Services to Conduct a Needs Assessment for Substance Use Prevention and Treatment Services among Special Youth Populations Using Qualitative Methods, Protocol 2:

In-Depth Interviews with YOUTH regarding the system of Care

State of Hawai`i, Department of Health, Alcohol and Drug Abuse Division
contract with
University of Hawai`i at Mānoa, Department of Psychiatry, Research Division
[DOH ASO Log 19-239]

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Report Date:

September 27, 2021

This report has been prepared by the Research Division of the Department of Psychiatry (DoP), University of Hawai`i at Mānoa for the Alcohol and Drug Abuse Division (ADAD) of the State of Hawai`i, Department of Health (DoH).

This report is intended to be received by and distributed solely among designated staff of DoP and ADAD.

This report has been reviewed and approved by ADAD. It may be used for public dissemination.

Suggested citation: Helm S, Miao T, Onoye J, Monick B, Masuda T, Rehuher D, Juberg M, Sabellano-Tsutsui T, Taeza-Gutter G, Kanemoto R, Guillermo M, Topinio J, Lawler A. (2021). *Services to conduct a needs assessment for substance use prevention and treatment services among special populations youth using qualitative methods. Protocol 2, In-depth Interviews with Youth regarding the System of Care*. Department of Psychiatry, University of Hawai`i at Mānoa. Final version, 9/27/21.

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1. Project Overview

Introduction. The Department of Psychiatry (DoP) has been contracted by the State of Hawai`i Department of Health, Alcohol and Drug Abuse Division (ADAD) to conduct a needs assessment focused on special populations of youth in the State of Hawai`i. The special populations included in this Needs Assessment are youth who often are not identified or overlooked in school-based surveillance studies, but have elevated and unique substance use prevention and treatment needs[1].

Five special populations of youth were identified through discussions with ADAD in Fall 2018 regarding substance use disparities, which mirror public sector services (Table 1). In addition to these five, other health disparity subgroups of interest were identified - youth who identify as Native Hawaiian, COFA Nation/Micronesian, sexual and gender minorities, as well as from rural areas. The state population[2] has shown that 68% of youth reside on O`ahu and 32% reside on the rural neighbor islands of Ni`ihau, Kaua`i, Molokai, Lana`i, Maui, and Hawai`i Island. Table 2 (next page) highlights rural schools as well as Native Hawaiian and Micronesian student enrollment at public schools statewide. According to 2019 Hawai`i State Department of Education annual reports[3], Hawaiian students generally account for the largest proportion of rural school enrollment. While often identified as demographic descriptors, the health disparities manifested by these groups may be attributed to institutionalized policies and practices that disadvantage them[4].

Table 1. Special Populations – Service Systems and Health Disparities

Service System (Abbreviation)			**Description of Youth**
1	Substance Use	SU	Participating in Alcohol, Tobacco, and Other Drug (ATOD) use treatment program
2	Mental Health	MH	Participating in MH services, including co-occurring SUD
3	Juvenile Justice	JJ	Involved in the juvenile justice system
4	Foster Care	FC	Living in out of home placement in the state foster care system
5	Homeless	HO	Needing safe, stable, permanent housing, either living with or without family
HD Population (Abbreviation)			**Description of Youth**
a	Native Hawaiian	NH	The indigenous population of Hawai`i
b	CoFA Nations	CoFA	CoFA Nations migrant and local youth, often referred to as Micronesian
c	Sexual & Gender Minority	SGM	LGBTQI, transgender, gender non-conforming
d	Rural	R	Youth living in rural areas: counties of Kaua`i, Maui, Hawai`i, parts of O`ahu

Cultural Competence, Humility & Inclusivity. To ameliorate health disparities, cultural humility and cultural competence are important for public policy, health and wellness practices, and in social and health sciences. Cultural competence is described as an end-point toward which people strive through the conscious practice of cultural humility. The practice of cultural humility is a lifelong process of learning about others, and embracing an attitude of openness to cultural identities that are most important among the diversity of populations with whom we work. These principles may be used within and across public service systems to analyze disparities and create inclusivity in the broader system of care. Systemic changes for equity among all people and cultures occur through partnership building and advocacy. This report is written in the spirit of cultural humility by highlighting the lived experience of youth in public systems of care, including substance use interventions.

[1] The scope of this contract does not include a literature review demonstrating the elevated need among these special population youth. Readers are referred to this overview: https://ncsacw.samhsa.gov/files/working-with-adolescents.pdf

[2] Research and Economic Analysis Division (2018) Hawaii 2013-2017 ACS (American Community Survey) 5-Year Estimates by Census Tracts. Dept. of Business, Economic Development and Tourism, State of Hawaii. https://histategis.maps.arcgis.com/apps/MapSeries/index.html?appid=dff86c08e0894d2c8d205a177d72b9cd

[3] These data are from pre-pandemic school enrollment reports: State of Hawai'i Department of Education. Accountability Resource Center Hawai'i. (2019). School Status and Improvement Report. Office of Strategy, Innovation and Performance; Assessment and Accountability Branch; Accountability Section. http://arch.k12.hi.us/school/ssir/ssir.html

[4] National Institute on Minority Health and Health Disparities. (2018). Research Framework. Retrieved November 2019: https://www.nimhd.nih.gov/about/overview/research-framework/nimhd-framework.html See also: https://pttcnetwork.org/centers/global-pttc/culturally-and-linguistically-appropriate-practices-priority-area

Table 2. Statewide Public School Complex Areas by County – Student Enrollment

County	Island	Complex Area	Complex	Rural	Native Hawaiian %	CoFA Nation Ancestry/ Micronesian %	Total Enrollment
Kauai	Kaua`i	Kapa`a-Kaua`i-Waimea	Kapa`a	Yes	28*†	1	3,162
			Kaua`i	Yes	22	3	3,794
			Waimea	Yes	36*†	2	2,314
	Ni`ihau		Ni`ihau	Yes	100*†	0	9
Maui	Maui	Baldwin-Kekaulike-Maui	Baldwin	Yes	32*†	6*	4,359
			Kekaulike	Yes	33*†	2	4,275
			Maui	Yes	16	7*	7,328
		Lahainaluna-Hana-Lana`i-Molokai	Lahainaluna	Yes	19	1	3,210
			Hana	Yes	78*†	0	348
	Lana`i		Lana`i	Yes	16	7*	560
	Molokai		Molokai	Yes	80*†	0	912
Hawai`i Island	Hawai`i	Hilo-Waiakea	Hilo	Yes	42*†	9*	4,185
			Waiakea	Yes	26*	4	3,708
		Ka`u-Kea`au-Pahoa	Ka`u	Yes	39*†	17*	876
			Kea`au	Yes	41*†	5	3,075
			Pahoa	Yes	45*†	6*	1,443
		Honoka`a-Kealakehe-Kohala-Konawaena-	Honoka`a	Yes	36*†	4	1,703
			Kealakehe	Yes	28*†	14*	4,351
			Kohala	Yes	40*†	3	776
			Konawaena	Yes	37*†	7*	3,245
City & County of Honolulu	O`ahu Honolulu District	Farrington-Kaiser-Kalani	Farrington	No	9	1	7,386
			Kaiser	No	10	0	3,673
			Kalani	No	9	1	3,513
		Kaimuki-McKinley-Roosevelt	Kaimuki	No	12	17*	4,824
			McKinley	No	11	19*	4,308
			Roosevelt	No	22	3	5,864
	O`ahu Central District	Aiea-Moanalua-Radford	Aiea	No	16	8*	3,696
			Moanalua	No	9	2	5,075
			Radford	No	4	2	5,652
		Leilehua-Mililani-Waialua	Leilehua	No	13	4	7,354
			Mililani	No	14	1	7,956
			Waialua	Yes	2	0	1,413
	O`ahu Leeward District	Campbell-Kapolei-	Campbell	No	15	1	9,663
			Kapolei	No	29*†	2	6,812
		Pearl City-Waipahu	Pearl City	No	17	2	7,244
			Waipahu	No	9	6*	8,346
		Nanakuli-Wai`anae	Nanakuli	Yes	70*†	3	2,196
			Wai`anae	Yes	46*†	2	8,198
	O`ahu Windward District	Castle-Kahuku	Castle	Yes	45*†	1	3,934
			Kahuku	Yes	34*†	0	3,307
		Kailua-Kalaheo	Kailua	No (Kailua) Yes (Waimanalo)	40*†	1	3,718
			Kalaheo	Yes	15	0	3,192

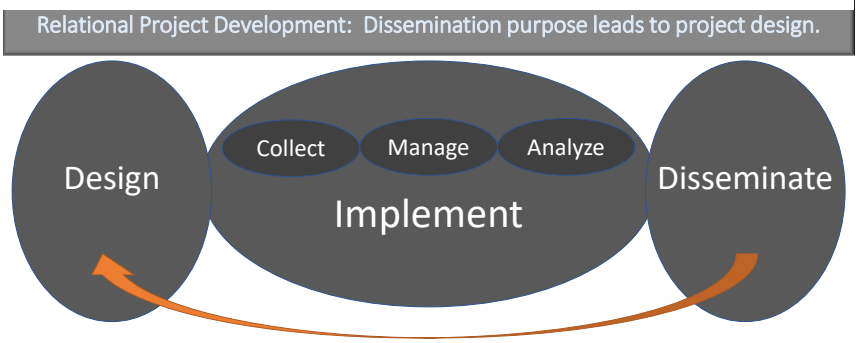
** Indicates that complex percentage is higher than the statewide average for Native Hawaiian (average=23.13%) and CoFA Nation Ancestry/Micronesian (average=5.03%) student enrollment. Statewide enrollment average calculated using SSIR data (2018-2019 school year).*

† Indicates that complex percentage is higher than the statewide percentage of Native Hawaiian residents (average=26.9%). Data taken from the US Census Bureau, Population by Race (Race Alone/Combination) (2018). Data on CoFA Nation Ancestry/Micronesian residents not available.

Project Development & Relational Design. The DoP Research Division uses a relational design approach to project development in which the client (ADAD) is engaged in discussions about the intended use and purpose of a project (dissemination). In this collaboration, both groups define what will be disseminated and how, which then informs the project design, as depicted by the arrow going from dissemination to design (Figure 1). ADAD staff and DoP faculty collaboratively identified the health disparity groups through a series of meetings in 2018.

The discussion on high risk youth and disparities in service utilization was initiated by ADAD during planning sessions to update the 2007-2008 Hawai`i Student Alcohol, Tobacco, and Other Drug (ATOD) Use Study. The ATOD study was last conducted by DoP as a statewide school-based surveillance of youth substance use[5]. It became evident that ADAD required both an updated statewide school-based needs assessment, as well as a Special Populations Needs Assessment. Therefore, this Special Populations Needs Assessment was designed using qualitative methods, and may be viewed as a companion to the 2019-2020 ATOD Youth Needs Assessment Study[6] which uses a quantitative design.

Figure 1. Relational Design Workflow



Statewide Youth Needs Assessment. Youth who are perceived to be most in need of ADAD-funded treatment services may be the least likely to complete a school-based survey – due to consent and assent procedures or school absence. Furthermore, the unique circumstances experienced by special populations youth may be overlooked in standard survey techniques designed to protect anonymity. To overcome these representational challenges, DoP and ADAD collaboratively designed this qualitative youth needs assessment to obtain credible statewide data on the needs of special populations of youth. While the school-based ATOD survey is designed to be representative of the broader school age population in the State of Hawai`i, this qualitative needs assessment was designed to highlight the unique needs of specific special populations of youth, and the professionals with experience caring for them. This in-depth qualitative needs assessment along with the quantitative school-based surveillance work synergistically to provide a robust picture of youth substance use needs in the State of Hawai`i[7].

Qualitative Youth Needs Assessment Report Series. In addition to this report, two prior reports were completed and made available on the ADAD website. The first youth needs assessment report in the series consisted of data collected from professionals across the state using a rapid assessment technique[8]. The data were used to generate interview questions posed to selected professionals, as reported in the second report of the series[9]. These two "professionals reports" set the foundation for interview questions with youth as described here, in this third of three reports: a set of eight focus group interviews were conducted from August to December 2020 with 26 youth.

[5] https://health.hawaii.gov/substance-abuse/files/2013/05/2007StatewideReport.pdf
[6] In collaboration with the Hawai`i State Department of Education, the 2019-2020 ATOD Survey was administered to students at school, using an opt-out parental consent procedure to maximize participation among youth at school. The final report is forthcoming in 2021-2022.
[7] This Special Populations youth needs assessment (ASO Log 239) and the ATOD Survey needs assessment (ASO Log 238) are separate contracts, so the reports are submitted separately on different timelines.
[8] Helm et al (2020). https://health.hawaii.gov/substance-abuse/files/2020/05/19-239_InterimReport_Helmetal_2020_200427.pdf
[9] Helm et al 2021. https://health.hawaii.gov/substance-abuse/files/2021/04/Youth-Needs-Assessment_Interviews-with-Professionals.pdf

2. Project Design – Protocol 2: Youth

Design Overview. This youth needs assessment has used a two-protocol qualitative design (Table 3). As noted above, Protocol 1 was a rapid needs assessment using an anonymous online survey among professionals across the state (report 1). Protocol 2 consisted of in-depth interviews with a purposive sample of professionals (report 2) and a purposive sample of youth (current report, #3)

This *Youth Interviews Report* presents findings in which the views of youth regarding the continuum of care and system of care were the focus. The continuum of care consists of the array of services distributed across the state (what), while the system of care refers to how these services are delivered, accessed, and used (how). By agreement with ADAD, all data are owned by the Department of Psychiatry and will not be given to ADAD or any other entity at any time, as a way to protect anonymity of participants, organizations, and communities.

Table 3. Project Design – Two Protocols.

Protocol 1: Rapid Needs Assessment	Protocol 2: In-depth Needs Assessment
Online Anonymous Survey	Face-to-Face Interviews via Zoom
views of *professionals* who provide care to youth in one or more of the special populations groups	Zoom-based individual interviews with *professionals*. Zoom-based focus group interviews with *youth*.

IRB Approval. This Needs Assessment was deemed "Not Human Subjects Research" by the University of Hawai`i Human Studies Program (HSP) because the primary purpose of the project was to fulfill a service contract with the state, as opposed to generalizable knowledge (see Appendix A, HSP letter). All representations of this Needs Assessment must be characterized under the rubric of evaluation, as opposed to research.

Statewide Sampling Framework & Participant Recruitment. Organizations across the state provided assistance by referring youth with lived experience in the public sectors of care: substance use, juvenile justice, foster care, and homelessness[10]. These organizations identified a project liaison to assist with participant recruitment. Specifically, liaisons followed their organizations' internal policies for identifying youth and ensuring that the youth would be able to participate via videoteleconferencing in a safe manner and with parental consent for minors, and that youth would be comfortable participating in a small group discussion with other youth. In some cases, the organization set up a room on their site to host the youth so that they would have easy access to videoteleconferencing. In other cases, youth used their personal computer or cell phone.

Sample Description. Eight focus group interviews were conducted with a total of 26 youth. Ages ranged from 14 to 21 years old. Four focus groups were hosted by organizations whose primary responsibility is in the juvenile justice public sector, and included 14 youth. Two focus groups were hosted by organizations whose primary responsibility is foster care, and included 5 youth. One focus group was hosted by an organization whose primary responsibility is to address homelessness and unstable housing, and included 4 youth. Finally, one focus group was hosted by an organization whose primary responsibility was school-based youth substance use interventions, and included 3 youth.

It should be noted that the majority of focus groups, and therefore participants, represented the juvenile justice public sector. This is due to the difficulty in reaching youth related to the pandemic. As may be obvious, youth residing in secure facilities or other residential programs were residing in safe settings with social distancing and other safety protocols. Whereas youth involved school-based settings during the pandemic were very difficult to reach. Thus, we are extremely grateful to our community partners in gathering their youth constituents for this needs assessment project. And we are incredibly grateful to all the youth who shared their views about the system of care in spite of the challenges related to the pandemic.

[10] Although the mental health public sector was included in prior aspects of this needs assessment, due to the pandemic and need to conduct interviews remotely using videoteleconferencing, the Department of Psychiatry and ADAD agreed that for participant safety, youth with experience in the mental health system would not be recruited to participate.

Data Collection. One-hour interviews were conducted in a small focus group format, adapted to video teleconferencing (Zoom). The lead interviewer for all interviews was the principal investigator. In addition, two project associates served as notetakers/observers for each interview by attending to participant comfort and safety, taking notes, and audio recording the interviews.

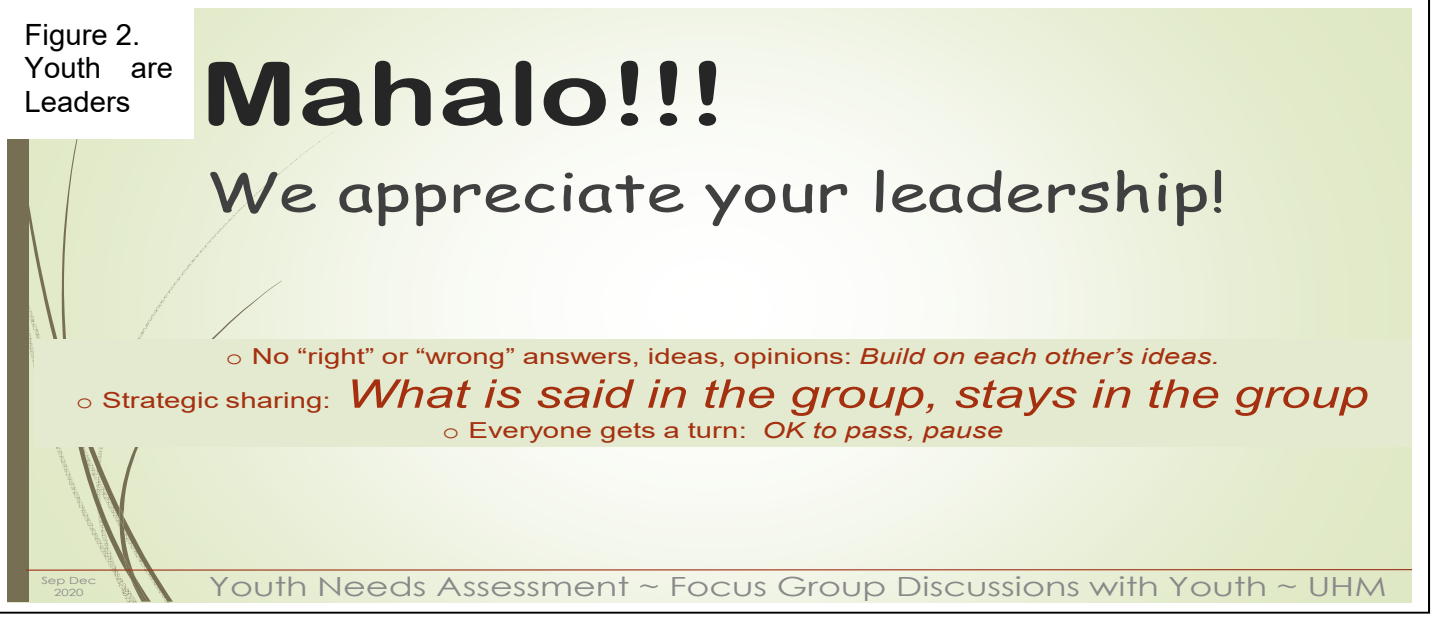
Prior to initiating the interview, a 30-minute consent and orientation was conducted with the group of youth convened to participate in the interview (Refer to Appendix B for orientation slides). Once youth expressed an understanding of the process and agreed to proceed, the interview began. Interview questions were grounded in the findings from professionals, in which rapid assessment results collected from an online survey of 50 professionals indicated important themes (accessing services, the school as a partner, the continuum of care/system of care, and health disparities)[11], which were then clarified via in a set of in-depth interviews with 25 professionals[12]. Three open-ended questions were posed to the youth, as well as a final wrap-up question (see Table 4 for interview questions).

Interviews were conversational, and to encourage youth to think about the system of care beyond their personal experiences, we also asked youth to imagine being a counselor, school principal, or director of a public agency like ADAD. As a result, some of the quotes included in the results section may sound like a statement from a professional, but are in fact the views of youth. At the conclusion of the interview we reminded youth of the ground rule regarding confidentiality and respecting each other's privacy by not sharing what each other had said. We also acknowledge that it takes courage to speak up on behalf of youth wellness when one is still a youth. We expressed gratitude for their leadership in expressing their views about how to improve the system of care, given their expertise as youth with lived experience (Figure 2).

Table 4. Open-Ended Interview

Question #	Discussion Duration	Interview Topic
1	15-18 minutes	How do youth access ATOD substance use services?
2	15-18 minutes	What is the role of the school in substance use?
3	15-18 minutes	What other services would be useful for youth?
4	~10 minutes	What other ideas do you have to improve the system of care?

Figure 2. Youth are Leaders



[11] Report posted on the ADAD website: https://health.hawaii.gov/substance-abuse/files/2020/05/19-239_InterimReport_Helmetal_2020_200427.pdf
[12] Report posted in the ADAD website: https://health.hawaii.gov/substance-abuse/files/2021/04/Youth-Needs-Assessment_Interviews-with-Professionals.pdf

Data Management. Interviews were audio-recorded, transcribed verbatim and checked for accuracy, then de-identified and analyzed. We used our own audio-recorders rather than the Zoom audio recording feature to ensure the audio data were secure, and the files were compatible with our data management and analysis software. Immediately following the conclusion of the interview, audio data were uploaded to our secure platform, then deleted from the audio recorders. Subsequently, a transcript was typed verbatim by one project associate, then checked for accuracy (edits made as needed). The verified transcript was de-identified: In addition to de-identifying participants, names of people or organizations were given pseudonyms, as well as specific locations. The de-identified transcripts were used in the analysis: eight focus group interviews yielded over eight hours of interview data, with the eight transcripts consisting of 130 pages of data.

Data Analysis. Our analytic strategy may be referred to as mixed methods, meaning it is largely a qualitative needs assessment which was enhanced by quantitative tools. We collected qualitative data, qualitatively coded the data for themes, then quantified the themes in order to highlight the most prominent themes in this report. In other words, the results highlight prominent themes because they were discussed in detail across the eight focus group interviews with youth.

Data analysis occurred in two steps. First, each transcript was consensus coded for both a priori and emergent themes for the content analysis. Consensus coding is one strategy for ensuring quality in qualitative data analysis. Quality analysis occurs in teams, so that trained coders' views inform the analysis process. This means discrepancies in coding are inherent in high quality coding. In consensus coding, two or more team members code independently, then during consensus coding meetings they compare their analyses. Discrepant views are discussed, and code definitions are updated in the codebook to reflect new meaning. Consensus coding promotes accurate coding by ensuring that discrepancies are not ignored by setting an agreement rate of less than 100%.

A priori themes are those that are expected to be in the data as a result of prior phases of the needs assessment and specific interview questions asked. In other words, these are themes that are established before coding begins. These included: trauma & coping, contexts of substance use, the role of peers, schools, and family; services and accessing services; and social support and social networks. Emergent themes literally emerge from the data, and become evident only upon analyzing the interview data as a set. In other words, these are themes that are emerge after data collection and analysis begin.

Second, the consensus coded data[13] were entered into the computer assisted qualitative data analysis software, NVivo[14]. This software quantified the data in terms of two important metrics – references and files. References are the number of times a theme is mentioned across each of the transcripts. Files refer to the number of transcripts in which a theme was mentioned. Whereas there is no limit to the number of references possible in a data set, the number of files is limited to the number of transcripts, in this case eight transcripts from each of the eight focus group discussions. Using these two metrics, the most prominent themes were content analyzed using the NVivo software again. The content analysis is presented in the findings section.

Project Review & Dissemination. This report was written by the youth needs assessment team, then reviewed by ADAD staff, whose edits were incorporated into the final version. In addition, results were shared in a webinar hosted by the Hawai'i Youth Services Network[15]. The webinar was attended by 41 professionals across the state (See Appendix C for webinar flyer). Insights gained from this interactive webinar also were incorporated into this report. Overwhelmingly, the webinar participants expressed that these results aligned with their clinical insights and professional experiences.

[13] Consensus coded data include all eight transcripts from each of the eight focus group discussions with youth.
[14] Link to NVivo software website: https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/about/nvivo
[15] HYSN advertised the webinar via their September newsletter, which is distributed via email. Our team also shared the webinar flyer with ADAD to distribute. And we also shared the webinar flyer directly with the organizations who assisted with this project. Attendance included 41 people.

3. Findings – Protocol 2: Youth Interviews

Overview. The youth substance use services field has relied on a risk and protective factors (RPF) approach for over two decades, which is grounded in the theory of human ecology.[16] The field of public health refers to this as the social ecological model, while developmental scientists refer to the ecodevelopmental model.[17] The main point is that individuals are embedded within multiple socio-cultural contexts that influence their well-being: individual, micro, meso, exo, macro (Table 5). The influence of these contexts changes over time as a result of human growth and development. The findings are presented with the lower order levels first (individual, micro, meso levels), then the higher order levels (exo, macro levels).

Within these levels, the content analysis identified inter-related themes presented below. Each theme is described in brief, generally accompanied by selected quotes in italics and a figure depicting the concept expressed by youth.

Table 5. Findings Organized by Eco-Developmental Systems Theory

System	*Brief Definition with examples*	*Level*	*Findings*
Individual	The focus is on the person themselves, and their specific experiences of wellbeing.	*Lower Order*	***Theme 1**: Trauma* ***Theme 2**: Coping*
Micro	The immediate settings in which individuals live. With youth, the usual focus is one or more micro-level settings - family, peers, school.		***Theme 3**: ATOD Services* ***Theme 4**: Getting in Trouble as an entry point*
Meso	Dynamic interaction between a set of two or more micro settings, such as the school as a site for substance use service delivery.		***Theme 5**: Peers have a Role in the System of Care* ***Theme 6**: School as Formal Social Support Network*
Exo	Institutions that govern or structure micro and meso levels through policy, law, or other rules and guidelines.	*Higher Order*	***Theme 7**: Youth identified Gaps*
Macro	Societal, philosophical, cultural influences, such as democracy, capitalism, hierarchies of human value that contribute to health disparities, etc.		

[16] Bronfenbrenner, U. (1979). *The ecology of human development. Experiments by nature and design*. Cambridge, MA: Harvard University Press.

[17] Szapocznik, J., & Coatsworth, J. D. (1999). An ecodevelopmental framework for organizing the influences on drug abuse: A developmental model of risk and protection. In M. Glantz & C. Hartel (Eds.), *Drug abuse: Origins & interventions* (pp. 331–366). Washington, DC: American Psychological Association.

Ecodevelopmental Systems: Individual Level

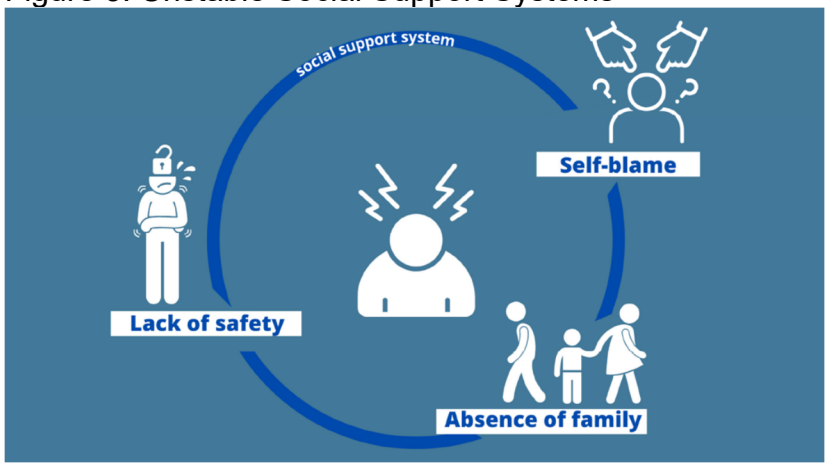
Theme 1: Trauma

Youth shared a number of experiences related to trauma and coping when describing their views on accessing services, the role of the school, and other support services. The analysis indicated that youth experience trauma that *leads to* participating in the system of care (pre-system trauma), as well as experiences of trauma as a *result of* participating in the system of care (system trauma).

Pre-System Trauma. Pre-system trauma represents the difficulties and adversity that youth experienced before becoming involved with public systems of care, e.g. juvenile justice, child welfare, foster care, or homeless services. The traumatic experiences that the youth discussed were related to family problems such as domestic violence or child abuse/neglect, unstable housing or homelessness, their own substance use or mental health problems or that of a family member, and getting into trouble at home, school, or community. Taken together, the pre-system trauma experiences expressed by the youth included a) scenarios of unstable social support systems and b) family substance use.

a) Unstable Social Support System. More than half of the focus groups discussed unstable social support systems. Due to fractures in familial structure, running away from home, and absence of stable adult relationships, participants lacked secure and safe social supports, which led to feelings of fear, issues with safety, and instances of self-blame (Figure 3).

Figure 3. Unstable Social Support Systems



> [Interviewer asked about what would have helped]. *Well I would help them out, or get them in a shelter. Or foster family or something. Because that's what I've been doing, I didn't have no family. So, I [don't] like [to] see any other kid go through what I had to go through.*

b) Family Substance Use. Half of the focus groups discussed the impact of family substance use. Youth described their family circumstances before public system involvement and their stories included instances of parental substance abuse and the presence of substance use in family life. Beyond exposure to alcohol, tobacco, and other drugs, these youth also witnessed dependency and the normalization of substances within the home and by family members.

> [Interviewer asked about foster care and substance use overlap]. *I think stress has a lot to do with it. Especially because like one of the big reasons youth … in Hawai'i end up in care are for … parents using substances… When I saw my parents or older people in my life or my family were stressed or if they're happy or sad or mad, it was always, whatever emotion it was, it always led to using some kind of substances. So, I think that often times youth kind of see that. Whether they're in care, before they're in care or while they're in care and kinda just replicate that 'cuz that's all they kind of know of the actual, of coping skill. So, I think that would be, that's a big reason why youth in care use substances*.

System Trauma. System trauma refers to the difficulties and adversity that youth experienced after becoming involved with public systems of care. Although public system services are designed to help, the youth

described conditions of system involvement as traumatic in terms of: a) system objectification, b) the stigma associated with being involved with public system services, c) mental health complications. Finally, (d) substance use was described as a reaction to system involvement.

a) System Objectification. More than half of the focus groups discussed system objectification. Participants discussed system objectification as the conditions in which they felt their agency and voice were marginalized or silenced, caused disconnection in their lives, and the feeling of having no one to advocate for them. The system caused them to feel like objects and not like whole people, as described here.

…But, for a little bit of details from my complications while being in foster care, overall like I, not like fully messed up and it just. … So, I ended up being in foster care and then my mentality from 15 years old to age 18 was I wanted to be reunified [with family] 'cuz that's who I was raised with my whole life before, well not my whole life but the time that I left foster care at the age of 2 to 15 ... So, that was always my mindset and, you know, it was a little but complicated because, you know, the state always kept on telling me, "you're not getting reunified …", you know, "it's not a possibility, nothing's gonna happen". And then all the over, like more and more situations came in just because, you know, that because my [family] is my permanency, he's my social capital, he's the person that I always go to no matter for what and he's the person I cherish forever. So, hearing that from, you know, my foster, not my foster parents but like my social worker, my guardian…

b) Mental health complications. Half of the focus groups discussed their experiences within these public systems as distressing to their mental health. A participant stated that, "the whole time I was in foster care I wasn't myself basically, I was so, like, broken down." Other participants echoed this experience by mentioning feelings of isolation, depression, and hopelessness.

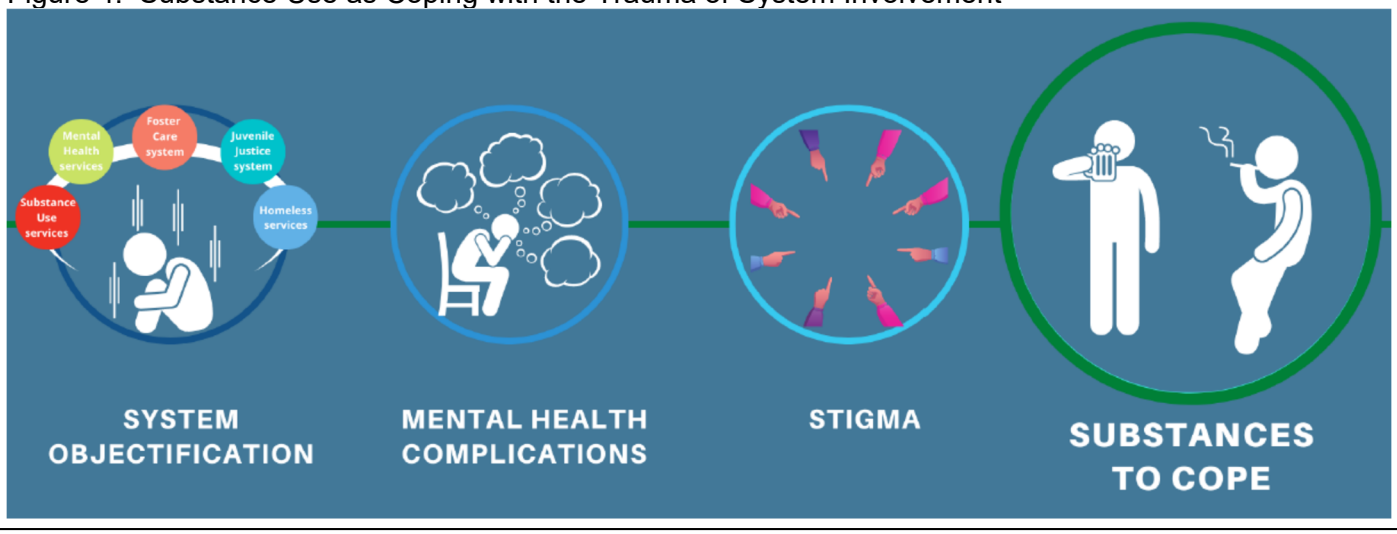
…for me it was a lot of depression, you know, from not. Because I was in foster care at a young age, it was always depression of not seeing my family, so I would always reiterate back to the substances…

c) Stigma of system involvement. Several focus groups mentioned the stigma that was associated with system involvement. The youth discussed ways that others labeled them as a result of their involvement with public systems. They mentioned how being associated with these systems caused distress when others learned of their involvement. For example, a participant expressed being treated differently due to their involvement with the foster care system.

…When we're emotionally unstable and traumatized as [we] are, especially if you're younger and you just kind of get thrown in the system, you don't really want to feel that pity from everybody, you kind of just want the comfort. Not the [pity]… you just want more of a stability…[The] normalization that you're just a regular kid. Like you're just a human, not a different category of species just because you're in foster care.

d) Substance Use as Coping with the Trauma of System Involvement**.** Almost every focus group discussed how substances were used as an active coping mechanism. These groups expressed that substance use served as a form of emotional pain relief and escapism, particularly as it related to the trauma of system involvement (Figure 4).

Figure 4. Substance Use as Coping with the Trauma of System Involvement



Theme 2: Coping

Coping. As a reaction to traumatic and adverse experiences, youth discussed different coping mechanisms. The American Psychological Association has described coping as "the use of cognitive or behavioral strategies to manage the demands of a situation when these are appraised as taxing or to reduce the negative emotions and conflict caused by stress".[18] The youth participants discussed various coping strategies including a) program misalignment & running away, b) avoiding school, c) self-perspective, d) retrospection on support, and e) reframing as coping.

a) Coping with Program Misalignment. Youth in most of the interviews discussed a misalignment between the services and programs offered to them and their needs and wants (Figure 5). They explained that they did not feel interested in the services that were being offered, how they withheld information from their social workers, and ran away from services and programs. These forms of coping appear to represent the misalignment between public system services and the youth's needs and preferences.

Figure 5. Coping with Program Misalignment

18 American Psychological Association, 2020, APA Dictionary of Psychology, Retrieved from https://dictionary.apa.org/coping

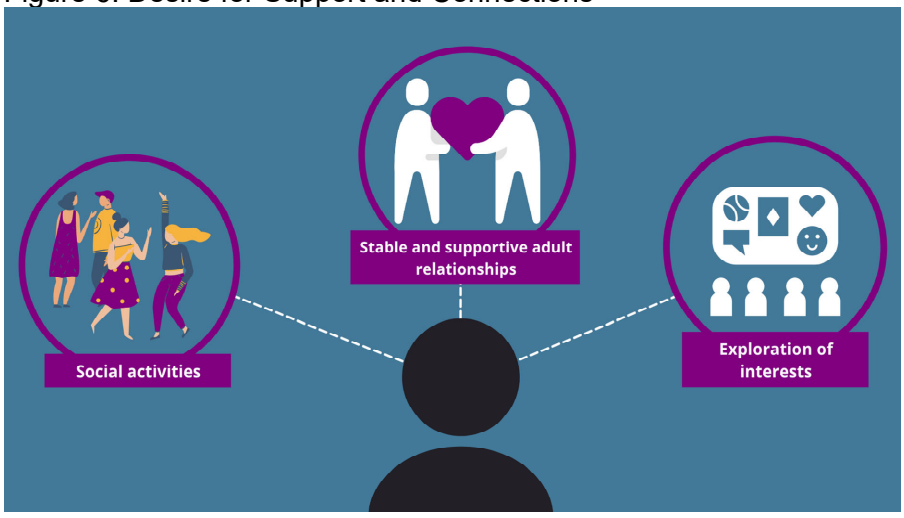
I feel that like, even if there was like words of advice to give to these kids… these kids are probably not gonna be convinced that they should go to substance abuse places because they could be run away. They could, you know, just choose not to go to a drug treatment program cuz they wanna stay on drugs.

b) Avoiding school. In half of the focus groups, youth discussed avoiding school entirely or leaving school property to use substances. Some youth described school as an "unhelpful" place and somewhere where they don't "like going to."

Nah, same thing like, I don't like school, so I never really liked going to school. I only used to skip school, just for do the bad things that I enjoy doing.

c) Reframing as Coping. Counterbalancing deficits they noted in the current system, the youth also indicated strengths that helped them persevere, which may be considered reframing as a form of coping. Youth shared their positive outlook when reflecting on support that might have helped them in the past, as well as the future plans they envision for themselves. For example, each focus group discussed how they had wished they had had more stable and supportive adults in their lives, more social activities without substances present, and more opportunities to explore and develop their interests (Figure 6).

Figure 6. Desire for Support and Connections

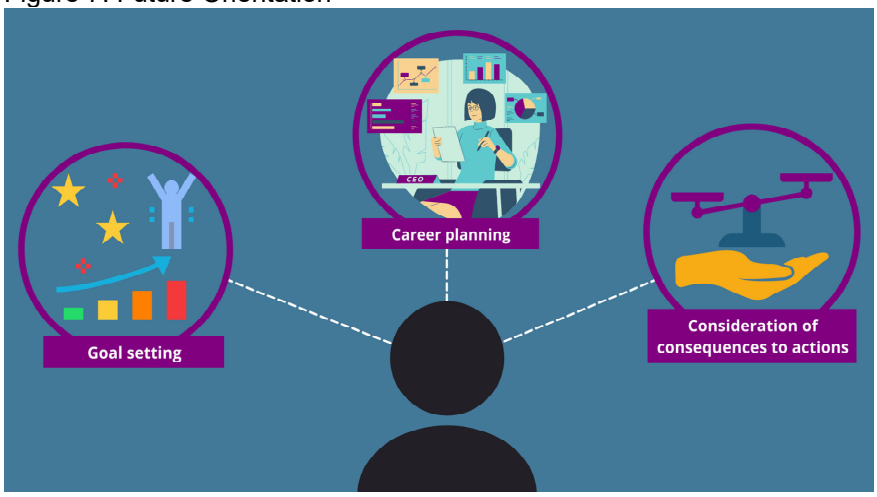


Youth in care are moved from school to school and home to home a lot. So, the stability is not something that's always happening for youth in care… I think for youth who have at least one person or one program or one sport or one thing that they can consistently do through each move or each school. I think some kind of support system that's consistent through all those moves I think is one of the main things for me at least and other youth that kind of help youth not to use substances. Or support them in more positive activities, or positive support, or moral support, is at least having some kind of, one constant through all the moves.

Each focus group also indicated a clear future orientation, in spite of experiences of trauma and the various coping strategies they have used. The youth discussed future goals, career aspirations, wanting better for themselves beyond their prior life experiences, and knowing that there are consequences to their actions (Figure 7, next page).

If you don't work for it, you're not going to get nothing at the end. If you work hard and know what you want is what you want. Keep on stepping ahead, keep working until you get what you need and what you want, what you always wanted to have in life. Because nothing is going to come to you in like a heartbeat. Like you gotta work for it. … If you want money, you want a house, you want GED, you want all of this stuff, you gotta work hard for it. You get nothing in life for free. Like how everybody says, you have to work for what you want, what you have. If you don't [you will] get stuck in the bottom.

Figure 7. Future Orientation



Ecodevelopmental Systems: Micro & Meso Levels

Theme 3: ATOD Services

Youth discussed two subthemes related to alcohol, tobacco, and other drug use (ATOD) services: 1) avenues to engage in existing services; and 2) personal strategies to avoid ATOD use. With respect to engaging in services, these points were made by the youth: a) service continuity, b) harm reduction support, c) education, d) disciplinary action, and e) program choices. With respect to personal strategies to avoid ATOD use, the youth made these points: a) keeping busy, b) ATOD access, and c) school navigation.

Engage in Services. With respect to engaging in services, these points were made by the youth: a) service continuity, b) harm reduction support, c) education, d) disciplinary action, and e) program choices.

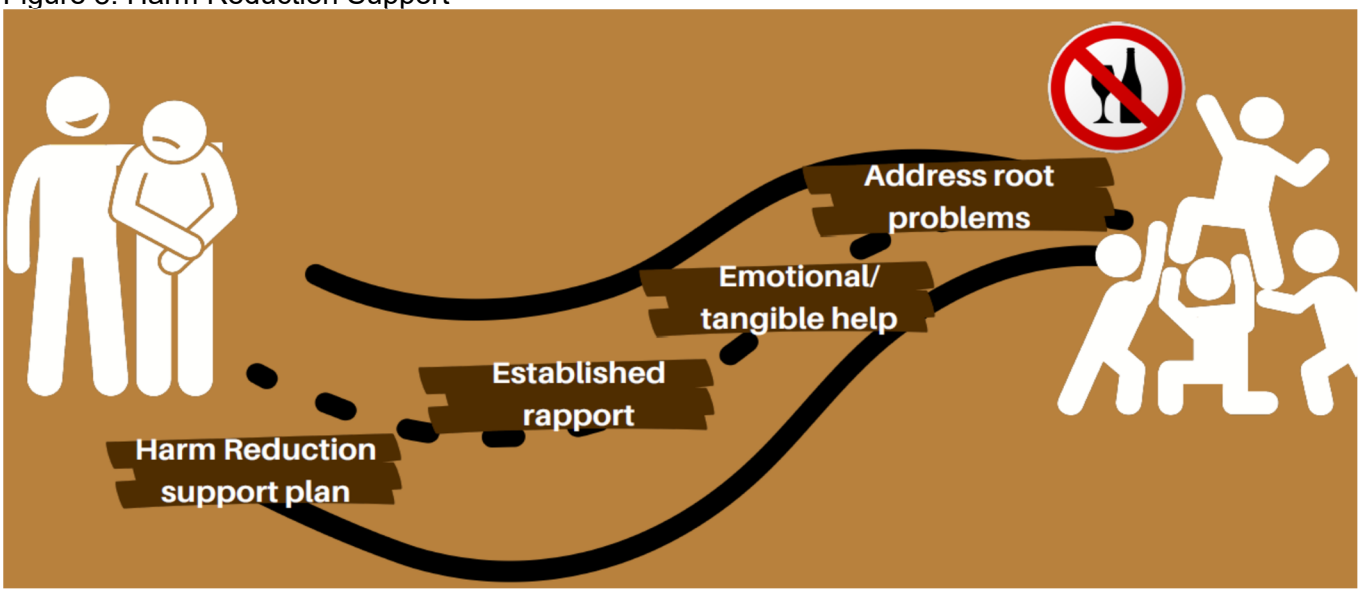
a) Service Continuity. Half of the focus groups discussed the need for service continuity. Youth described the need for continuing programs that had been offered in elementary school into high school and the importance of starting services at a young age.

[Teen Substance Use Prevention Program] really was a big help in elementary. Unfortunately, I didn't have that accessible in intermediate and or high school... high school …was like a school of drugs and, you know, it was all over the place and it was always there and even if you're doing good outside of school, you know, you still relapse… it was hard for me and I mean I really wish there were programs and, you know, assistance for the schools I should say for more drug classes or substance classes like [Teen Substance Use Prevention Program] to be in high school and middle school.

b) Harm Reduction Support. Each focus group described the concept of harm reduction, albeit not necessarily using that terminology. Some youth felt that their assigned worker was not doing enough to support them, particularly with substance use recovery. For example, youth described unmet requests for additional emotional support, a need for better rapport with workers and volunteers, help in addressing root causes of ATOD problems, supportive group classes, and a clear substance reduction support plan (Figure 8, next page). For prevention, youth mentioned personal development, community connection, drug education, and classes surrounding peer pressure.

For me when I had been on probation for drug use, would have been to put me with classes that would've helped instead of just putting me on probation and expecting me to have that strong will all on my own so young. I only mention this because I did have a relapse when I was on probation… it was so hard, you know, school is so much peer pressure with friends, and I went to a new school so I wanted to fit in. And I ended up having a relapse, but I think having like classes to…just to walk you along those steps until you're completely done from your like relapse-stage.

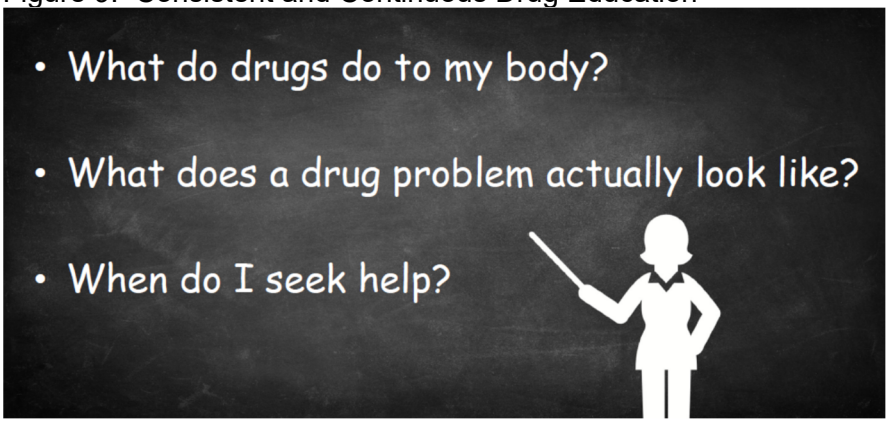
Figure 8. Harm Reduction Support



c) Education. More than half of the focus groups discussed the need for basic substance use education (Figure 9), as well as how to recognize a substance use problem, dealing with ATOD in social situations, and facing substance use issues.

I think a lot of kids who are on the edge of getting help and not getting help, they know that they're, what they're doing is partially problematic, but they're not really sure to the degree. And they're not really sure if it's something that they need to reach out and do…I think it would be about educating them…what does a substance use problem like really look like?

Figure 9. Consistent and Continuous Drug Education



d) Disciplinary Policies. A couple of the focus groups discussed the ineffectiveness of certain types of disciplinary policies. For example, school suspensions and warnings were perceived to be ineffective deterrents to substance use. Instead, they generally recommended support services, as in the quote below. In the context of residential facilities, including incarceration, youth described the use of rewards and

punishments (possibly a form of contingency management), which they felt did not address root causes of their problems, substance use or otherwise.

So, pretty much like when I was in school and we would get caught with like bad stuff, they would just take it away and then suspend us. But if we, but if it was like the first time then they just like gave us like a warning. And then if they catch… constantly then they put us in like [Substance Abuse Group] or like they try to find us help... If I was to catch a kid with marijuana in his bag or like drugs, I wouldn't just like suspend them. I would like try and help them.

e) Program Choices. Almost half of the focus groups discussed the need for ATOD recovery support. Youth described mandated or school sanctioned programs, and suggested greater flexibility for program options. Youth advocated for voluntary programs as opposed to mandated programs. Although mandated programs were perceived to have additional benefits, such as access to other resources and services, some youth believed they would have greater engagement with programs and an increased sense of agency if participation was voluntary.

They just keep on drug testing me and when I piss dirty they send me to all kind of rehabs and programs and drug counseling. It just doesn't work 'cuz they force you to do it. That's why when I wanted to come [to the program I am enrolled in now] then it would help because I wanted to do it. And they didn't force me to do it.

Personal Strategies to Avoid ATOD Use. With respect to personal strategies to avoid ATOD use, the youth made these points: a) keeping busy, b) ATOD access, and c) school navigation.

a) Keeping Busy. Half of the focus groups discussed the need for activities that keep youth busy and away from ATOD use. Youth expressed the need for after school programs – particularly those on school campus for ease of access, deeper community connections, and extracurricular activities to protect youth from ATOD use (Figure 10).

Figure 10. Keeping Busy

And you know, especially in [Rural Community], when I went to this afterschool program, like for me I was not home. So, I didn't have to see a lot of the stuff that happened at home. Or see my parents using substances, or see my sister self-medicate. Like I was taken away from that because I was at school, or I was at my afterschool program. So, I think just having other things for youth to do is helpful. Even if they're not necessarily supposed to help youth stop using substances.

b) ATOD Access. Nearly half of the focus groups discussed the ongoing exposure to and access to substances while attending recovery support programs. Youth described issues surrounding ATOD tolerance and ATOD connections during recovery programs. Paradoxically, despite being actively involved in a program, these youth suggested that their peers may have created social connections that encouraged relapse.

…If we [were] in one open program instead of one doctor's facility, then that mean[s] we would be seeing a lot of people around that would trigger us…

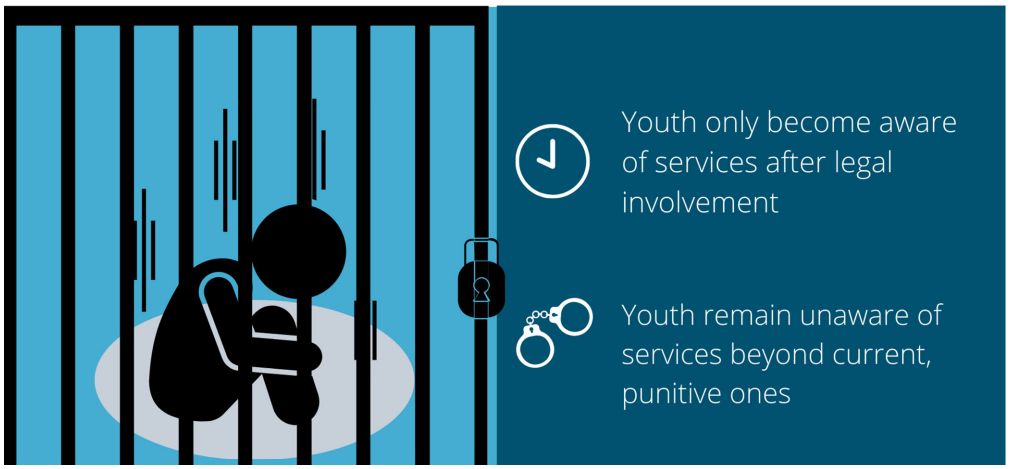
c) School Navigation. One focus group described challenges related to asking for help from school staff. Youth expressed the need to balance a desire to ask for help while simultaneously avoiding getting in trouble.

I'd say you have to do it very carefully. You have to think about what you're saying. And especially with the time periods in which things are taking place, because if you're someone who has done drugs at school or something, you have to make sure you're saying that in the past tense and not in the present...you have to be very careful about how you speak in the school environment, specifically. …it's really not easy, but it's just, you have to. You have to find someone who you can be, you know, relatively sure enough that you can confide in this person and they will, they will lead you to some sort of help, you know, someone who you really connect with and trust like that.

Theme 4: Getting in Trouble as an Entry Point

Across the eight focus groups, youth mentioned experiences of getting in trouble due to substance use and for other related reasons. Getting in trouble was an emergent theme. In general, youth described a substance use system of care based on a reactive rather than proactive stance, such that getting in trouble served as an entry point into the system of care. Further, the focus group participants suggested that youth often only become aware of services after they have become involved in the legal system, and may even remain unaware of services beyond those that are provided in response to a punitive response to substance use (Figure 11).

Figure 11. Getting In Trouble as an Entry Point to the System of Care

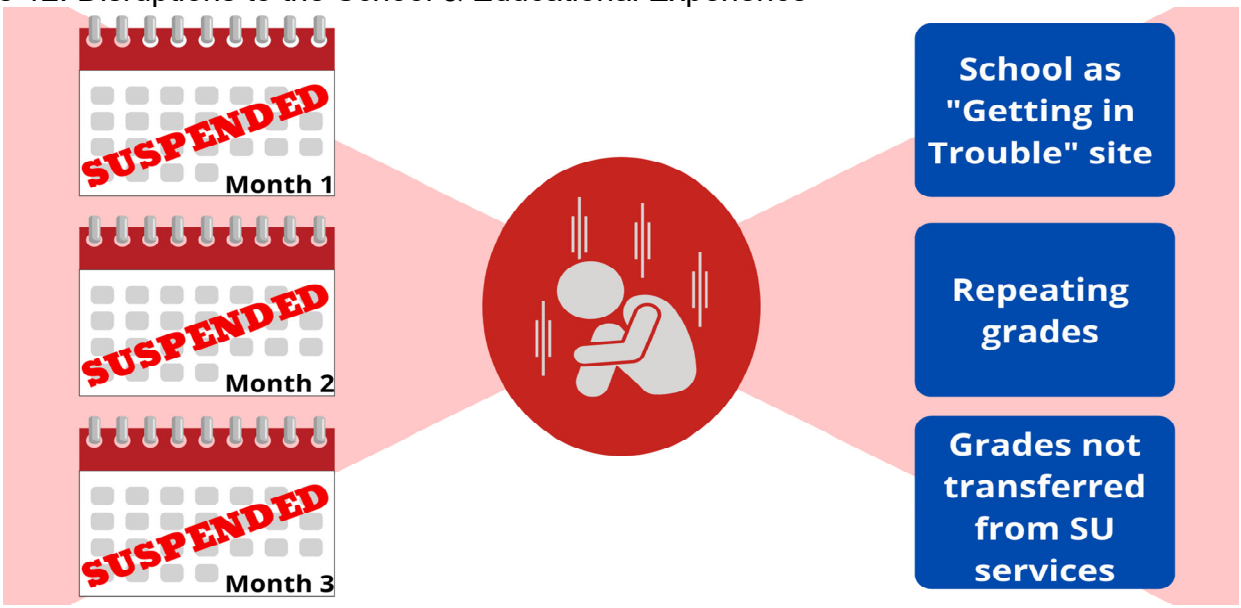


In terms of the micro/meso level, contexts of "getting in trouble" were related to 1) disruptions to the school and educational experience, 2) residing in a secure detention or prison facility, and 3) and the broader communitywide settings across one's life trajectory.

Disruptions to the School/Educational Experience. Getting in trouble was described in terms of disrupted educational experiences. Youth explained that substance use at school resulted in up to 90 days suspension (Figure 12, next page). Youth also felt that schools did not do a good job of accommodating students who would benefit from accessing substance use services as opposed to being punished. This was captured by accounts of having to repeat a grade due to long suspensions, the inability to catch up after returning to school, and grades not transferring between schools and the mandated programs that youth attended.

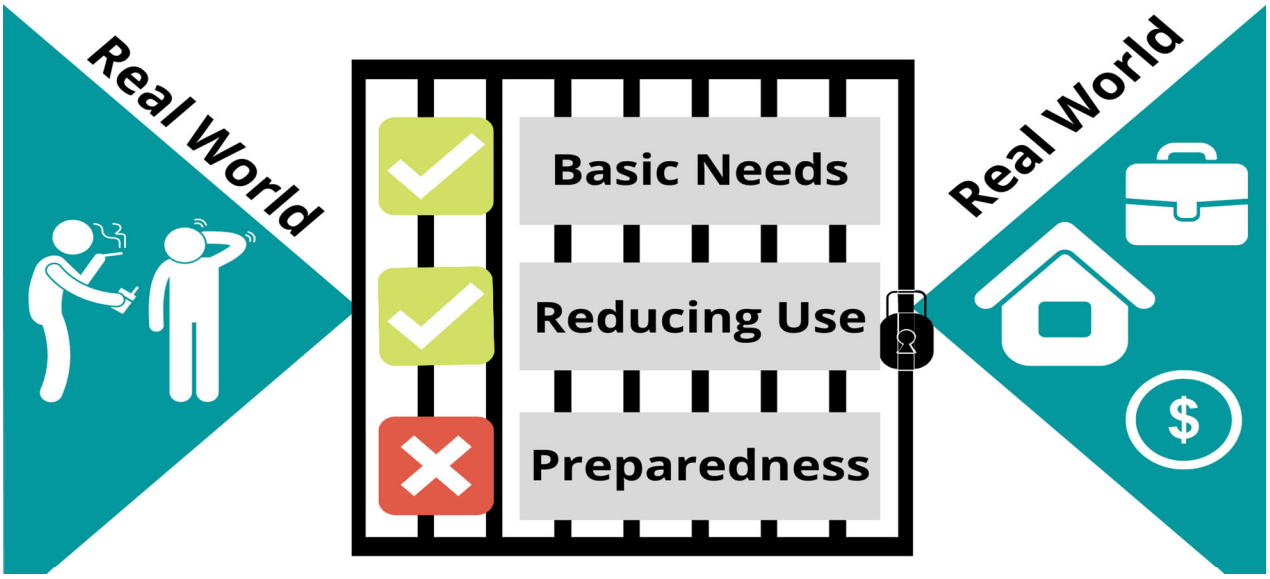
… Say we get arrested and shipped out to another island to go to detention home or rehabs. When they make us go to school, they should have our grades transfer because our grades don't transfer and that's another reason why I failed and I did all my work and I was doing good and my grades didn't transfer. And I failed my first ninth grade year and I was so mad. So, I think they should have a better way of like looking at grades.

Figure 12. Disruptions to the School & Educational Experience



Secure Facilities. Over half of the focus groups discussed secure detention or incarceration. Secure facilities were described both positively and negatively (Figure 13). When discussed positively, youth appreciated secure facilities as a place where reduced ATOD use was possible simply because access to substances was not possible. Additionally, facilities were described positively because

Figure 13. Secure Facilities



youths' basic needs were met - food, shelter, and medical services. However, these positive features were counterbalanced by negative accounts in which youth did not feel prepared for challenges beyond the secured facility. Youth described secure facilities as separate from the "real world," which left youth feeling unprepared to reduce ATOD use and achieve stability beyond the facilities.

> *… In here we stay sober and also, we get the education we don't get when we're on the outs…We get the help we need, we get everything taken care of in here.*

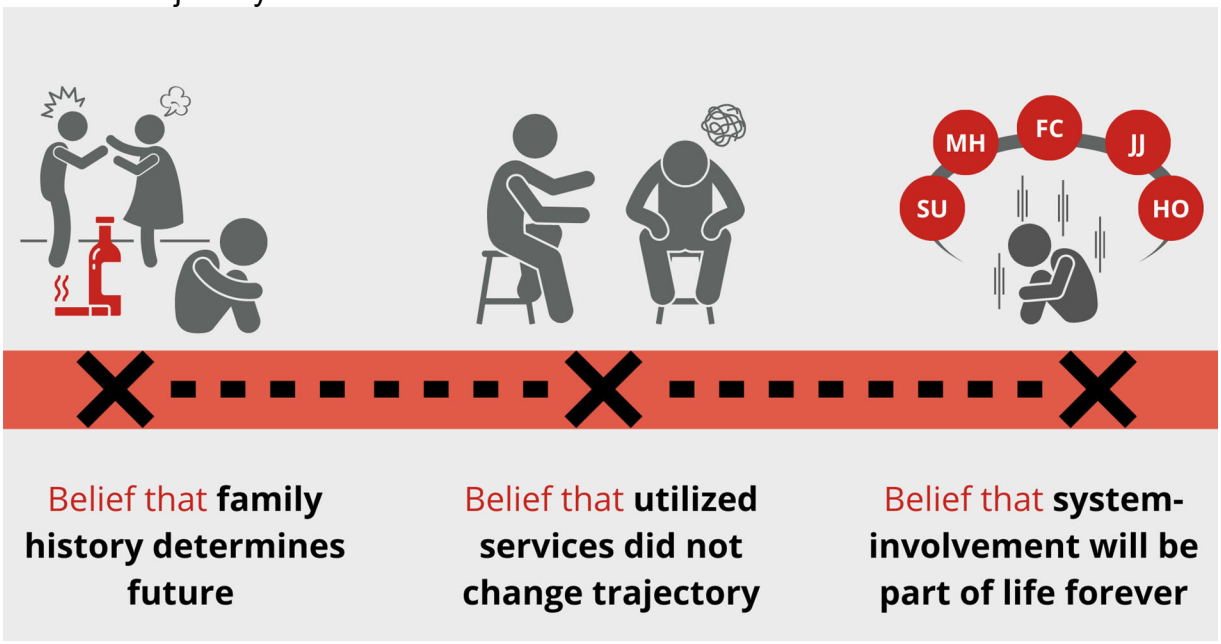
> *… you won't to have access to it, but you also creating them more and then once you find out you have the opportunity to get out, you're going to go right back into that. And then it all depends … if you want to stop or not. If you just want to keep doing what you want to and not try to benefit yourself.*

Life Trajectory. Third, beyond the school setting and secured facilities, getting in trouble had consequences across settings expected in one's life trajectory (Figure 14). In half of the focus groups, youth described the perception that getting in trouble and being involved in the various public sector systems of care would have consequences through out their life trajectory and carry over into other settings in their life. In thinking about both their present and their future, youth described feeling that system-involvement would be a feature of their lives forever. Specifically, participants expressed a sense of determinism, the feeling that a family history of system involvement determines one's future. For example, exposure to family substance use either led youth to steer clear of substance use altogether or contributed to them feeling that substance use would be part of their life trajectory. Similarly, youth expressed that some programs do not effectively change the course of their life trajectory, expressing that substance use issues persisted despite participating in numerous programs.

> *Once you get involved with the system, like they're forever gonna be in your life. Like, there's good and bad to it.*

> *The bad really does outweigh the good.*

Figure 14. Life Trajectory



Theme 5: Peers Have a Role in the System of Care

Not surprisingly, the influence of peers on substance use was a key theme. Their views indicate that peers have a role in the system of care, that youth serve as both protective and risk factors for substance use, and that there is room for improvement in the system of care by intentionally positioning peers as helpers. Youth made two distinct but related points: 1) peer influence, and 2) substance use settings among peers (Figure 15).

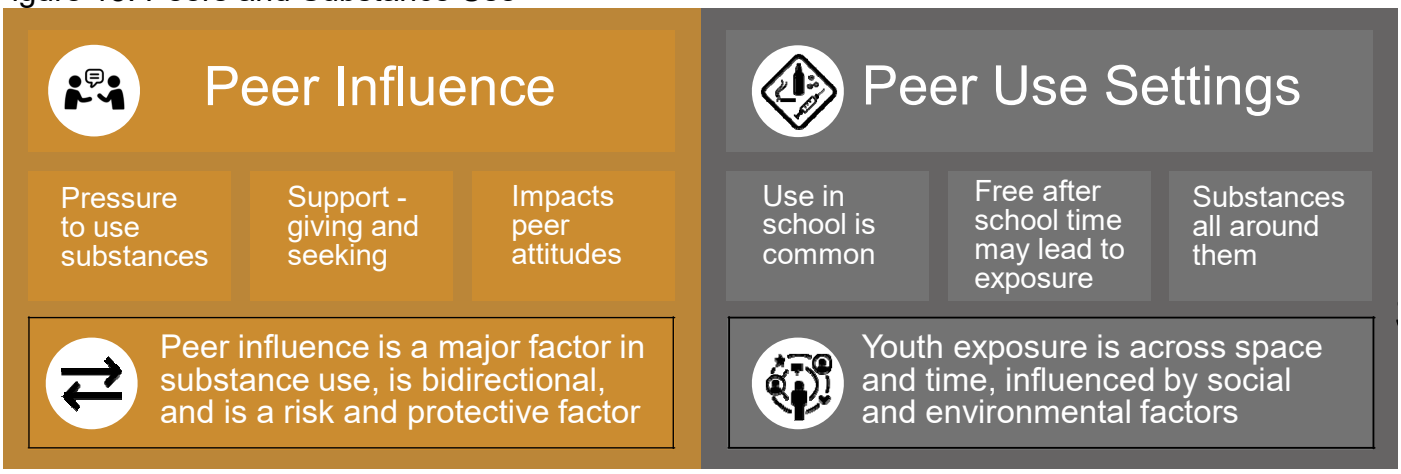
Peer Influence. Nearly every focus group discussed peer influence either in terms of peer pressure or peer support, as well as attitudes toward substance use and escalated use. Youth experienced both peer pressure to use substances to fit in and belong, whereas youth also experienced peer support to stop/prevent substance use.

> *It was so hard... school is so much peer pressure with friends and I went to a new school so I wanted to fit in. And I ended up having a relapse.*

> *Or they take it a step further and they start trying to do what all the other people they've met in there [rehabilitation center] do. And in some cases, it's worse than the substance they were already using.*

> *It was just my two best friends, they really helped me get through a lot of my problems. So, they were telling me a lot of stuff. So, I was like, okay, I realize this, and I should really quit.*

Figure 15. Peers and Substance Use



Substance Use Settings among Peers. Youth described substance use settings, or the types of locations where kids use drugs and alcohol. This included at school, as well as community settings including during afterschool hours. Overall, the youth interviews suggested that kids feel surrounded by substance use by peers, at home, school, and beyond.

> *...already had used most the drugs by the time you're in high school or middle school [...] My school, our thing was alcohol, weed, and pills.*

…like no matter how hard [the administration] tried, [students] still [were] doing it behind their backs.

... if you don't play a sport there's really nothing for you to do except wait there or you leave with your friends... you just have all this time to figure out how to wreak havoc, wreak hell.

And honestly it doesn't just come from school, it comes from the streets around it, there's hang out spots, there's the chill outs, there's the scrap spots, like everywhere like.

Theme 6: The School as Formal Support in the System of Care

The School and school-related issues were the most frequently mentioned theme, as already evident in the individual level results and the micro/meso level results presented above. Youth acknowledged the role of the school as a site for connecting to substance use services in over 130 mentions across the eight focus groups. This finding suggests that in spite of the myriad of critiques outlined above, youth continue to perceive The School as a critical site for accessing formal support. The School theme included these points: 1) the symbolism of school, 2) instrumental help, 3) emotional support, 4) recognizing needs and sharing information.

The Symbolism of The School. In each of the eight focus groups, the school symbolized a variety of benefits and shortcomings according to the youth (Figure 16). Participants view schools as an important entry point into the continuum of care. Schools symbolize both the service and the connection to outside services. Although participants generally noted that schools were fundamental to the quality of care they received, they also indicated areas for improved quality of care: more supportive attention from staff, and better trained staff. For example, youth explained that schools stigmatize substance use, which was perceived as a barrier to help-seeking. Youth also recognized that schools are the place to receive drug education and to empower them to develop a sense of agency about informed choices regarding substance use. Schools also symbolized a place to participate in extracurricular activities - where youth spend their free time after school, develop a sense of community, and find protection against environments in which substances are used. However, the youth explained that schools bar participation among youth who had gotten into trouble for substance use, which was viewed as punitive and lacking support.

Figure 16. Symbolism of The School

Well, to help all youth in general, I wanna say having like resources like [Human Services Organization]. I was in there for two years when I was in elementary and it was always

about substance use and how to stay away, how to say no, how to say no to peer pressure and things like that. Just resources like that for kids when they're young all the way up to even high school is such a great thing to be a part of. Because learning all those things as a young kid also kinda helped me on a better path to determine whether or not if I wanted to be like the norm that I grew up around, the norm of substance abuse.

Instrumental Help. Instrumental help refers to tangible support, for example help with homework, getting a ride to school, or guidance in navigating complex service systems. In each of the eight focus groups, youth discussed the importance of school-based services for addressing their needs. Youth indicated that that schools can help them navigate and create links to other critical services in the continuum of care. These youth also recognized the fundamental role schools may play in helping youth develop a sense of agency to overcome the unique challenges that they face. Participants described the importance of having trustworthy staff in whom youth may confide about their challenges with ATOD use.

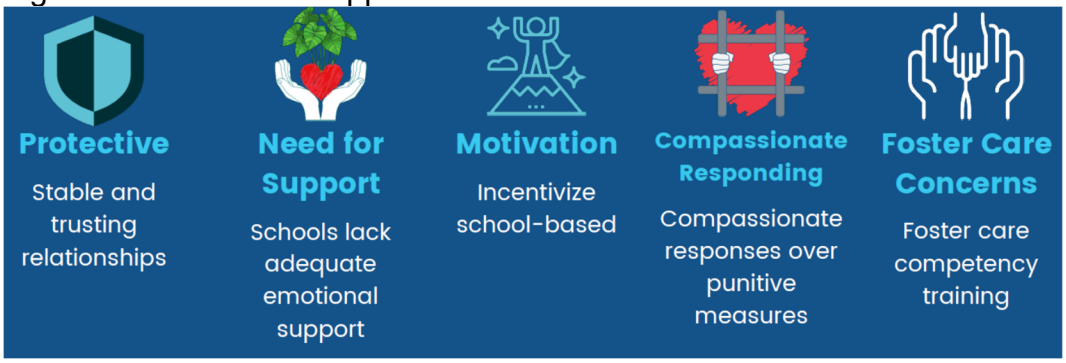
On the other hand, youth noted that school-based instrumental support was not always effective. Specifically, some youth felt that schools were designed for youth whose lives were stable, which marginalized youth experiencing instability and life challenges. This in turn inhibited youth from reach out for help with their ATOD use due to fear of repercussions. As an example, the 90-day mandatory suspension for substance-related incidents was mentioned. Lastly, youth mentioned that many school-based programs, such as drug education, are ineffective and don't lead to sustainable behavioral change.

I was actually in a substance use services at my high school… we have like school-based counselors … and it was like pretty much drugs, alcohol and counseling. So, because back then, I will admit, like from personal experience … I did some hardcore stuff and, you know, the school was actually concerned for me so they put me in the school-based counselling and I was in it for like almost all of my high school years.

Emotional Support at Schools. In nearly all of the focus groups, youth commented on how important it was to receive emotional support at school (Figure 17). Emotional support was perceived to be a useful protective factor against substance use. Yet, youth noted that formal settings often lack adequate emotional support. This in turn means that youth turn to informal social support networks, which are underprepared for the gravity of issues that these youth face.

Regarding the need for greater emotional support at schools, youth indicated that they would like incentives to drive motivation to participate in school-based services, an increase in compassion with a decrease in punishment. Lastly, these youth also suggested that school staff would benefit from training to understand the unique challenges among youth in foster care (e.g. support and understanding rather than pity).

Figure 17. Emotional Support at Schools



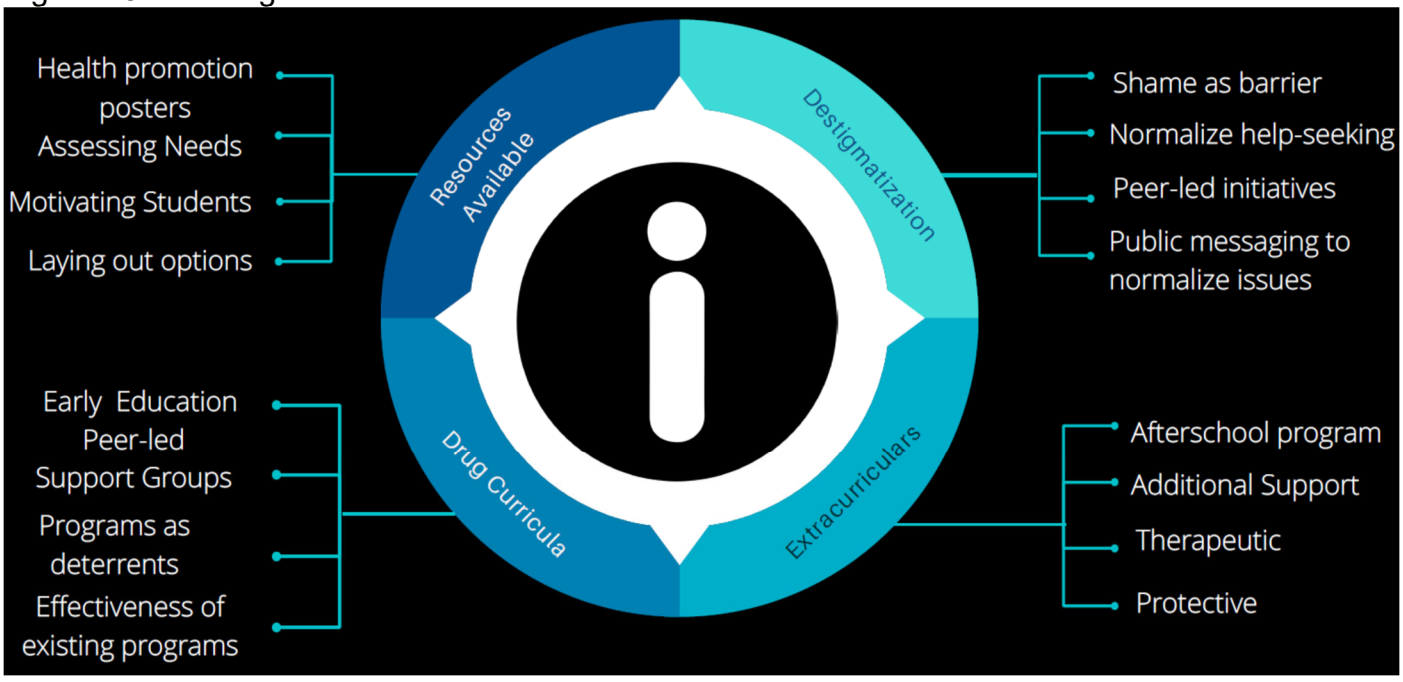
… if you get caught with it there's consequences… you would either get like suspended or something. But like I would really enforce like that, it's no tolerance of substance abuse and stuff…Like I'm pretty sure children are not gonna admit that they're wanting help but if you can see how they are, like their eyes, their body language, you can see how they are acting. They're really begging or crying out for help…I won't suspend, I'd be like 'oh, you need help. This is serious stuff.' I'd get to the bottom of it and help them.

Recognizing Needs and Sharing Information. In over half of the focus groups, youth expressed how schools play an important role in assessing the ATOD issues that youth face. While some school staff were perceived to enforce a zero-tolerance policy, other staff were perceived to be aware of drug use, even in classrooms. This variability was perceived to be problematic, especially when paired with punitive rather than compassionate responses.

So, I feel like if I was a principal, establishing something so that kid feels as if they weren't a part of the stigma...Something to get to know them, to get to know their circumstances, to know how they feel about themselves so you can know how to help.

In each of the eight focus groups, youth commented that The School represents a viable avenue for sharing information on services and resources by informing students of the dangers of drug use through drug education and the available resources and extracurricular programs; and also by destigmatizing help-seeking (Figure 18). As an example, youth advocated for programs and community leaders that make help-seeking "cool", and through messaging campaigns that normalize ATOD use interventions. The focus groups noted the importance of extracurricular programs at school to offer additional support. Many participants noted that extracurricular activities can be therapeutic and serve as an effective protective factor against further ATOD use. Lastly, drug curricula were seen as a protective factor when delivered at an earlier age (i.e. elementary school and middle school) and through peer-led support groups.

Figure 18. Sharing Information at School.

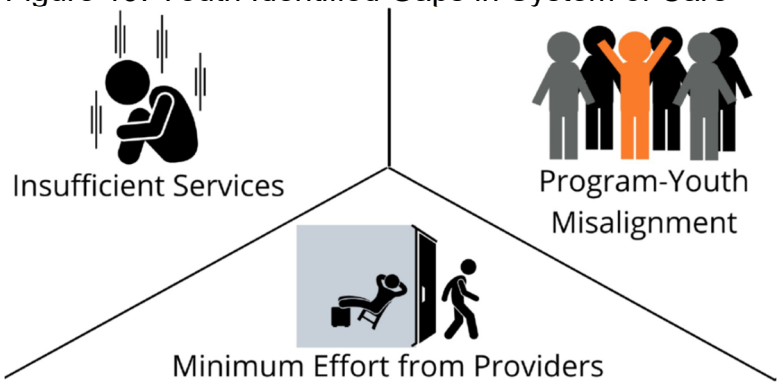


Ecodevelopmental Systems: Exo & Macro Levels

Theme 7: Youth-identified Gaps in the System of Care

Throughout the eight focus group interviews, the youth identified a number of contradictions, juxtapositions, and flaws in the system of care based on their lived experiences. Collectively, these youth-identified gaps in the system of care highlighted three issues: a) insufficient services, b) program misalignment, c) minimum effort from providers (Fig. 19).

Figure 19. Youth Identified Gaps in System of Care

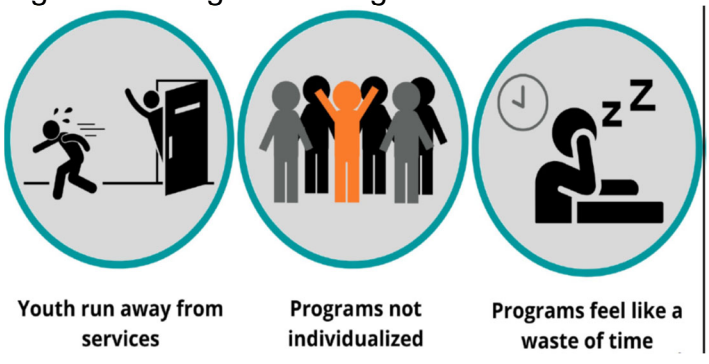


Insufficient Services. Youth described a variety of experiences with programs that did not work well for them. Nearly each of the eight focus groups expressed that many services fail to adequately address youths' needs, in part because programs do not seem to address the root causes that lead to their substance use - family dynamics, generational or historical experiences, and mental health challenges. Youth expressed that services seemed to be designed as a "one size fits all" approach, which they did not agree with. Youth mentioned a critical lack of rural-based services and desires for more community-based programs. Additionally, youth expressed desires for youth specific versions of substance use programs.

> *I think what should be available on any island or anywhere in the world, I think a youth narcotics anonymous or a youth alcoholics anonymous would be perfect…I mean why is it only available for adults? You know what I mean 'cuz in order to reach that point you have to grow up and become an adult and then you get to go into that. It's not available to everybody.*

Program Misalignment. Related to insufficient services, youth expressed the perception that programs are not well aligned to youth needs and wants (Figure 20). Almost every focus group discussed a program misalignment, sometimes resulting in youth running away, exiting early, or simply not showing up. The youth also pointed out that a lack of individualization resulted in low participation, which then impacts youth who do want to participate. Other youth expressed that services feel like a waste of time because activities are not relevant or interesting. These programs ranged from voluntary school-based services provided by the school or community

Figure 20. Program Misalignment



agencies on campus, as well as court or otherwise mandated programs or services such as foster care[19].

> *But like, most of us don't even want to go and then, so we don't even buy in 'til we're there and things start to […] go good there, then we start to buy in. But most of us don't even make it to that point, because […] we don't, we run. We just leave. We just stay there to sleep, eat, re-up on our energy, food, and dip.*

Minimum Effort from Providers. In almost half of the focus groups, youth described instances in which they felt their provider was not working hard enough. There was the sense that some professionals slacked at their jobs, pushing off tasks that ultimately impacted their quality of care. Youth discussed situations in which they felt uncared for by providers and lacking personal connections to them. In some focus groups, youth acknowledged that service providers may be overworked and underpaid.

> *… they get mentally drained from their job with so much cases, with so much kids to handle, that right before I turned 18, my social worker quit on me…And I was just so shocked…I know I was a handful, but how could you just quit because I'm about to turn 18. You're supposed to be there for me all the way 'til I turn into an adult, even afterwards because a caseworker is supposed to be in my eyes, is kinda like your voice as a foster youth. They're supposed to be telling the judge what you're wanting for yourself. So, when you're switching caseworkers all the time because they have too many cases, or you're moving too much, it's kind of overwhelming on both of you 'cuz they [are] working so hard, you're trying to get help, and… everybody's falling short.*

[19] During the interviews, we did not encourage youth to name specific agencies or individual staff members. We did not want youth to feel like they were being interrogated. In addition, many of these youth currently (or in the near future) may be participating in services provided by organizations or staff that they perceive to represent misalignment. We did not want these youth to feel like they were tattling or feel like they would risk being kicked out of programs, or not accepted by programs they have critiqued. The goal of the interviews was to collate their perceptions of the system as opposed to a specific entity. Furthermore, all transcripts were de-identified prior to data analysis – specific agencies, programs, services, and staff names have been blinded.

4. CONCLUSION

Reflections on the Pandemic. At the time of this writing (September 2021) the social, economic, and health strains of the pandemic are still upon us, in fact they have heightened due to the delta variant. Although there is hope among the Hawai`i population that ongoing efforts at vaccination and more restrictions on social gatherings will quell the current surge, mental health complications and substance use problems experienced by youth[20] are expected to continue to rise. For this needs assessment, we interviewed youth statewide in the Fall of 2020, several months after the state had ordered a general lock-down and had not yet initiated easing of these restrictions. The findings described here are based on youths' reflections on the system of care primarily from the years prior to the pandemic, as well as the initial six months during the pandemic (summer/fall 2020).

Summary of Findings and Potential Implications for Future Directions. As noted in the introduction, this qualitative youth needs assessment is a companion to the quantitative Hawai`i Student Alcohol, Tobacco, and Other Drug Use (ATOD) Survey needs assessment (report forthcoming). A benefit of this qualitative approach is that we have been able to learn about the system of care and continuum of care for youth substance use from the people who are best acquainted with it – namely youth with lived experience. Through the set of eight focus group discussions with 26 youth aged 14 to 21, these youth shed light on the findings from both the rapid assessment and the interviews with professionals[21]. Below are a set of potential implications (Table 6) for future directions.

Table 6. Potential Implications

System	Findings	Broad Implications
Individual	**Theme 1**: Trauma **Theme 2**: Coping	Universal SBIRT with a harm reduction/trauma informed care foundation - inclusive of both mental health and substance use, and acknowledges existing trauma as well as the potential for system trauma.
Micro	**Theme 3**: ATOD Services **Theme 4**: Getting in Trouble	Provide substance use services early and continuously throughout childhood, adolescence, and into emerging adulthood inclusive of prevention and education, as well as treatment and recovery. Improve the system of care to expand access so that youth do not have to get in to trouble to receive substance use services.
Meso	**Theme 5**: Peers have a Role in the System of Care **Theme 6**: School as Formal Social Support Network	Expand substance use intervention activities to include peer-to-peer programs, for example as has been effective in youth suicide prevention in Hawai`i[22]. These data affirm that youth rely on their school for much needed support. The substance use system of care would benefit from cross-sector professional development, such that leaders in the two state systems continue to work together on an integrated approach to care as well as professional development among school-based educators and school and community-based providers of care.
Exo Macro	**Theme 7**: Youth Identified Gaps	There appears to be a macro-cultural divide between youth who desire compassionate care and the system that is based on punitive action.

[20] https://www.civilbeat.org/2020/12/loneliness-anxiety-and-insomnia-how-the-pandemic-is-impacting-hawaiis-teens/
[21] Reports posted on the ADAD website: https://health.hawaii.gov/substance-abuse/files/2020/05/19-239_InterimReport_Helmetal_2020_200427.pdf , https://health.hawaii.gov/substance-abuse/files/2021/04/Youth-Needs-Assessment_Interviews-with-Professionals.pdf
[22] https://www.hawaii.edu/news/2021/04/13/youth-suicide-prevention-grant/

At the *individual level*, youth revealed personal histories of *trauma and coping*, both as a lead into the system of care as well as a result of being involved in the system of care. Universal Screening, Brief Intervention, and Referral to Treatment (SBIRT, see Appendix D) with a harm reduction/trauma informed care foundation would usefully emphasize of both mental health and substance use needs, and acknowledge existing trauma as well as the potential for system trauma.

It follows that the *micro level* analysis pointed toward the way in which youth access services. Specifically, youth expressed a nostalgia for the *substance use services* they fondly recall from elementary school to continue into middle and high school, and beyond. They expressed that these services paradoxically wane as youth age and become increasingly involved in substance use, and their narratives are a call for an intensification of services as youth age. A caveat to this was the one clear path to accessing services for adolescents seems to be by *getting in to trouble*, thus underlining the importance of improved SBIRT.

At the *meso level*, youth with lived experience in the public sector view the *peer context* both adversely and as an untapped source of informal support, and generally desire improvements in *The School* as a primary point of entry into service access. Peers have a role in the system of support, as it is commonly understood that kids lean on other kids for tacit and implicit life advice. These interviews affirm this is the case, and perhaps more so, among youth with lived experience in the system of care, possibly due to the extensive trauma they have experienced in the adult world. While the youth in these focus groups acknowledged that their peers do not have all the answers, and often can lead them astray, youth want their peers to be among their initial sources of support. Although, the system of care currently is not structured this way, there are examples of youth advocacy groups in foster care and peer support networks linked with caring and trained adults for suicide prevention in Hawai`i[23]. It would behoove the state system of care to seek ways to fortify participatory peer-led approaches across the system of care (substance use, mental health, juvenile justice, foster care, homelessness), as well as in schools. In addition to their peers, youth also rely on *The School* for support and to access substance use and other services. Given the myriad of shortcomings and concerns expressed by the youth, it also would behoove the two public agencies (Department of Education and Department of Health, Behavioral Health Administration-Alcohol and Drug Abuse Division) to work more formally on cross sector collaborations.

At the *exo and macro levels*, youth pointed to a cultural divide between themselves as youth who desire a system of care based on ideas of compassion rather than punitive action. This cultural divide at the macro level transcends the way the service system is structured at the exo-level. Specifically, there are not enough services that meet their interests and are accessible in ways that align with their inherent trauma-informed and harm reduction desire. Youth do not want to be perceived or labeled as problems, yet they must be labeled in order to get services. The experience of dehumanization that stems from macro and exo levels is acknowledged by youth when they share that the service providers seem to be overworked and do not have time to care for them. Clearly, these youths' narratives heed the call for increased investment in workforce development and professional development across the systems of care. A promising approach is to recruit youth with lived experience into the workforce, perhaps initially through peer advocacy and other participatory youth strategies, and then by guiding people with lived experience toward higher education and certification as a professional substance use counselor. This approach should extend beyond direct service roles, with intentional development so that providers (a.k.a. these youth) with lived experience are supported to ascend through the ranks to positions of authority and decision making that can inform and reshape the system.

[23] See articles by Goebert, Sugimoto-Matsuda, Chung-Do, Rehuher and colleagues, for example: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7260881/ , https://manoa.hawaii.edu/publichealth/directory/jeanelle-sugimoto-matsuda , https://digitalscholarship.unlv.edu/jhdrp/vol8/iss4/8/

5. Appendices.

Appendix A. HSP Letter.
Appendix B. Interview Orientation slides.
Appendix C. Webinar Flyer.
Appendix D. SBIRT Literature Review.
Appendix E. Glossary of Abbreviations.

Appendix A. HSP Letter

UNIVERSITY of HAWAI'I SYSTEM

Office of Research Compliance
Human Studies Program

TO:	Helm, Susan, PhD, University of Hawaii at Manoa, Psychiatry
FROM:	Rivera, Victoria, Dir, Ofc of Rsch Compliance, Social&Behav Exempt
PROTOCOL TITLE:	Special Populations Needs Assessment for Substance Use Prevention and Treatment Services - Program Evaluation for Providers\
FUNDING SOURCE:	
PROTOCOL NUMBER:	2019-00113
APPROVAL PERIOD:	Approval Date: February 15, 2019 Expiration Date:

NOT HUMAN SUBJECTS RESEARCH DETERMINATION

Dear Helm,

The above referenced study, and your participation as a principal investigator, was reviewed and determined to be Not Human Subjects Research (NHSR). As such, your activity falls outside the parameters of IRB review. You may conduct your study, without additional obligation to the IRB, as described in your application.

The NHSR Determination is based upon the following Federally provided definitions:

"Research" is defined by these regulations as " a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge."

The regulations define a **"Human Subject"** as "a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention or interaction with the individual, or identifiable private information."

All Human Subjects Research must be submitted to the IRB. If your study changes in such a way that it becomes Human Subjects Research please contact the Research Compliance office immediately for the appropriate course of action.

Please contact this office if you have any questions or require assistance.

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Biomedical Sciences Building B104
Honolulu, Hawai'I 96822
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Fax: (808) 956-8683
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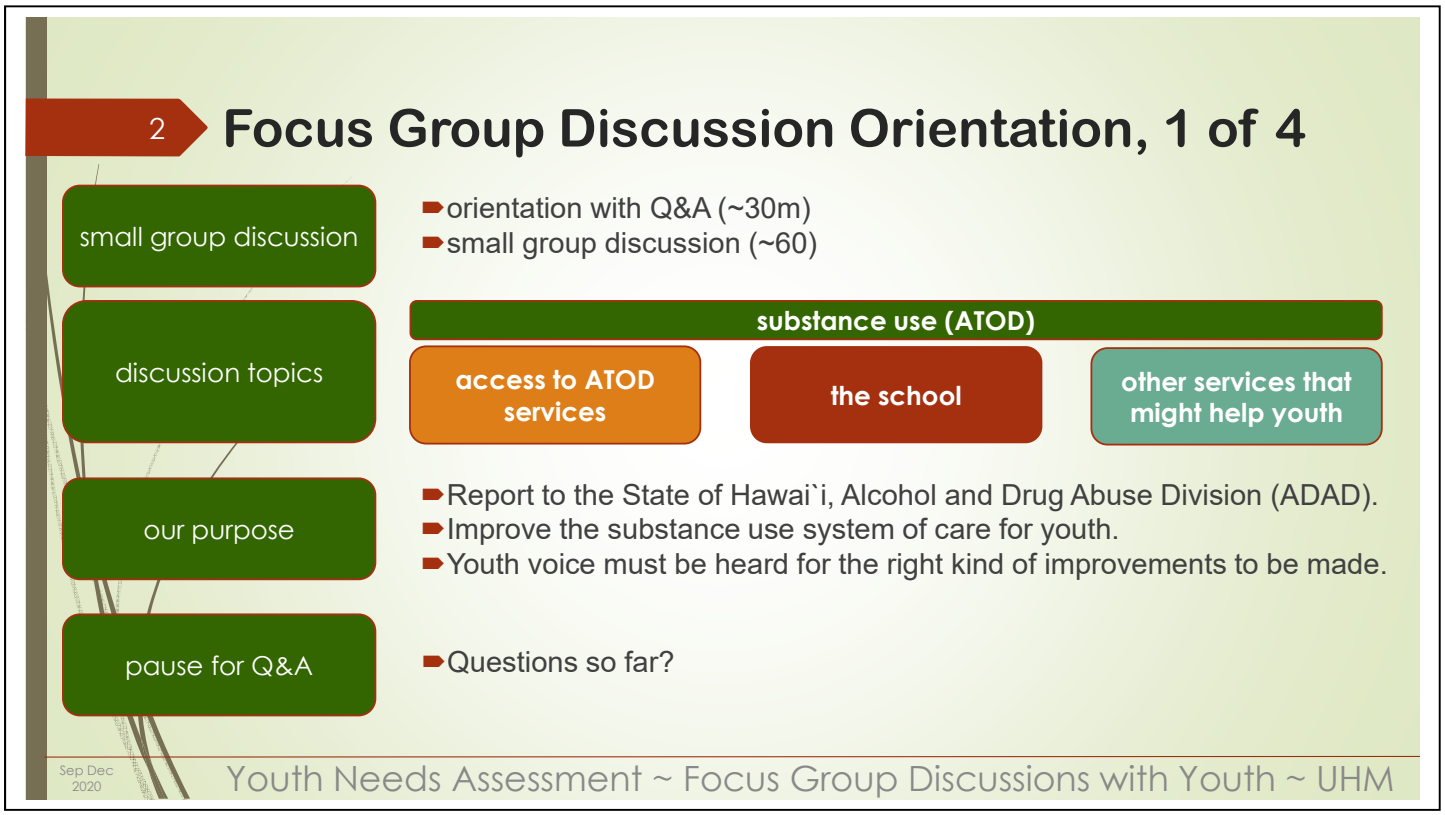
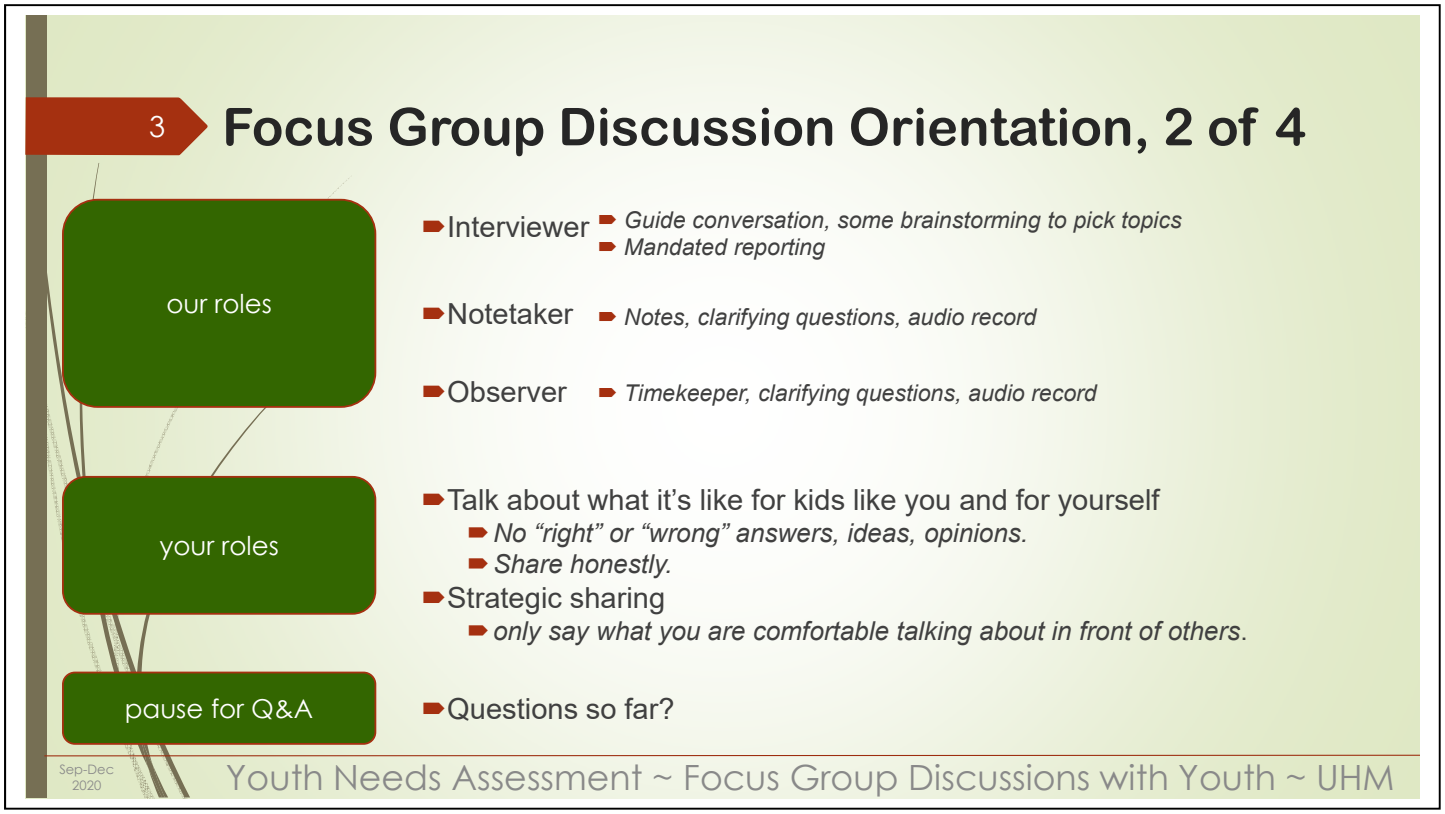
Appendix B. Interview Orientation Slides





4 Focus Group Discussion Orientation, 3 of 4

benefits & risks

- No direct benefit.
- We will mail a mahalo gift card to you.
- Voluntary, can take a break and/or stop at any time.
- Transcribe & de-identify 'data'.
- Request: respect each other's identity and what is shared.

protections, safety, ground rules

- No "right" or "wrong" answers, ideas, opinions…
  - *Build on each other's ideas.*
- Strategic sharing…
  - *What is said in the group, stays in the group*
- Everyone gets a turn (OK to pass, pause, stop).
- Limit distractions (e.g. silence cell phones)
- Other ideas???

pause for Q&A

- Questions so far?

5 Focus Group Discussion Orientation, 4 of 4

permission

- Permission to begin:
  - *Verbal consent/assent.*
  - *Say your **name** & **age**.*
  - *Then say if you agree to participate.*

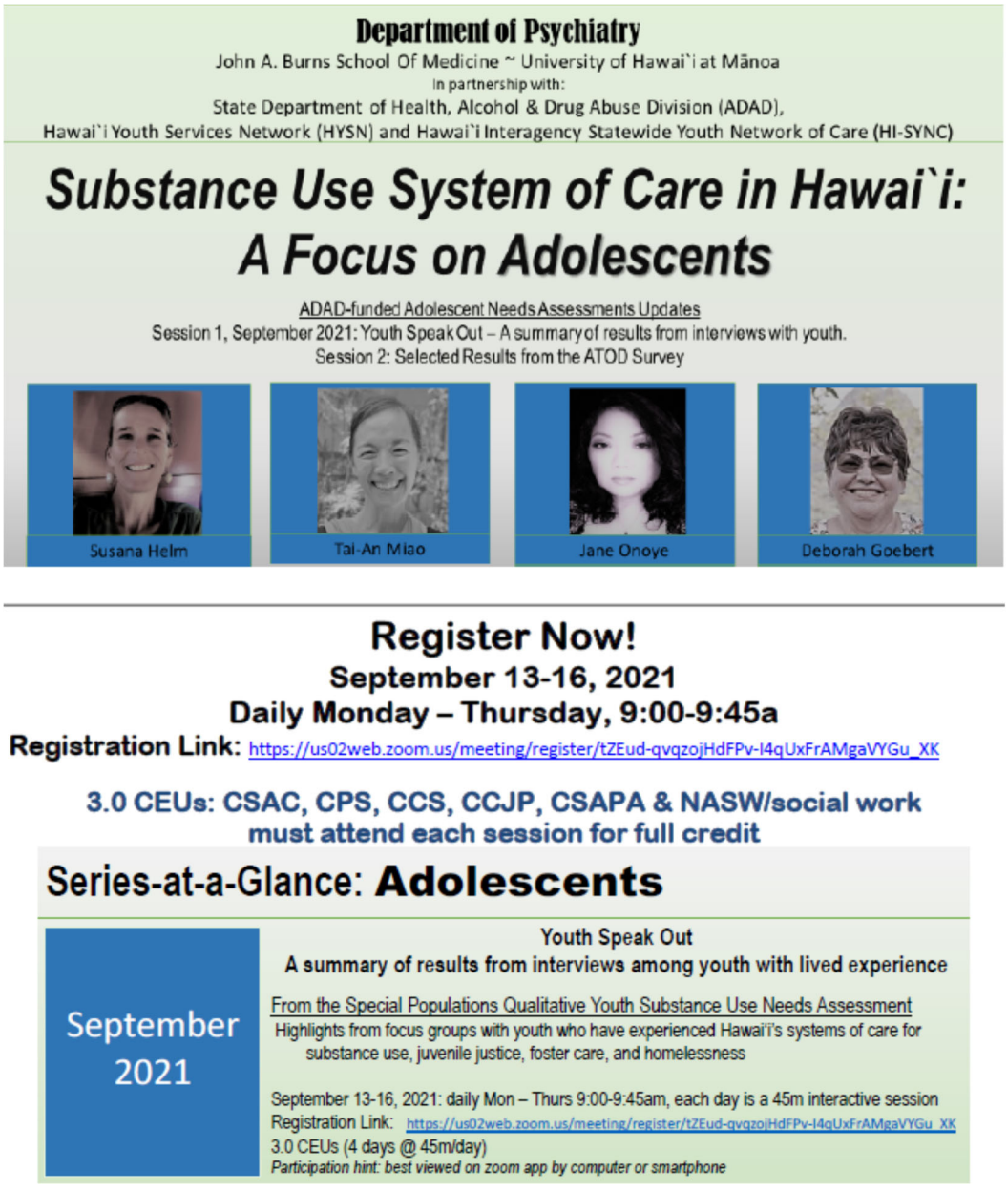
gift cards

- Your mailing address:
  - *type in the chat and/or say aloud.*

begin

- Audio check: *Make sure we can all hear one another*
- notetaker & observer: *audio recorders on.*
- Youth Group: *zoom audio & video on.*
- All: *Introduce ourselves*

Appendix C. Webinar Flyer



Appendix D. SBIRT Literature Review

Report title:
Screening, Brief Intervention, Referral for Treatment:
SBIRT for Youth Substance Use & Mental Health Brief Report for ADAD

Suggested Citation: Juberg M, Helm S, Miao T. (2021). *Screening, brief intervention, referral for treatment. SBIRT for youth substance use & mental health. Brief report for the State of Hawai`i Department of Health, Alcohol & Drug Abuse Division*. Unpublished Technical Report, Department of Psychiatry, University of Hawai`i at Mānoa, Honolulu HI.

I. Overview

Substance use at an early age has been linked to earlier onset of substance use disorders, lower academic performance, absenteeism, and greater rates of dropout (Community Catalyst, 2021; Volkow, Han, Einstein, & Compton, 2021). While the reasons for substance use initiation are myriad, youth with mental health problems often use drugs as a coping mechanism, which can further exacerbate these underlying conditions (Chadi, Li, Cerda, & Weitzman, 2019; Knight, Vickery, Faust et al., 2019). Adding to the problem, very few youth who would benefit from substance use interventions actually receive the help they need. For example, surveys conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimate 8% to 11% of adolescents who qualify for drug treatment received treatment from a specialty facility (Ahrnsbrak et al., 2019; Winters, 1999). In addition to substance use and mental health stigma, other systemic barriers to treatment include the lack of resources, treatment options, and accessibility (SAMHSA, 2005). One strategy to promote early identification is screening, brief intervention, referral to treatment (SBIRT), an evidence-based approach that is supported by the American Academy of Pediatrics (Levy & Williams, 2016).

II. Screening, Brief Intervention, Referral to Treatment (SBIRT)

SBIRT is an evidence-based approach to identify and screen those who engage in alcohol and other drug (AOD) use (Barbor, Del Boca, & Bray, 2017). SBIRT has three primary components to effect meaningful reductions in drug use and related risks, and may be conducted with adults and youth in a variety of clinical, school, and community settings (SAMHSA, 2013).

- The first component includes a brief screening for all types of substances with individualized feedback and advice. For youth who endorse substance use above a designated threshold in the screening phase, a full assessment may be conducted once referred for treatment.
- The second component is a brief intervention that helps youth become aware of risks of continued substance use, elicits internal motivation to change, and helps identify behavior-change goals. The brief intervention component is the hallmark of SBIRT and is theoretically and practically effective for youth. In particular, brief interventions are structured around a developmental theory of normative patterns of substance use. Brief interventions help youth to adjust their perception of normative drug use and may lead to further insight of their own problematic use. Motivational interviewing is the main approach for the brief intervention, characterized by a non-confrontational style that is better received by youth who see these drug problems as highly personal (Dubow, Lovke, & Kausch, 1990). Furthermore, the brief interventions focus on action-oriented goals that promote greater engagement as opposed to more lecture-oriented approaches (NIDA, 1997).
- The last component of SBIRT is the referral to treatment to connect adolescents to substance use treatment services. As mentioned above, youth who endorse substance use above a designated threshold in the screening phase may be referred to treatment, which would begin with a full assessment.

III. Evidence of SBIRT's Effectiveness

A growing body of research has validated SBIRT as an effective intervention strategy for youth in clinical and community settings (Community Catalyst, 2021). SBIRT originally was implemented by SAMHSA in 2003 in a variety of medical settings. In the SAMHSA cross-site study among one million screened youth, results showed clinically meaningful reductions in almost every measure of substance use (Barbor et al., 2017). Importantly, SBIRT implementation across

multiple sites was associated with improvements in treatment system equity, efficiency, and economy. Over the past two decades, advancements and innovations in SBIRT are refining its utility for mental health and substance use among youth.

School-based SBIRT implementation has been shown to be feasible, acceptable, and beneficial. One study in two urban New York schools suggested that nearly all students voluntarily accepted the brief intervention session and that this model had minimal academic interference (Curtis, McLellan, & Gabellini, 2014). Another large study conducted in Massachusetts prior to a statewide roll-out of school-based SBIRT showed that 74% of participants had a positive experience of school-based SBIRT (Chadi, Levy, Wisk, & Weitzman, 2020). Notably, the Massachusetts study documented that adolescents found it helpful to confide and seek information about drug use with an adult outside of the home.

Lastly, various school-based studies have indicated overall positive improvements for substance use across a number of substances (Mitchell et al., 2012; Winters & Leitten, 2007). These improvements included both reduced binging episodes and minimized drug related consequences, however data on the abstinence rates over a six-month period is mixed (Mitchell et al., 2012; Winters & Leitten, 2007). These studies have documented a higher degree of success when students received the brief intervention with parents than receiving the brief intervention alone. School-based interventions are more accessible than medical settings for youth (Clayton et al., 2010, Wagner et al., 2004, Weinstein, 2006) and have been found to be 21 times more likely to elicit visits for mental health issues, particularly for BIPOC youth and adolescent males (Juszczak, Melinkovich, & Kaplan, 2003).

IV. Recommendations

Best Practices with Youth. Each of the three components of the SBIRT framework incorporate recommendations based on evidence-based research, developmental theory, and access to services. Furthermore, the federal Office of Addiction Services and Support (OSAS) has approved three full screening instruments. Among these, the CRAFFT (1, used in Hawai`i) and the S2BI (2) appear most prominent, followed by NIAAA Alcohol Screening for Youth (3). The CRAFFT is an alcohol and drug behavioral health screening tool for use with children under the age of 21 and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse. It contains a series of six questions developed to screen adolescents for high-risk alcohol and other drug use disorders. The S2BI is a seven-item tool that assesses alcohol use among youth and adolescents between 12 and 17 years old. It specifically screens for tobacco, marijuana, prescription drugs, illegal drugs, inhalants, herbs or synthetic drugs. The NIAAA Alcohol Screening for Youth assesses the drinking habits of the youth's friends and then their own. Organizations interested in implementing SBIRT may benefit from SBIRT toolkits that include guides, skills practice and assessment, video trainings, webinars, and access to face-to-face trainings (Community Catalyst, 2021).

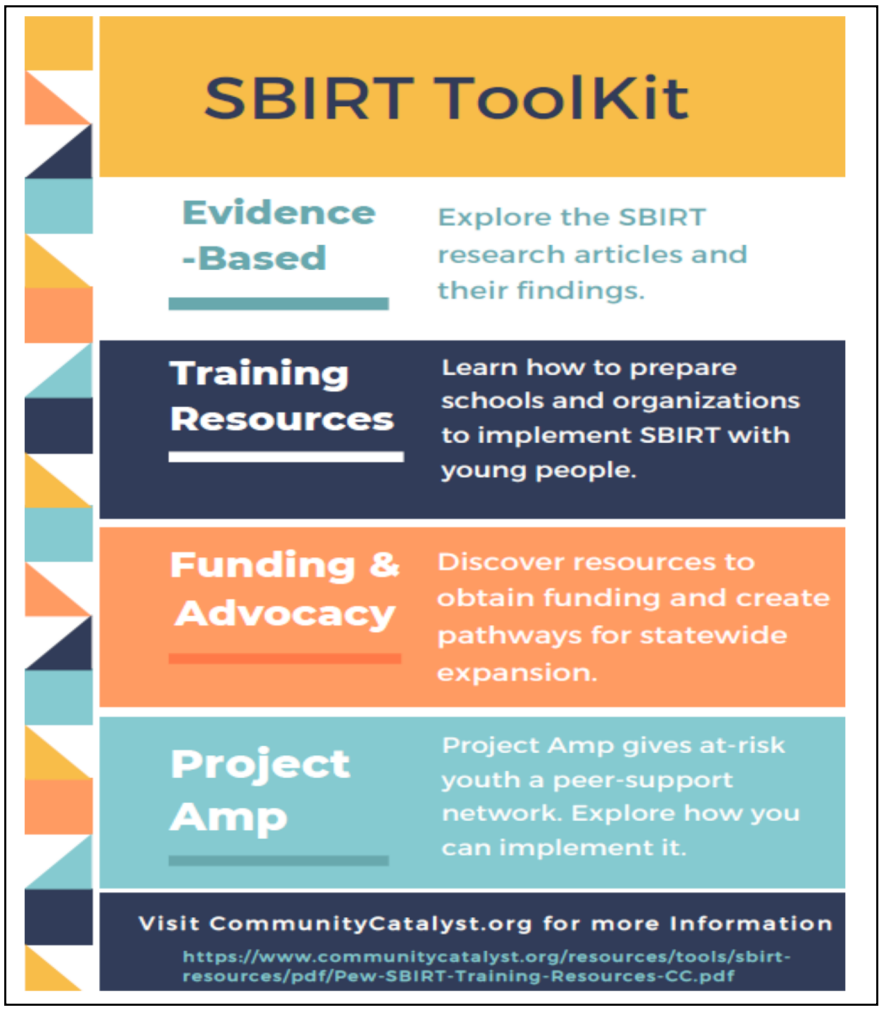
1. Knight, J. R., Sherritt, L., Shrier, L. A., Harris, S. K., & Chang, G. (2002). Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of pediatrics & adolescent medicine*, *156*(6), 607-614.
2. Levy, S., Weiss, R., Sherritt, L., Ziemnik, R., Spalding, A., Van Hook, S., & Shrier, L. A. (2014). An electronic screen for triaging adolescent substance use by risk levels. *JAMA pediatrics*, *168*(9), 822-828.
3. National Institute on Alcohol Abuse and Alcoholism (US). (2011). *Alcohol screening and brief intervention for youth: A practitioner's guide*. National Institute on Alcohol Abuse and Alcoholism, US Department of Health and Human Services, National Institutes of Health.

Implementation Fidelity Monitoring. Programs are encouraged to utilize the SBIRT Checklist for Observation in Real Time (SCORe), a protocol for assessing adherence to evidence-based SBIRT service delivery (Babor et al., 2017). SCORe gives providers a structured method to routinely monitor adherence and empowers them with an effective tool for program evaluation. Similarly, FRAMES (Feedback, Responsibility, Advice, Menu, Empathy, Self-efficacy) is a protocol for Motivational Interviewing, an essential component in most SBIRT protocols and also can be leveraged to monitor adherence.

Sustainability. Sustainability of SBIRT programs will depend on the ability to integrate best practices and fidelity monitoring into existing social systems of care in which youth participate –schools, community programs, and health care. Although pediatric primary care clinics traditionally have the infrastructure to integrate SBIRT, school-based systems are well-positioned to incorporate SBIRT practices to increase access and potentially submit for Medicaid reimbursements through certified school counselors, following lead of other states like New York (Curtis et al., 2014). Organizations can

access a compendium of resources that include strategies for developing advocacy campaigns, creating pathways for universal screenings in schools, and financing programs (Community Catalyst, 2021). This compendium also highlights the development of Project Amp, a peer-support strategy to close service gaps and reduce substance use among emerging adults.

Building on Lessons Learned. A number of limitations of SBIRT implementation must be considered based on lessons learned in the system of care. Research has documented students' concerns about confidentiality and potential repercussions (Mitchell et al., 2012), which may contribute to potential unwillingness to return to follow up appointments (Levy et al., 2020). Recommendations have been made to conduct SBIRT outside of schools or in a private space, increase training on confidentiality, incorporate the voices of youth at all stages of SBIRT implementation so the program remains youth-centered, maintain a focus on health promotion, and finally ensure that the disclosure of ATOD use does not result in disciplinary action (Chadi et al., 2020). Additionally, schools must to consider the need for additional training for school counselors to be able to navigate these barriers to treatment and provide effective evidence-based interventions. Notwithstanding these limitations, SBIRT offers a viable public health initiative by focusing on system level issues that can further protect the development of youth who may be using substances. The Community Catalyst compendium (2021, see graphic summary to the right) offers organizations the toolkit to facilitate the immediate implementation of SBIRT into their existing systems of care.



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Appendix E. Glossary of Terms and Abbreviations

Abbreviations

ADAD	Alcohol and Drug Abuse Division
ASAM	American Society of Addiction Medicine
ATOD	Alcohol, Tobacco, and Other Drugs
CAMHD	Child & Adolescent Mental Health Division
COFA	Compacts of Free Association
COVID-19	Coronavirus Disease of 2019
DoE	Department of Education
DoH	Department of Health
DoP	Department of Psychiatry
FC	Foster Care
HO	Homelessness
HSP	Human Studies Program
JJ	Juvenile Justice
LGBTQ+	Lesbian, gay, bisexual, transgender, queer, and others
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual, and others
MH	Mental Health
NH	Native Hawaiian
RPF	Risk and Protective Factors
SGM	Sexual and Gender Minorities
SU	Substance Use

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