the Privatization of the Child and Adolescent Mental Health Program*. The follow-up work was limited to recommendations pertaining to *Felix* issues covered by the objectives of this audit.

During our audit, we reviewed a limited number of case files at family guidance centers and schools in two school districts. While a random selection of files was originally planned, we were unable to do so because our access to case files was severely limited by restrictions imposed on us by the departmentsí interpretation of federal confidentiality laws. Consequently, our sample was limited to a judgmental selection of cases in three school complexes each from the Department of Educationís Central Oahu District and the Hawaii District. Eighteen cases were selected and the corresponding case files kept by the school and the family guidance center serving each case was reviewed. The findings and conclusions from this review are limited to the cases selected and cannot be said to reflect system-wide conditions.

As directed by Acts 25 and 281, SLH 2000, we reviewed and evaluated activities related to new mental health treatment programs implemented by the Department of Healthís Child and Adolescent Mental Health Division. We requested information on and reviewed the status of any

new programs and related reports. The division has implemented only one new program, Multisystemic Therapy. The Department of Health was mandated to submit process and outcome evaluations at least 20 days prior to the Regular Session of 2001. We reviewed the only evaluation report issued to date. We will continue to monitor and review reports as the Multisystemic Therapy program reaches a more mature stage.

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

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Chapter 2

Felix Compliance Efforts Lack Focus While Costs are Understated and Insufficiently Controlled

The Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973, the federal statutes on which the *Felix* consent decree is based, impose a substantial financial burden on the State. This makes it imperative that the Departments of Education and Health, charged with compliance with *Felix*, optimally deploy the resources provided to them and provide the Legislature with adequate and relevant information to allow for legislative oversight. We have found that the departments fall short on this charge because the system of care developed for children needing mental health care has not produced the hoped for results. Financial systems lack capabilities and coherence to produce useful reports to the Legislature on the cost of *Felix*. Furthermore, the departments lack an effective mechanism to link mental health services to educational goals to ensure that mental health services are effective and appropriate.

Summary of Findings

1. The Stateís system of care, created by the Departments of Education and Health to comply with the *Felix* consent decree, is not achieving the expected results. As a result, after almost seven years of working on compliance, the Departments of Education and Health are in the process of redirecting the focus for delivering services to *Felix* class children.

2. The Departments of Education and Health do not provide a full and accurate picture of the costs of their efforts to comply with the *Felix* consent decree. In addition, the transfer of the mental health services administration for most *Felix* children from the Department of Health to the Department of Education may reduce available cost information.

3. The Stateís system for monitoring improvements achieved through mental health services is inadequate because individual education programs lack objective, measurable goals, and treatment plans are not linked to educational goals.

The System of Care Does Not Achieve the Expected Results

There is little if any scientific evidence that mental health services typically provided by the health departmentís Child and Adolescent Mental Health Division to Hawaiiís special education students produce intended benefits. As a result, the Departments of Education and Health are in the process of undertaking a major shift in direction to provide children with the effective system of care mandated by federal law and the *Felix* consent decree. This shift includes a transfer of fiscal and administrative responsibilities for most mental health services from the Child and Adolescent Mental Health Division to the Department of Education. This transfer is potentially costly because of the Department of Educationís questionable readiness to assume these responsibilities.

Traditional mental health services lack evidence for effectiveness

Mental health services provided by the Child and Adolescent Mental Health Division to *Felix* children in Hawaii have been primarily based on a traditional clinical service model. The modelóHawaiiís system of careóprovides services by mental health professionals in outpatient, day treatment, and residential or institutional settings. Outpatient services include face-to-face individual, group or family therapy provided in the most natural environment, such as in school, at home, in the community, or at a therapistís office. Day treatment options include school-based or institutional programs offering structured educational and therapeutic services for children with emotional, behavioral or developmental problems. Institutional settings can involve placement in a residential or psychiatric hospital. Other mental health services provided by the division include intensive support services, designed to avert a referral to or facilitate a return from an inpatient setting, and community based services, including therapeutic foster homes.

However, scientific studies on the effectiveness of traditional clinical mental health treatments indicate that there is little if any evidence that these services are effective outside a controlled research environment.

This conclusion was reached in a 1998 report for the U.S. Surgeon General and substantially confirmed by a Hawaii task force of mental health professionals reporting in August 2000 on the most promising treatments for child and adolescent mental health disorders. A member of that task force stated that scientific literature shows little correlation between the type of services and results. In fact, except for severe cases, the critical ingredient may be the presence of positive relationships. Appropriately trained counselors, for example, may be just as effective as mental health professionals.

It must be noted that such findings do not mean that clinical treatments do not work, but rather that researchers found no proof that they work, especially in real life situations as opposed to controlled ìlaboratoryî

settings. Nevertheless, a study comparing the effectiveness of psychotherapy to academic counseling found psychotherapy to be slightly less effective in improving a childís functioning. A proposed explanation is that a relationship with a caring adult benefits children as much as formal clinical therapy. An interesting finding of the study was that parents whose children received psychotherapy expressed higher levels of satisfaction with the services provided than did parents whose children received academic tutoring. This prompted the authors to question the usefulness of consumer satisfaction surveys for measuring the outcome of treatments because of the apparent bias favoring the clinical treatment.

Additional services the division provides include ìflex fund servicesî and respite services. In FY1999-2000, the Child and Adolescent Mental Health Division was authorized to spend about $1.5 million for flex services. Flex fund services comprise structured youth classes, medications, drugs and drug screens, transportation, interpreters and therapeutic equipment. Flex services provided for recreational activities, such as horseback riding or aikido lessons, have attracted public attention. However, the court monitor confirmed that such services can be a cost effective alternative to professional intervention. According to the Child and Adolescent Mental Health Division, total statewide spending on recreational services was about $97,000 for FY1999-2000.

Respite services provide temporary relief to families from the daily demands of caring for a disabled child. According to the divisionís clinical standards, these services are provided in combination with other mental health services to reduce the risk of out of home placement, abuse or neglect. According to division personnel, respite services would typically consist of two to eight hours a week, but we have found that respite service authorizations can go as high as 162 hours a month or about 40 hours per week. According to the Child and Adolescent Mental Health Division, parents of, in some cases several, autistic or hyperactive children, for example, face a huge demand on time and emotions in their childrenís constant need for care. Respite services allow relief or an opportunity to attend to necessities such as shopping, medical or dental visits. In some cases, respite care can also involve overnight care, such as in a respite foster home.

Compliance with process brought questionable results

The Department of Education has embarked on major adjustments to its approach to complying with the Individuals with Disabilities Education Act (IDEA), on which the *Felix* consent decree is based.

The Department of Education had previously assumed that procedural compliance with the requirements of the IDEA would produce a quality program for students with disabilities. However, procedural compliance

monitoring has not had the anticipated success; consequently, the department changed its focus by adopting a continuous improvement monitoring system. This system is intended to identify needed support and ensure best program practices and effectiveness in addition to enforcing legal requirements and measuring results of corrective action.

Concurrently, the department, for the past year, has prepared for a major reorientation of its approach to serving *Felix* children. This reorientation entails a move to a school-based approach described by the department as the ìeducation modelî to provide mental health care. The department assumed responsibility for mental health services for approximately 6,000 of the 11,000 *Felix* children effective July 1, 2001. Representing those needing low-end level of care, these children previously received mental health care from the Child and Adolescent Mental Health Division. The education model emphasizes proactive skill development within school and home to promote positive social behavior versus focusing on reducing troublesome behavior and crisis management. The services will be available through a combination of education department employees and contracted mental health professionals.

Similar school-based mental health care programs have already been in place for several years in at least two other states.

Compliance efforts are inadequately planned

Inadequately planned efforts of the Departments of Education and Health will be costly and services may not be appropriate. The departmentsí implemented efforts will burden taxpayers unnecessarily and may result in ineffective or overly costly programs that are difficult to change once established.

The departmentsí efforts are in part due to the federal courtís priority on complying with the consent decree over adequate planning and cost effectiveness. The federal court acknowledged that the State, while under pressure to comply, would not be able to do so in the most cost-effective manner. Even so, the departments are still obligated to use state resources prudently and to provide effective services. However, insufficient planning for the transferred responsibility for low-end students to the Department of Education will prove costly. Moreover, the health department has made a statewide commitment to a new family treatment program which has not yet been evaluated for effectiveness.

Insufficient planning for transferred mental health care will be costly

As part of a reorganization for providing mental health services to students, the Department of Education assumed fiscal and administrative responsibility for administering school-based mental health services for 6,000 *Felix* children in July 2001. While the concept of school and

family based services has support as a best practices model, the Department of Education has not adequately planned for this transition. As a result, the State may incur millions in additional costs before planned improvements to services are realized.

Emergency funding requests in the 2001 legislative session for school-based mental health services indicated that the transfer will mean reduced accountability and diminished ability to recover costs from the federal government, partially because the Department of Education is ill prepared to assume the fiscal management of mental health services. Our conclusions are based on information available to us at the end of our fieldwork, when the transfer was still five months away. However, it is doubtful that these deficiencies can be remedied in that time.

The education department lacks controls already in place at the Child and Adolescent Mental Health Division to oversee provider billings. Schools, lacking mental health professionals, began authorizing school-based mental health services in FY2000-01 as part of transition preparations. The budget for these school-based services of $21.5 million for FY2000-01 is projected to be exceeded by $14.9 million (69 percent), according to an emergency funding request from the Department of Health. We requested explanations for this projected budget overrun from both departments. The responses we received indicate that a major contributing factor is a failure to ensure the continuity of the administrative controls established by the Child and Adolescent Mental Health Division. Such controls include scrutiny for appropriateness of provider billings by staff with mental health experience.

In addition, the transfer of responsibility to the Department of Education will affect federal reimbursements for students eligible for Medicaid. The department has no plans to pursue Medicaid reimbursements for eligible children. Currently, the State, through the Child and Adolescent Mental Health Division, receives approximately $6.8 million in reimbursements. The amount that may be lost to the State from unreimbursed school-based mental health services could be as high as $2 million a year.

Moreover, open questions remain about the Department of Educationís ability to manage mental health services effectively and economically, during the transition to a school-based system. The department does not have the in-house expertise to administer clinical standards for mental health services provided by private sector mental health professionals. The department estimates that due to a shortage of candidates, it may take up to three years to hire the professionals needed to manage mental health services at a level similar to that currently in place at the Child and Adolescent Mental Health Division. Control over quality of services

will be in the hands of student services coordinators, who typically are teachers. Also, the lack of in-house expertise in the mental health field is likely to place much reliance on providers for the appropriateness of their billings. The departmentís inability to effectively scrutinize billings may allow providers to take advantage of education.

Finally, relative inferior ability of the Department of Education to match the Child and Adolescent Mental Health Divisionís data processing capability will leave the Legislature with a more fragmented picture of *Felix* funding. The divisionís computerized systems can generate numerous statewide cost reports on substantially all *Felix*-related mental health services. Flexible reporting capabilities allow summary presentations on resource allocations and costs. For example, flex-spending reports include the amounts spent on respite services and recreational services such as horse riding, martial arts, dancing, etc. The Department of Education currently cannot produce similar reports. As a result, detailed expenditure reports for services provided to approximately 6,000 children will no longer be available. This will significantly reduce accountability and the opportunity for legislative scrutiny.

Unproven new program is implemented on a large scale

The Child and Adolescent Mental Health Division has made a substantial commitment of resources to establish Multisystemic Therapy (MST) on a statewide basis. At least 14 people were hired to administer the program, and an estimated $5 million was expended on implementing the program through the end of FY2000-01.

The 2000 Legislature required the Department of Health to evaluate any new treatment or service programs. Only one program, Multisystemic Therapy, was introduced and, therefore subject to this requirement. The department contracted with the University of Hawaii to conduct the evaluation. The resulting report raises concerns about the programís effectiveness. The concerns support a more fiscally cautious approach to introducing the Multisystemic Therapy program. The evaluation concluded:

- While there is credible support from research for potential effectiveness of Multisystemic Therapy, the program lacks scientific evidence that it works as advertised by its creators for Hawaiiís targeted population. Multisystemic Therapy research has been targeted mostly on serious, violent, and chronic juvenile offenders, and Hawaii is one of only two sites where the program is applied to persons with serious behavioral and emotional problems. In fact, concerns about cultural considerations and the ìgeneralizabilityî of Multisystemic Therapy to Hawaii have already surfaced. Strategies to address

these concerns have been developed by the division but had not been implemented during our review.

- Completed studies on the empirical validity of Multisystemic Therapy were performed by researchers associated with the originators of the program. Currently, Multisystemic Therapy does not meet the criterion of a well-established, empirically validated treatment. To meet that standard, at least two different investigating teams must have conducted the research.

The divisionís own task force for reviewing scientific support for clinical mental health treatment options also voiced concerns about the effectiveness of treatment programs in Hawaii. The task force cited the importance of considering ìrobustnessî of treatments in rural areas, appropriateness of treatments with various cultural groups, and difficulties in training therapists in Hawaii, noting that available research falls short of addressing some of these concerns.

In follow-up discussions with the author of the evaluation, we confirmed that Multisystemic Therapyís efficacy lacks empirical validation from teams that are independent from its creators. The originators, incidentally, also have a financial interest through an affiliate who is a vendor of the program to the State of Hawaii. In addition, we learned that it is unusual for vendors of treatment programs to provide evaluations. According to the author, it has been shown in the social sciences that as much as 50 percent of study outcomes can be explained by researchersí leanings. For this reason, no program should be deemed effective unless it has been tested in truly independent scientific studies, and evaluations should not be controlled by a party with an interest in their outcome.

Considering the above concerns, committing to implementing unproven programs on a large statewide scale is not a best practices approach. Experts on establishing best practices recommend that smaller pilot-type trials be set up to ensure that a program is effective, allowing for modifications or cancellation, if appropriate, before it is implemented on a large scale.

The Departments Do Not Provide a Full Picture of the Cost of *Felix* Compliance

The Departments of Education and Healthís reporting on the financial impact of complying with special education and *Felix* requirements understates the Stateís financial commitment and lacks accuracy and transparency. In addition, the financial management infrastructure supporting the *Felix* compliance effort does not mirror the activities of the system of care being implemented under the consent decree. The departments lack the capability that corresponds with best practices in delivering services to children and their families.

Financial information on the cost of Felix *is inaccurate, inadequate, and misleading*

Stakeholders, including the Legislature, do not have a full picture of the cost of *Felix* because fiscal information submitted by the Departments of Education and Health is inaccurate and lacks transparency. *Felix*-related financial reports omit millions of dollars in costs, contributing to misleading comparisons with national averages that understate Hawaiiís commitment to special education. In addition, the departmentsí financial reports do not provide a separate accounting for the *Felix* consent decree.

Cost reports are understated, by as much as $41 million

We requested reports on *Felix* spending from the Departments of Education and Health. The Department of Education provided the budget and expenditure report for special education shown in Exhibit 2.1. The Department of Health submitted a report of actual and estimated expenditures for the Child and Adolescent Mental Health Division, shown in Exhibit 2.2. The reports convey substantially the same information that was submitted to the Legislature.

We found that these reports do not represent an accurate accounting of *Felix*-related costs because these costs are intermingled with the costs of services provided to other disabled children. Most importantly, the reports collectively understate actual costs by an estimated $37 and $41 million respectively, for FY1999-2000 and FY2000-01. For example, in FY2000-01 an estimated $31 million in *Felix*-related employee benefits for the two departments and an additional estimated $10 million for special education transportation are excluded from the reported cost of serving disabled children.

Adjusted for the unreported costs, the Stateís funding for compliance with the IDEA was an estimated $337.7 million for FY1999-2000 and is estimated to reach $438.2 million in FY2000-01. Exhibit 2.3 presents these amounts as ìTotal IDEA Compliance.î Funding for the portion of IDEA compliance under Department of Education control, which substantially encompasses special education, amounts to $193.2 million and $259.8 million from all funding sources for FY1999-2000 and FY2000-01 respectively. The special education budget is identified by the Department of Education as program EDN150.

Except for special education transportation, we did not attempt to determine the impact of special education needs affecting other programs because of the subjective nature of such an endeavor. However, special education needs clearly impact other programs. For example, regular education teachers are required to attend individual education program meetings and perform administrative tasks related to special education. Also, school administration workloads related to special education demands have been reported to us to be as high as 50 percent. The costs of these services are not included in the departmentís reports of special education costs.

Exhibit 2.1
Department of Education Special Education Operating Budget and Expenditures for FY1999-2000

PROGRAM	APPROPRIATION			ALLOCATION			Expenditure
EDN 150 COMPREHENSIVE SCHOOL SUPPORT SERVICES	FTE PERM	FTE TEMP	AMOUNT	FTE PERM	FTE TEMP	AMOUNT	Jun-00
SPECIAL EDUCATION SERVICES							
17131 SPED in regular schools	2,597.0	211.5	$83,270,641	2,597.0	211.5	$83,026,984	$79,166,483
17155 Individualized Education Program Plans	-	-	$423,770	-	-	$423,770	$451,950
15635 SPED Felix	158.0	40.0	$3,191,760	158.0	40.0	$3,188,339	$1,799,410
17201 Hawaii Center for the Deaf/Blind	49.0	2.0	$2,024,459	49.0	2.0	$2,003,069	$1,976,651
15632 Hawaii Center for the Deaf/Blind - Felix	6.0	2.0	$194,977	6.0	2.0	$194,686	$170,090
17207 Pohukaina	20.0	-	$650,600	20.0	-	$648,988	$390,193
17210 Jefferson Orthopedic Unit	9.0	-	$333,662	9.0	-	$333,058	$271,220
17351 SPED summer school	-	-	$2,148,759	-	-	$2,143,073	$2,207,004
17746 Attorney and related fees	-	-	$373,697	-	-	$347,607	$347,607
17170 Contracted SPED services	-	-	$886,751	-	-	$824,842	$833,525
17711 Transition services	41.0	1.0	$1,795,062	41.0	1.0	$1,792,969	$1,446,279
17724 Occupational skills learning center	4.0	-	$105,926	4.0	-	$105,926	$110,237
Subtotal	2,884.0	256.5	$95,400,064	2,884.0	256.5	$95,033,311	$89,170,649
STUDENT SUPPORT SERVICES							
15630 Counseling - Felix	69.0	-	$2,374,728	69.0	-	$2,369,422	$2,181,138
15638 Counseling EAS - Felix	-	100.0	$1,418,000	-	100.0	$1,418,000	$790,742
15634 Care coordinating services	38.0	-	$1,420,337	38.0	-	$1,413,896	$327,962
15673 Resource teachers - Felix	17.0	3.0	$681,529	17.0	3.0	$672,279	$744,584
15674 Primary prevention/intervention - Felix	107.0	27.0	$2,977,697	107.0	27.0	$2,939,198	$2,693,792
15676 Contract evaluation services - Felix	-	-	$1,740,000	-	-	$1,618,520	$1,618,520
15677 Section 504 statewide implementation	-	1.0	$31,403	-	1.0	$31,403	$62,663
15678 Section 504 - Felix contracts	-	-	$0	-	-	$0	$4,739
15672 Student services coordinators - Felix	75.0	5.0	$2,119,765	75.0	5.0	$2,111,911	$7,146,246
17174 Behavioral management services	35.0	4.0	$1,657,808	35.0	4.0	$1,657,808	$441,641
16202 Instruction for pregnant adolescents	3.0	-	$122,486	3.0	-	$121,765	$116,691
16204 Home/hospital Instruction	-	-	$1,441,756	-	-	$1,441,756	$1,410,055
Subtotal	344.0	140.0	$15,985,509	344.0	140.0	$15,795,958	$17,538,773
PRIVATE AGENCY PROJECTS							$0
17712 Special Olympics	-	-	$128,925	-	-	$119,924	$119,924
Subtotal	-	-	$128,925	-	-	$119,924	$119,924
ED. ASSESSMENT/PRESECRIPTIVE SERVICES							$0
28050 District diagnostic services	293.0	148.0	$16,475,451	293.0	148.0	$16,413,358	$15,082,784
28671 Contracted diagnostic services	-	-	$349,486	-	-	$332,237	$223,574
28701 Summer recall services	-	-	$841,094	-	-	$841,094	$728,744
28175 Felix diagnostic services.	20.0	-	$842,856	20.0	-	$839,960	$759,284
Subtotal	313.0	148.0	$18,508,887	313.0	148.0	$18,426,649	$16,794,386
STAFF DEVELOPMENT							$0
28176 Training/retention - Felix	-	-	$2,136,604	-	-	$1,987,435	$1,613,295
33292 Project Rise	5.0	-	$289,503	5.0	-	$285,173	$356,168
15683 Project Rise - Felix	24.0	4.0	$1,444,183	24.0	4.0	$1,430,700	$1,215,300
33256 SPED EA training - Felix	6.0	-	$371,518	6.0	-	$362,157	$239,342
Subtotal	35.0	4.0	$4,241,808	35.0	4.0	$4,065,465	$3,424,105
ADMINISTRATIVE SERVICES							$0
25045 Student Support Services - administration	2.0	-	$135,431	2.0	-	$125,814	$53,987
25237 Student Support Services section	8.0	-	$459,262	8.0	-	$455,771	$205,178
28177 CSSS Felix	-	-	$122,890	-	-	$117,335	$60,814
28178 Section 504 implementation - Felix	1.0	-	$410,272	1.0	-	$385,678	$354,535
25037 SPED	6.5	-	$360,167	6.5	-	$356,990	$270,820
15629 Felix administration	7.0	-	$966,834	7.0	-	$922,727	$1,073,044
33257 Felix management information sysytem	3.0	-	$1,120,760	3.0	-	$1,053,111	$1,305,048
Subtotal	27.5	-	$3,575,616	27.5	-	$3,417,426	$3,323,426
Total EDN 150	3,603.50	548.50	$137,840,809	3,603.50	548.50	$136,858,733	$130,371,263

Source: Department of Education

Exhibit 2.2
Department of Health Child and Adolescent Mental Health Division *Felix*-Related Expenditures

	FY1999-2000	FY2000-01	FY2001-02
HTH460 - CAMHD			
Total General Fund Expenditures (Actual and Estimated)	$108,285,002	$95,083,301	$88,266,875
Total Special Fund Expenditures as reflected in Analysis (Estimated)		$4,230,741	$6,538,189
HTH495 - CAMHD			
Total General Fund Expenditures (Actual and Estimated)	$3,400,567	$4,690,002	$4,579,218
Total Special Fund Expenditures (Estimated)	N/A	$369,213	$559,253
Total Expenditures (Actual and Estimated)	$111,685,569	$104,373,257	$99,943,535
Less: Budgeted Amounts (includes General and Special Fund Appropriations)	$106,545,982 [1]	$91,359,408	$97,148,980
Add: Carryover from Prior Fiscal Year	N/A	$5,139,587 [2]	N/A
Equals Additional Funds Required through Emergency Appropriation or Supplemental Budget Request	$5,139,587 [2]	$18,153,436 [3]	$2,794,555 [4]

NOTES

1. This amount includes the $42,459,294 emergency appropriation that was provided in FY1999-2000.

2. This deficit amount was carried forward to FY2000-01 and is being addressed by the FY2000-01 emergency appropriation of $18,153,436.

3.

HTH460	General Fund Request	$16,885,924
HTH460	Special Fund Request	378,646
HTH495	General Fund Request	850,000
HTH495	Special Fund Request	38,866
	Total	$18,153,436

4.

HTH460	General Fund Request	$987,858
HTH460	Special Fund Request	924,329
HTH495	General Fund Request	762,449
HTH495	Special Fund Request	119,919
	Total	$2,794,555

Source: Behavioral Health Administration, Department of Health

Misleading comparisons understate the Stateís financial commitment

The Stateís commitment to special education has reached between approximately 21 and 34 percent of total direct educational funding, which is as much as double the national average. But the Department of Education uses inaccurate statistics to make the claim that special education spending is not out of control.

Information presented by the Department of Education to justify a FY2000-01, $41 million emergency funding request for special education included a statement that Hawaiiís special education budget represents 14 percent of the total education budget, compared with a national average of 24 percent. We requested the Department of Education to provide us with the source on which the claimed national average figure of 24 percent is based. The department was unable to do so.

We then contacted the U.S. Department of Education sponsored Western Regional Resources Center and the Center of Special Education Finance (CSEF), both of which stated that the national average special education to total education ratio is clearly less than 24 percent. The CSEF, is one of the most authoritative resources on this topic. According to a recent CSEF publication, the best available estimate (1998-99) for a national average of special education to total K-12 education spending is approximately 13 percent. One of its state-specific studies issued in 1998, indicates that 6.32 percent of total K-12 educational expenditures (excluding capital expenditures) go to special education.

To further estimate special education costs, we computed the ratio of Hawaiiís special education funding to total direct instructional funding. We adjusted the total education budget by deducting amounts not typically included in K-12 instruction cost reports, such as debt service, risk management, and adult education costs. We further adjusted the FY1999-2000 and FY2000-01 budgets and emergency funding requests by adding the estimated costs of employee benefits and transportation related to special education. The results indicate that Hawaiiís commitment to special education represented 20 and 22 percent of total K-12 appropriations in FY1999-2000 and FY2000-01, respectively. If all costs mandated by the IDEA and other federal laws on which the *Felix* consent decree is based are included, state funding increases to 31 and 32 percent of K-12 education appropriations for the same two fiscal years. Exhibit 2.3 represents the components of our computations. Note that the special education percentage is slightly higher if only general fund resources are considered.

Exhibit 2.3
Fiscal Impact of Special Education and IDEA Compliance in Hawaii

	FY1999-2000		FY2000-01	
	General Fund	All Sources	General Fund	All Sources
Total Education				
FY2000 Budget	$824,892,486	$971,864,859	$1,090,955,086	$1,249,931,491
Emergency Request	-	-	41,247,070	41,247,070
Less adjustments				
Adult Education	(16,418,870)	(19,448,785)	(16,418,870)	(20,777,023)
Debt Service	-	-	(87,067,527)	(87,067,527)
Risk Management	-	-	(2,767,162)	(2,767,162)
Total Education	$808,473,616	$952,416,074	$1,025,948,597	$1,180,566,849
Special Education				
Budget	$137,840,809	$160,188,577	$154,035,833	$180,954,518
Employee Benefits	23,700,000	23,700,000	28,100,000	28,100,000
Emergency Request	-	-	41,247,070	41,247,070
Transportation	9,300,000	9,300,000	9,500,000	9,500,000
Total Special Education	$170,840,809	$193,188,577	$232,882,903	$259,801,588
Percent of total education:				
School-based services only	21%	20%	23%	22%
Population of SPED students	22,800	22,800	20,138	20,138
Funding per student	$7,493	$8,473	$11,564	$12,901
Other IDEA mandated services				
Mental Health Services	$87,176,966	$97,729,202	$91,801,845	$102,227,171
0-3, Early Intervention	11,192,912	14,184,277	12,359,123	12,726,622
DOH Employee Benefits	3,400,000	3,400,000	3,300,000	3,300,000
School Health Services	2,301,048	2,423,468	2,436,407	2,436,407
Emergency Funding Requests				
Mental Health Services	25,922,733	26,340,245	48,654,825	48,654,825
0-3, Early Intervention	-	-	7,217,390	7,217,390
DHS Foster Care	-	-	1,800,000	1,800,000
Total Other Mandates	$129,993,659	$144,077,192	$167,569,590	$178,362,415
Total IDEA Compliance	$300,834,468	$337,265,769	$400,452,493	$438,164,003
Percent of total education:				
IDEA compliance	32%	31%	34%	32%
IDEA students incl. age 0-3	24,750	24,750	22,238	22,238
IDEA funding per student	$12,155	$13,627	$18,008	$19,703

Source: FY2001-07 Executive Budget, emergency funding requests and other information provided by DOE, CAMHD and DOH Family Services Division.

Note: IDEA refers to the Individuals with Disabilities Education Act, and other federal laws on which the *Felix* Consent Decree is based. Total IDEA compliance funding represent all costs of complying with these federal requirements.

It must be emphasized that education spending comparisons among states based on a single indicator may not be reliable because of a lack of reporting standards and widely divergent practices in accounting for special education. For example, Hawaiiís special education budget excludes the cost of regular education involvement in special education, physical and occupational therapy (for FY1999-2000), transportation, employee benefits, mental health services, programs for gifted children, and services to the pre-kindergarten population served by the Department of Health. However, these services may be included in special education spending reports of mainland states. If the items above (except for costs of programs for gifted children) are included, Hawaiiís FY2000-01 funding of special education would be between 23 and 34 percent of total education funding from the general fund, 22 percent and 32 percent from all funding sources. This substantially exceeds at least one other stateís percentages and may be as much as double the estimated national average of 13 percent.

Because a single ratio indicator for comparisons may be interpreted differently and lead to conflicting results, we also computed Hawaiiís special education funding per student, as shown in Exhibit 2.3. Based on funding provided to and requested by the Departments of Education and Health, Hawaiiís per student financial commitment from all funding sources ranges between $8,500 and $13,600 for FY1999-2000 and an estimated $12,900 to $19,700 for FY2000-01. As shown in Exhibit 2.3, the low range includes only special education program (EDN150) and related services while the high range includes all services to comply with the IDEA. A Center for Special Education Finance Summary of FY1998-99 special education expenditures reported by other states indicates a range from approximately $3,000 to $12,500, and averaging around $7,000, indicating that Hawaiiís per student expenditure for special education ranks amongst the highest in the nation.

Felix costs are intermingled with other costs

A substantial portion of the *Felix* compliance costs cannot be identified because the Department of Education does not account for *Felix* and special education spending separately. The Department of Healthís Family Health Services Division, the agency responsible for serving children from birth to age 3 with IDEA-required programs, also consolidates costs for *Felix* services with those programs that are not *Felix*-related. As a result, the departments cannot provide stakeholders, including the Legislature, with an accurate accounting of the cost of complying with the *Felix* consent decree.

The Department of Education takes the position that the federally mandated special education services under the IDEA and Section 504 must be satisfied for all eligible children without regard to their status

under *Felix*. Therefore, according to the department, the focus of accountability is on the system of care for all disabled children, not just the *Felix* class.

Coordinated financial management of Felix *costs is lacking*

The Departments of Education and Health are moving to adopt best practices in delivering services to children and improving coordination across departmental boundaries, but are not initiating improvements to coordinate fiscal management and reporting systems. Reports providing *Felix* financial data lack transparency because they are specific to departments, not the *Felix* effort. Departmental information systems presently lack common identifiers and are therefore unable to combine cost data to facilitate coordinated planning, tracking and managing costs, and producing reports to reflect the overall impact of the *Felix* compliance effort. The transfer of mental health services administration to the Department of Education will further impede the availability of comprehensive and clear financial information and may reduce Medicaid reimbursements for eligible *Felix* costs.

Computer systems in existence and under development appear to have the technological capability to support a *Felix* management information system but have not been designed to provide coordinated financial management support. Until this is remedied, the Departments of Education and Health will lack an important tool to manage *Felix* costs, and the Legislature and other stakeholders will not have all the information needed to make informed decisions.

Financial data on *Felix* costs is scattered and lacks transparency

Fiscal information presented on the *Felix* compliance effort is fragmented because it is specific to departmental or divisional efforts, rather than to the system of care as mandated by the consent decree. The computer systems generating the information have varying data-capturing and reporting formats, which can make it difficult to relate their meaning or impact to the *Felix* compliance effort. For example, the Department of Healthís Child and Adolescent Mental Health Division reports purportedly represent the cost of statewide mental health services and are used for comparisons with other states. However, such reports exclude the services (e.g., to autistic children and their families) provided by the Department of Education and the Department of Healthís Family Health Services Division. Also excluded is the cost for children placed in private schools by the Department of Education. The fragmented cost-reporting problem increases as other agencies provide *Felix* services. For example, the Department of Human Servicesí expansion of its therapeutic foster homes programs for *Felix* children is reported as a human services department cost rather than that of the system of care.

In light of the above examples, the need for cross-agency management information systems, including compatible data and reporting structures, becomes apparent. Research on multi-agency support systems for children and families points to this need and the substantial benefits from developing such systems. The Center for Special Education Finance reports that the failure to collect data and costs displaying the range of programs offered creates a significant barrier to accurate estimates of special education expenditures. Such is Hawaiiís current condition of fragmented information systems.

Financial management systems for *Felix* are not coordinated

The Departments of Education and Health lack a coordinated management system, which is needed to effectively support the fiscal aspects of the *Felix* implementation effort. They have not coordinated the capabilities of their respective computer systems for cost reporting.

The *Felix* consent decree requires the departments to develop an interagency management information system to support the system of care to be implemented for *Felix* children. The departments intend to satisfy this requirement using the *Felix* Interagency Management Information System (FIMIS), which will serve as a depository of data from which each department can extract data needed for its purposes.

Our audit work was limited to examining the financial reporting capability of the Departments of Education and Healthís *Felix*-related computerized management information systems. From discussions with agency personnel and review of reports, we found that the Child and Adolescent Mental Health Division has a working system, CAMHMIS, which has been in use for several years, although continually updated. It is designed to track cases, satisfy Med-QUEST reimbursement requirements and assign and report costs of services. In addition, it contains a module designed to monitor outcomes of services.

This system provides the division with substantial flexibility in reporting and analyzing cost data. For example, it can report costs of services by individual child, by provider, by school, and by type of service, and provide agency-wide totals. This type of capability, if matched by other agencies involved in the *Felix* compliance effort, such as the Department of Education, would provide specific identification of costs as well as the full fiscal impact of the *Felix* decree.

The Department of Education, on the other hand, does not currently have a functioning computer system to manage special education services. There is a system under development, the Integrated Special Education (ISPED) system, which was scheduled to become operational by July 2001. From available design outlines and discussions with personnel involved in the development of ISPED, this system will be able to track

cases and account for services when operational. However, the department has decided not to include the capability of assigning costs to services provided at this stage, although such has been determined to be eventually desirable.

As a result, the education departmentís ISPED system as currently designed will not match the Child and Adolescent Mental Health Divisionís ability to assign costs to services. The potential of FIMIS to be a financial management tool and provide *Felix* stakeholders with coordinated financial reports cannot be realized. We were also informed that the two systems do not share a unique identifier for each child, making it difficult to match records across departmental boundaries. Preliminary tests indicated that as many as 50 percent of attempted matches between the systems fail. This confirms concerns our office expressed in Report No. 98-20, *Assessment of the Stateís Efforts Related to the Felix Consent Decree,* where we criticized the departments for failing to collaborate in their development of an integrated management information system and opting instead to share information.

Transfer of mental health case management to the Department of Education may weaken cost management

The Department of Education is in the process of assuming full responsibility for administering mental health services for approximately 6,000 special education students whose needs can be met by a school-based system of care. This number represents about 55 percent of the *Felix* population previously served by the Department of Healthís Child and Adolescent Mental Health Division. The ability to track the cost of these services in detail may diminish because the Department of Education lacks the cost accounting capabilities available to the Child and Adolescent Mental Health Division. As a result of this transfer of responsibilities, the Department of Education will be unable to maintain the advanced cost reporting for statewide mental health services currently available through the Child and Adolescent Mental Health Division.

The divisionís CAMHMIS information system provides capabilities required to qualify for federal Medicaid reimbursements for *Felix* services. During FY1999-2000, the Child and Adolescent Mental Health Division recovered an estimated $6.8 million for all *Felix*-related Medicaid services. The Department of Education currently has no plans to recover such eligible costs for mental health services to children whose care is being transferred to the department. According to a Department of Education estimate, the State will lose about $2 million per year, partially as a result of the departmentís lack of required systems capabilities to recover Medicaid costs.

Coordinated interagency fiscal management is lacking

The Departments of Education and Health lack adequate coordinated management of *Felix* costs. A recent study concluded that interagency service delivery requires a more collaborative approach to support financial management and controls that span divisional and departmental boundaries. Divergent responses from the departments to our queries about a large budget overrun for school-based mental health services illustrate the absence of coordinated fiscal management. The Department of Healthís FY2000-01 emergency funding request for $14.9 million exceeded its budgeted amount of $21.5 million by 69 percent. Department of Health management attributes the budget overrun to schools that are providing services at much higher levels (note that the *Felix* class population has been stable) and the departmentís marginal influence over team-based decisions to authorize school-based mental health services. The Department of Education, on the other hand, cites the reduced involvement of Department of Health care coordinators in IEP team decisions as a major contributing factor. However, we were informed that it is not uncommon for teachers to recommend unneeded services to remove a disruptive *Felix* child from a regular education classroom.

Failing to take joint responsibility for management controls for school-based mental health services is having a sizable undesirable fiscal impact. These high levels of services and costs are expected to continue until the Department of Education can recruit the mental health professionals needed to manage the school-based mental health services system. At this time, the department estimates that it will take two to three years for this system to be fully staffed.

The *Felix* consent decree requires the departments to develop not only a system of care providing seamless delivery of services, but also a supporting computerized information system. While the departments have accomplished improved coordination in service delivery, this cannot be said about the financial management of these services. The departments rely on traditional financial accounting systems to account for and report on the fiscal impact of their transactions. They do not appear to plan or manage their overlapping fiscal concerns in a coordinated manner.

Cost accounting is important for adequate planning and management of resources

Cost accounting is well established in the private sector and increasingly recognized as an important tool to assure effective management of resources in government, including special education. Traditional government accounting focuses on ensuring that expenditures are made

in accordance with law and policy. It is described as a ìtop downî model in that funding is tracked first at program level and then by lower tier objectives. Cost accounting, in contrast, attempts to match expenditures to activities or services at the lowest practical level, typically in combination with output or performance data. The information flow is ìbottom upî and allows for a multitude of routine and ìas neededî financial reporting options for management analysis at different levels, such as individual students, schools, service providers, or disability classification. Such information is valuable in planning for, determining, evaluating, and comparing the actual cost of services.

When matched with performance data, actual cost data can help answer questions on cost-effectiveness. As a result, researchers and experts in the special education financing field are increasingly calling for cost accounting systems that help determine not only whether funds are spent properly but also whether they are spent well.

The federal government has been leading the effort to introduce activity-based costing models to the government sector. The U.S. General Accounting Office stated in March 2000 congressional testimony that ìConclusions about what the government is accomplishing with the taxpayersí money cannot be drawn without linking performance with program and cost information.î

Activity Based Costing is one of the best-known cost accounting models. It provides the fullest practical accounting of the costs of activities including overhead in a given process, and traces these costs to services. Knowing what resources go into each service helps in making informed management decisions relating to:

- Performance measurement cost control, and improving program results;
- Budgeting, by providing accurate data to agencies and lawmakers on the use of resources at the level where costs are incurred, allowing accurate analysis of variances;
- Cost-effectiveness and efficiency analyses, by relating costs to outcomes and predetermined objectives;
- Provision of services in-house or through the private sector; and
- Benchmarking ñ comparing and evaluating the performance of organizational processes in pursuit of best practices.

Activity Based Costing has been successfully implemented in several states, and similar cost accounting models have been proposed specifically for special education and multi-agency systems engaged in service delivery to children and families.

While the Child and Adolescent Mental Health Division has developed a management information system with extensive cost reporting capabilities, these capabilities do not extend to services provided in-house. This prevents the division, for example, from producing cost reports on programs like Multisystemic Therapy in the same detail as for procured services. This may impair cost-effectiveness comparisons between in-house and outsourced services.

The Department of Education has no plans for its ISPED system to include the ability to match costs to resources used. However, ISPED is designed to allow accommodation of cost accounting capabilities. The department can and should use cost accounting to improve its ability to manage and predict the cost of special education programs. Cost accounting can provide the Legislature with better information for budget requests and report on the effectiveness of its past spending decisions.

We reviewed the documentation and charts of accounts for the Department of Educationís Financial Management System (FMS) and concluded that it is consistent with a traditional financial accounting system, therefore lacking the capabilities of a cost accounting system. The Department of Education recognized the importance of developing state of the art financial and analytical capabilities over 30 years ago. The 1969 *Master Plan For Public Education in Hawaii* included this commitment: ìDevelop an advance system of financial forecasting, planning, and analysis that will realistically relate needs for resources and performance to costs and benefits.î

The Departments of Education and Health Have Not Established an Effective Link Between Mental Health Services and Educational Goals

The Department of Education does not ensure that individual education programs for *Felix* children contain objective, measurable goals, short-term objectives and benchmarks. In addition, the Department of Health accepts treatment plans for these children that do not link mental health services to educational goals. In the absence of measurable goals and linkage between mental health services and a childís learning, the departments have no assurance that mental health services provided to children are appropriate and effective in helping a child learn.

IEPs lack measurable objective goals and short-term objectives

Individualized education programs (IEPs) for disabled students do not always provide for an objective and measurable method to gauge educational progress as required by law. That is, because goals, objectives, and benchmarks are vague, evaluation criteria are not quantified, and evaluation procedures are subjective. This impairs the determination of educational progress and consistency in measuring progress in similar cases statewide. As a result, there is no assurance that related mental health services provided to members of the *Felix* class are appropriate.

IEPs must include measurable objective goals and short-term objectives

The Individuals with Disabilities Education Act (IDEA) requires that an IEP include a statement of measurable annual goals, including benchmarks or short-term objectives to determine whether a child is achieving the annual goals. Similar language was adopted in the *Felix* consent decree and in Section 8-56-38, Hawaii Administrative Rules. The purpose of annual goals, benchmarks, and objectives is to allow educators and parents to monitor progress during the year and, if appropriate, make adjustments according to the childís instructional needs.

We reviewed guidelines from the U.S. Department of Education, several states, and advocates for disabled children for definitions of the critical terms relating to goals of individual education programs. The results are shown in Exhibit 2.4.

Goals are not always objective and measurable

The Department of Education does not ensure that all goals, objectives, and benchmarks in IEPs are objective and measurable as required by law. In addition, goals lack a link to standards for the related curriculum.

In our review of IEPs contained in student case files we reviewed, we found that subjective methods of evaluation are used, such as teacher-made tests and observation. While these methods may be useful, they do not meet the requirements of the IDEA.

In the majority of the IEPs we reviewed, evaluation methods to assess academic progress relied on (subjective) observation and daily work. Also, some annual goals were poorly worded and failed to meet the requirement that goals be measurable. Some examples included:

Exhibit 2.4
Definition of Terms Relating to Annual Goals and Measuring Progress

- **Annual Goal**
  Describes what a student can be reasonably expected to achieve in specific areas of need in the following year with the help of the special education and related services provided under the IEP. Such goals must be related to an assessed deficiency, measurable, and useful for monitoring progress.

- **Short-Term Objectives and Benchmarks**
  Intermediate steps or major milestones moving the student toward reaching an annual goal, enabling parents, students, and educators to monitor progress during the year. Objectives state in behavioral, measurable terms what is to be accomplished and by what date. Benchmarks describe a targeted performance level within specified segments of the year.

Additional important concepts relating to measuring educational progress include:

- **Evaluation Criterion**
  Quantifies the level of performance needed to master an objective or benchmark. It is typically expressed as a numeric value, such as percentage of accuracy, number of times succeeded, etc.; and

- **Evaluation Procedure**
  The methods for assessing progress. These may include specific tests, teacher-made tests, curriculum materials, observations, and anecdotal records. However, teacher tests and observations, while useful, do not meet the IDEA requirements of being objective and measurable.

ìto increase skills in math,î

ìto improve writing skills,î

ìEnglish,î and

ì[student] will make more effort to attend and participate in school.î

These examples provide a poor basis for the department and parents to decide whether a child is receiving related services that are working, and they do not meet the definition of a goal (see Exhibit 2.4 for a definition of goal).

We did not find a single IEP with annual goals linked to a standard such as a grade or age related performance level, nor any standardized test used for measuring educational progress towards annual goals, even for academic subjects. Before a recent redesign, the IEP form did not list standardized tests as a part of the evaluation procedure. Annual goals fail to link the childís progress to state educational standards. Such a link is required for IEPs in other states and strongly suggested by federal law. Guidelines from another state, for example, suggest wording like: ì[Student] will increase reading skills to second grade level. [Student] will increase math skills by 1.5 grade levels. [Student] will demonstrate written language skills that include spelling at second grade levelÖ.î Also, the IDEA requires the inclusion of children with disabilities in state-wide assessment programs, either through regular assessment programs with appropriate accommodations, where necessary, or through alternative assessments. A document entitled, ìIDEA í97 Final Regulations, Appendix A Part 300-Notice of Interpretation,î obtained from the website of the U.S. Department of Education states that: ìIn assessing children with disabilities, school districts may use a variety of assessment techniques to determine the extent to which these children can be involved and progress in the general curriculum, such as criterion-referenced tests, standard achievement tests, diagnostic tests, other tests, or any combination of the above.î

Although it is the IEP team that develops annual goals and determines special education and related services needed, the U.S. Department of Educationís regulations assign to Hawaiiís Department of Education the responsibility for ensuring that the IEP is adequate: ìÖthe public agency has ultimate responsibility to ensure that the IEP includes the services that the child needsÖ.î

Objectives and benchmarks are not measurable

We found that objectives and benchmarks in IEPs we reviewed require subjective evaluation and/or are not measurable. The degree of achievement of objectives and benchmarks should tell parents whether the child is progressing as expected during the period described in the annual goal. Some of the objectives and benchmarks we reviewed clearly were not capable of providing that information. We identified vaguely worded objectives and benchmarks that were incapable of assigning a meaningful, objective measure of progress. Examples include:

> ìHe will remain on task with all necessary materials on hand 80% of the timeî;
>
> ì[student] will write an informative paper of 2-4 paragraphs 80% of the timeî; and

> ì[student] will experience success by completing assigned class-work, homework, following directions, and being on task 80% of the time.î

Subjective observation as to whether a child has improved results in, as one advocate puts it, ìthe criteria of mastery becoming 80% of a subjective opinion.î Also, most of the benchmarks and objectives we reviewed are designed to be achieved over an entire year. Guidelines from advocates, the U.S. Department of Education, and other states suggest that objectives and benchmarks should be sequential steps needed to move a student towards an annual goal within specific segments of the year to allow for regular reports on progress made towards the annual goal. In fact, an advocate calls progress reports the single most important procedural safeguard because it alerts the parent during the school year while there is still time to make corrections.

The evaluation procedure does not measure progress

Quarterly progress of children is reported in terms of ìPî (progress), ìN/Pî (no progress), and ìMî (mastered). Lacking quantified measures, these reports may convey whether in the teacherís subjective opinion, the child has progressed. However, they do not tell a parent, for example, the amount of progress that was made and how close a child is to reaching an annual or intermediate goal. Exhibit 2.5 provides a typical example illustrating the limitations of this type of progress measure. As a result, these progress reports not only fail to meet the measurability requirement of IDEA, the department and the IEP team also have no objective measure to determine whether the services prescribed in the IEP help a child benefit from its education.

Treatment plans are not linked to educational outcomes

The Child and Adolescent Mental Health Division uses treatment plans for services prescribed in IEPs that lack measurable objectives and lack a link to educational outcomes. The divisionís Clinical Standards Manual states that a treatment plan includes ìspecific goals, measurable objectives, target dates to reach objectives and appropriate intervention to achieve these objectives.î The manual also defines, for example, the purpose of therapy as to address problems preventing a child from benefiting from educational programs. We found, however, that school-related goals and objectives established for treatment plans are not measurable and relate only vaguely, if at all, to gains in benefits from education. The case files we reviewed included the following examples:

> ìIdentify client strengths of the learning process ñ attain appropriate peer relations,î

Exhibit 2.5
Reproduction of Actual Annual Goal/Progress Report Used for an Indvidual Education Program

INDIVIDUALIZED EDUCATION PROGRAM
ANNUAL GOAL/PROGRESS REPORT

Name:_____

Person(s) Implementing Goal:
SPED Teacher

Annual Goal # _____ ESY Goal # _____

English

EVALUATION METHOD
1 Tests
2 Observation; records
3 Daily work
4 Other_____

EVALUATION CODE
NP No progress: no gain/improvements
P Progress: shows gain/improvements
M Mastered: has learned the skills
NA Not applicable: not yet covered

Short-Term Objectives	Method of Evaluation	Progress Report				
		Date: 11/99 Q1	Date: 10/00 Q2	Date: Q3	Date: Q4	Date: ESY
1 He will answer comprehension questions based on selected readings with 80% accuracy desired.	1, 3	P	P			
2 He will write creative sentences, paragraphs & short essays with 80% accuracy in content, grammar, punctuation, & capitalization.	1, 3	P+	P			
3 He will complete spelling assignments & then be tested on the words for 90% accuracy.	1, 3	P	P-			
4. He will remain on task with all necessary materials on hand 80% of the time.	2	P	P-			
Comments:						

> ì[student] will continue going to school every day and complete her assignments,î and
>
> ì[student] will look into which school she would like to attend next year.î

We examined the criteria used for the Child and Adolescent Mental Health Divisionís contract monitoring program and a number of quality assurance reports. We found these criteria do not reflect that achievement of educational goals is a part of monitoring the outcomes of treatments. A division staff person confirmed that their focus is on the clinical needs of children and that they rely primarily on the Department of Education or IEP teams to monitor the effectiveness of mental health services in benefiting a childís educational progress.

Child and Adolescent Mental Health Division staff perform quality of care reviews of contracted mental health services providers. One of the divisionís contract monitoring reports of a provider noted that over 90 percent of the providerís individual treatment plans did not have clear, concise measurable objectives meeting compliance standards. This corresponds with our finding that the treatment plans we reviewed lack clear measurable objectives.

No assurance that children receive appropriate services

Without the ability to assess the effectiveness of services, the Departments of Education and Health are not in a position to ensure that services are appropriate. In addition, parents have no effective means to monitor progress and request modifications if needed.

This may be in violation of the *Felix* consent decree, which requires that the systemís infrastructure include mechanisms to monitor the implementation of individual education programs. The decree further requires immediate update and modification if services identified in the individual education program fail to meet the specified goals and objectives or to prevent and address deterioration.

Cost and consistency may be affected

Providing services that are not measured for appropriateness may not be helping a child benefit from educational programs and may also result in wasted taxpayer money. Ineffective treatments may extend a childís need for services unnecessarily. Without effective methods to monitor progress based on services provided and without coordination of clinical and educational goals, the departments cannot assure that mental health services are appropriate. In addition, the absence of standardized testing instruments for assessing progress toward IEP goals makes it difficult to achieve consistency in setting goals in similar cases throughout the

school system. Such tests, which may include standards-based, age or grade specific references, are promoted, advocated, and used in other states.

Independent Evaluation of Multisystemic Therapy is Premature

It is premature to reach a conclusion on the effectiveness of the Department of Health's Multisystemic Therapy program. Multisystemic Therapy is a Department of Health initiated program to provide services for children and adolescents with severe emotional and behavior problems. The department's program consists of two parts, home-based services and a continuum research project. The home-based services subprogram includes the delivery of services in community settings and is characterized by the short duration of treatment and provision of comprehensive services. The Child and Adolescent Mental Health Division contracts out all home-based services to private provider agencies. The continuum research project was implemented to address two limitations of home-based servicesññthe inability to provide continual services for a longer term and the inability to continue services when a child was removed from the home environment for safety reasons.

In accordance with the provision of Act 281, SLH 2000, the Department of Health's Child and Adolescent Mental Health Division submitted a preliminary evaluation of its Multisystemic Therapy program. The University of Hawaii's Department of Psychology, through a contract with the Social Sciences Research Institute, performed this evaluation.

We reviewed and discussed the evaluation report with its author. On this basis, we concluded that an independent evaluation is not possible at this time because the Multisystemic Therapy program is still in an early stage of implementation. The first children and their families began treatment under the home-based program in February 2000, and as of October 31, 2000, 51 families had entered and 35 had completed treatment. As of December 7, 2000, 13 families received services through the continuum program. The August 3, 2000 court order mandated that at least 56 youths will be receiving Multisystemic Therapy services by July 2001.

However, the university's evaluation of the Multisystemic Therapy program identified a number of concerns to be addressed by the program as a whole, including:

- A lower rate of referrals than projected has been experienced;
- Cultural considerations in adapting the Multisystemic Therapy to Hawaii;
- Community resistance and preference for traditional residential treatment programs;

- Difficulty recruiting qualified Multisystemic Therapy therapists; and

- Resistance from providers in fear of competition from Multisystemic Therapy.

In addition, the evaluation also noted for home-based programs that:

- Outcome measures for the home-based program are insufficiently standardized and precise to facilitate internal and independent evaluations;

The Department of Healthís Child and Adolescent Mental Health Division is, according to the evaluation report, aware of these concerns and has developed strategies to address them. We will continue to monitor and review process and outcome evaluation reports of the Multisystemic Therapy program and any new treatment or service program. We note that subsequent to completion of our fieldwork, the Multisystemic Therapy continuum program was terminated.

Recommendations

1. The Departments of Education and Health should develop and implement coordinated capabilities for detailed reporting and analysis of costs for complying with all federal special education requirements, including the *Felix* decree. All involved agencies should consider employing cost accounting and decision support systems to this end.

2. The Department of Education should consider adding to its integrated special education management information system, capabilities satisfying the requirements for Medicaid reimbursements to maximize available federal funding.

3. The Departments of Education and Health should submit interagency consolidated financial reports to the Legislature to account for and request funding for federally mandated special education requirements, including *Felix*-related mental health services. At a minimum, such reports should include the full and accurate costs by disability category and by statewide, district, school, and per pupil costs for the preceding fiscal year.

4. The Department of Education should ensure the use of consistent objective measurements for childrenís educational progress, including standardized testing instruments. In cooperation with the Department of Health, the department should use these measurements to help ensure that mental health services provided are effective and appropriate in meeting educational goals set by IEP teams.

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Responses of the Affected Agencies

Comments on Agency Responses

On December 7, 2001, we transmitted a draft of this report to the Board of Education and the Departments of the Attorney General, Education and Health. 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 Departments of the Attorney General and Health. A copy of the responses of the Department of Education and the Department of Health are included as Attachments 2 and 3 respectively. The Board of Education and the Department of the Attorney General did not submit written responses.

The Department of Education responded that it generally agreed with the recommendations made in our report. The department noted that its own internal audit also pointed to a need for understandable and comprehensive financial reports. The department also stated that it was committed to the implementation of sound fiscal and program management practices and that the audit recommendations would be helpful in developing this capability. Finally, the department noted that satisfying Medicaid requirements for reimbursement will require changes to more than the integrated special education system. However, it will develop the additional capacity to maximize reimbursements.

The Department of Health generally agreed with our recommendations but faulted the report for not reflecting the changes that have occurred since the completion of our fieldwork. The department stated that it does not support the statement that its Child and Adolescent Mental Health Division (CAMHD) ìlacks the capabilityî to support evidence based practices. However, we pointed out that our statement is relative to the financial management structure of the department and not directed at the delivery of services.

The department also takes issue with our finding that cost reports are understated because the department does not include the cost of employee related benefits in *Felix* cost reports, It noted that the omission was not intentional, and that such costs are reported elsewhere in the state budget. Had such costs been specifically asked for, the costs would have been identified. We disagree. A major legislative concern from the start of our assessment of the *Felix* compliance effort has been to identify *all* costs. The departmentís response is indicative and supportive of our finding that the department does not accurately and fully report *Felix*-related costs.

Furthermore, the department claims that we are incorrect in stating that the Family Health Services Division is unable to provide an accurate separation of *Felix* vs. non-*Felix* costs. As justification, the department notes that the divisionís Early Intervention Services Section is the service provider responsible for the birth to age three children and since all these children are considered *Felix* eligible, all costs are therefore *Felix* costs. However, we note that the information differentiating *Felix* from non-*Felix* costs was provided directly by Family Health Services Division staff and confirmed during fieldwork.

Moreover, the department appears to contradict itself. The department also states that CAMHD excludes the cost of services provided by the Family Health Service Divisionís Early Intervention Services Section from reports of statewide mental health services because the section is responsible for meeting all developmental needs of the birth to age three population. This statement appears to directly contradict the departmentís previous response that all of the sectionís costs are *Felix*-related.

Finally, the department while acknowledging our finding that treatment plans are not linked to educational outcomes, noted that significant progress has been made in this area and that the finding may not reflect current conditions.

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 7, 2001

COPY

The Honorable Patricia Hamamoto
Interim Superintendent
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 draft report, *Follow-Up and Management Audit of the* Felix *Consent Decree*. We ask that you telephone us by Tuesday, December 11, 2001, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Monday, December 17, 2001.

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

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

Sincerely,

Marion M. Higa
State Auditor

Enclosures

BENJAMIN J. CAYETANO
GOVERNOR

PAUL G. LeMAHIEU, Ph.D.
SUPERINTENDENT

STATE OF HAWAI'I
DEPARTMENT OF EDUCATION
P.O. BOX 2360
HONOLULU, HAWAI'I 96804

OFFICE OF THE SUPERINTENDENT

December 12, 2001

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

Dear Ms. Higa:

Thank you for the opportunity to comment on your recommendations in the draft report, *Follow-Up and Management Audit of the* Felix *Consent Decree.* I understand you based your recommendations in this report on work performed between August 2000 and July 2001. The Department conducted a more narrowly focused internal audit during the same period.

Attached you will find comments related to each of your recommendations. The comments reflect the Department's commitment to the implementation of sound fiscal and program management practices that lead to effective and efficient special education and related services to students in need of such services.

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,
Interim Superintendent

Attachment
PH:RC:sn

Recommendations	Comments
1. The Departments of Education and Health should develop and implement coordinated capabilities for detailed reporting and analysis of costs for complying with all federal special education requirements, including *Felix* decree. All involved agencies should consider employing cost accounting and decision support systems to this end.	The Department of Education through an internal audit recognizes the need for the capacity to provide a comprehensive financial report that provides information in an understandable format to improve communication and fiscal management. The Auditor's report and recommendations are helpful in the development of this capability within the Department.
2. The Department of Education should consider adding to its integrated special education management information system, capabilities satisfying the requirements for Medicaid reimbursements to maximize available funding.	Satisfying Medicaid requirements for reimbursement will require changes to more than the integrated special education system. However, the Department is modifying the integrated special education system to meet Medicaid requirements to receive reimbursements and is developing the additional capacity required to maximize reimbursements.
3. The Departments of Education and Health should submit interagency consolidated financial reports to the Legislature to account for and request funding for federally mandated special education requirements, including *Felix*-related mental health services. At a minimum, such reports should include the full and accurate costs by disability category and by statewide, district, school, and per pupil costs for the preceding fiscal year.	The Department of Education agrees that interagency financial reports including the full and accurate costs for the preceding fiscal year would improve communication regarding funding for the provision of federally mandated special education requirements. The development of the comprehensive financial reporting system by the Department will provide a foundation for this report.

Recommendations	Comments
4. The Department of Education should ensure the use of consistent objective measurements for children's educational progress, including standardized testing instruments. In cooperation with the Department of Health, the department should use these measurements to help ensure that mental health services provided are effective and appropriate in meeting educational goals set by IEP teams.	The Department of Education agrees that objective measurements of student performance, both standardized and individualized, are necessary to assess the effectiveness of school-based behavioral health and mental health services in supporting a student achieve educational goals established by IEP teams.

BENJAMIN J. CAYETANO
GOVERNOR

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

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

In reply, please refer to:
File:

December 17, 2001

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

Dear Ms. Higa:

Thank you for this opportunity to respond to the draft report entitled ***Follow-up and Management Audit of the Felix Consent Decree.*** While the Department appreciates the value that reports from the Office of the Auditor may offer, the Department has concerns that this audit report is not based on current information and does not reflect the status of compliance with the Felix Consent Decree.

The initial section of the report states that it is a follow up to previous audits; however, over a year has past since this investigation was complete, and much has changed in the management and evaluation of the Felix system. As stated in the report, many of the services provided to Felix class youth have been transferred to the Department of Education's (DOE) school based behavioral health services and programs.

Also, there has been a significant change in measuring system performance. On November 30, 2001, Federal Court Judge David Alan Ezra complemented the state for its commitment to demonstrating results for the Felix class youth. During that court hearing the state submitted that two-thirds (2/3) of the school complexes had achieved at least 85% on the compliance measure known as service testing. The state also made substantial progress in meeting all other the Federal Court requirements. The state has until March 31, 2002 to bring the remaining complexes into compliance and address the final outstanding benchmarks. Given these significant events, and given the purpose of reporting on follow up activities, it is disappointing that this was not included in the report.

Overall Review

A global review of the document shows a disconnect in the presentation of the report. Much of the data included in the report, and the text documentation, support that the Department has made progress since previous audit reviews. The text also supports that there are many strengths in the Child and Adolescent Mental Health Division (CAMHD) system. The topic headings and section titles often misrepresent the written text.

Review of the Report Objectives

1. Assess critical aspects of the State's fiscal management of compliance with Felix-related requirements, including its ability to account for and predict the financial impact of compliance.

The time period of this report was January 1998 – December 2000. Although the findings of this section may hold some value, caution should be used in assuming the findings are current or relevant to existing conditions. As stated above, there have been significant system changes in the past year.

The Departments Do Not Provide a Full Picture of the Cost of Felix Compliance

"The departments lack the capability that corresponds with best practices in delivering services to children and their families."

The Child and Adolescent Mental Health Division has provided leadership for a statewide initiative to evaluate and disseminate evidenced based mental health treatments. CAMHD has begun the process of disseminating this information to all employees and contracted provider agencies. In addition, CAMHD has recruited personnel to support the training, mentoring and practice development activities in accordance with these treatment approaches. The Department does not support the statement that CAMHD "lacks the capability" to support evidenced based practices.

Cost Reports are understated, by as much as $41 million

"For example, in FY 2000-01 an estimated $31 million in Felix-related employee benefits for the two departments...are excluded..." (page 18)

There was no intention to understate the cost of providing services to Felix youth. The Department has not been asked to include the cost of employee related benefits in the budget data. These costs are summarized elsewhere in the State budget. The

Department cannot be judged on not providing analysis that has never been requested. If the legislature requests that the Department report in this manner, it can be provided.

Felix costs are intermingled with other costs

"The Department of Health's Family Health Services Division, the agency responsible for serving children from birth to age 3 with IDEA-required programs, also consolidates costs for Felix services with those programs that are not Felix-related. As a result, the Departments cannot provide stakeholders, including the Legislature, with an accurate accounting of the cost of complying with the Felix consent decree." (page 23)

The above statement is incorrect. The Early Intervention Section (EIS) is responsible for serving all infants and toddlers under age 3 with special needs and their families. Because all infants and toddlers under age 3 with special needs are Felix eligible children, all EIS costs are therefore Felix costs.

There are two budget categories for EIS, HTH 530-CG and HTH 530-CO (this category is specifically for the Early Childhood Services Unit, a unit within EIS).

Financial data on Felix costs is scattered and lack transparency

"...the Department of Health's Child and Adolescent Mental Health Division reports purportedly represent the cost of statewide mental health services...However, such reports exclude the services (e.g., to autistic children and their families) provided by the Department of Education and Department of Health, Family Health Services Division." (page 24)

Early Intervention Services costs for services for children under age 3 are not included in CAMHD's costs for mental health services.

Services to children under age 3 differ from services to children from 3 - 20, as EIS is responsible for meeting ALL the developmental needs of infants and toddlers under age 3 with special needs and their families. This includes: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and, adaptive development.

Funding to specifically meet the social or emotional developmental needs of infants and toddlers under age 3 cannot be separated out of the EIS budget, as due to the children's age, these needs are met though the provision of all the early intervention services to children, and the support/education/training services to families.

Children with autism generally receive the full array of early intervention services as defined by IDEA (P.L. 107-19) and as identified on their Individual Family Support Plan (IFSP). Some children with autism, as part of the psychological services, receive intensive behavioral support (e.g., discrete trial training). This specific service can be separated from the entire budget, as these services are generally purchase of services contracts. However, these services working in conjunction with the other developmental services, are needed to meet the needs of infants and toddlers with autism.

Financial management systems for Felix are not coordinated

"The Departments of Education and Health lack a coordinated management system, which is needed to effectively support the fiscal aspects of the Felix implementation effort." (page 25)

The Department concurs with the statements in this section recognizing the value and importance of the CAMHD management information system. "This type of capability, if matched by other agencies involved in the Felix compliance effort....would provide specific identification of costs as well as the full fiscal impact of the Felix decree." CAMHD has prioritized the development of an information system capable of providing financial data and outcome progress. The recognition for these efforts is appreciated.

The Department is supportive of coordination of the management information systems across all agencies involved in Felix. Some discussions have taken place about the feasibility of such and endeavor, and will continue to occur between the departments.

2. Assess State's system for monitoring, on an individual student basis, the achievement of targeted improvements through services provided to students.

Treatment plans are not linked to educational outcomes

"We found, however, that school-related goals and objectives established for treatment plans are not measurable and relate only vaguely, if at all, to gains in benefits from education." (page 33)

Significant progress has been made in this area during the past year. CAMHD has prioritized the need to assure that each treatment plan has clear, measurable educational objectives, linked to the Individualized Education Plan (IEP). This is one specific area where the conclusion reached may no longer reflect current system performance.

"We found that these criteria do not reflect that achievement of educational goals is a part of monitoring the outcomes of the treatment." (page 35)

The CAMHD Management Information system is being modified to include a clinical module, which will allow for monitoring the progress on all individualized treatment goals. We agree that progress on educational goals is clearly an indication of the services and supports a child is receiving. However, it is also important to recognize that IEP goals and treatment plan objectives are only one means of evaluating youth progress. Child progress should not be measured by only one means of evaluation. There must also be focus given to other objective means of evaluating outcomes.

CAMHD has a very comprehensive evaluation system that includes the use of quarterly reviews as a measure of a youth's progress and symptomatology through a standardized instrument known as the Achenbach Child Behavior Checklist (CBCL). By evaluating a youth's progress through multiple means, the team and the system have a broader understanding of the effectiveness of the services and supports.

3. Assess any Child and Adolescent Mental Health program process and outcome evaluation reports submitted to the Legislature in compliance with Section 24.1 of Act 281 and Section 6 of Act 25, Session Laws of Hawaii, 2000 (SLH).

The Department agrees with the report statement that at the time of the previous report "it is premature to reach a conclusion." Currently, the Department is awaiting the second evaluation report on the state's implementation of Multisystemic Therapy (MST). The Department looks forward to reviewing the findings of this evaluation and remains committed to ongoing evaluation of any new treatment service.

"The continuum research project was implemented to address two limitations of home-based services – the inability to provide continual services for a longer term and the inability to continue services when a child was removed from the home environment for safety reason." (page 36)

The MST Continuum of Care was implemented as a hospital based diversion program for psychiatrically complex youth with severe emotional disturbance. This study was intended to evaluate the results of applying the MST model, with psychiatric oversight, to a different population than those served by the MST home based programs.

4. Make recommendations as appropriate.

The report makes two (2) recommendations pertaining to the Department of Health.

1 Develop a coordinated means of reporting Felix costs.
   a. Submit interagency consolidated financial reports to the legislature
   b. Consider use of cost accounting and decision support systems

2. Collaborate with DOE to ensure use of consistent and objective means of evaluating child progress.

The Department agrees with the Office of the Auditor that responding to these issues may assist the Legislature in gaining a more comprehensive understanding of the costs of the system of care for Felix youth, as well as evaluating the outcomes for this population. As stated in the report, the Department supports the need to ensure that information systems are designed in a manner that allows integrated financial report. The Department will continue discussing these issues with the DOE.

Closing

In closing, the Department is reassured that the text of the report attempts to capture an objective review of the Felix system, as it existed at that time. It is most disappointing to have this objective information presented under inflammatory and inaccurate headings and section titles. The headings and many of the summaries or conclusions are not representative of the contents of the report. The limitations of this report, due to the time delay from data collection to report production, should be acknowledged.

The Department of Health remains committed to working with the DOE to serve the mental health needs of children who need these services to benefit from other education whether or not this is acknowledged in this audit. Likewise, we are committed to working with the Legislature to address any legitimate concerns raised in this audit and to improve those services and our performance.

Sincerely,

Bruce S. Anderson, Ph.D., M.P.H
Director of Health