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

Interim report – Protocol 1, Professional Views

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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This report has been prepared by the Research Division of the Department of Psychiatry (DoP-R), 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-R and ADAD.

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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 prevention and treatment 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 not included in school-based surveillance studies, but tend to have elevated and unique substance use prevention and treatment needs[1]. Five special populations of youth (Table 1) were identified through discussions with ADAD in Fall 2018 regarding substance use disparities. These five categories mirror state and national public sector services.

In addition to the five special populations of youth, other substance use disparities exist. These disparity groups may be described as medically underserved areas (rural) or medically underserved populations (Native Hawaiian; CoFA Nation ancestry/Micronesian, and sexual and gender minorities). The state population[2] shows that 68% of youth reside on O`ahu and 32% reside on the rural neighbor islands of Ni`ihau, Kaua`i, Molokai, Lanai, Maui, and Hawai`i Island. Table 2 highlights rural schools as well as Native Hawaiian and Micronesian student enrollment at public schools statewide. According to 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 experienced by these groups partially may exist as a result of institutionalized policies and practices that disadvantage these groups[4].

To ameliorate health disparities, concepts like cultural humility and cultural competence are important for public policy, health and wellness practices, and in social and health sciences. Used across disciplines (e.g. public health, social work) to analyze health disparities and create inclusivity, cultural competence is described as an end-point for which we are striving through cultural humility. The practice of cultural humility is a lifelong process of learning about others. Practicing cultural humility means maintaining a dynamic relationship and an attitude of openness to cultural identity that are most important to other persons or populations. Partnership building and advocacy are necessary to make systemic changes for equity among all people and cultures. This report is written in the spirit of cultural humility by highlighting special populations youth, inclusive of intersecting health disparities.

Table 1. Special Populations of Youth

Special Population			Description of Youth
1	Substance Use	SU	Current or prior participation in SU treatment program or service system
2	Mental Health	MH	Current or prior participation in MH services system
3	Juvenile Justice	JJ	Current or prior involvement in the JJ system
4	Foster Care	FC	Current or prior experience living in out of home placement in FC or kinship care
5	Homelessness	HO	Current or prior need for safe, permanent housing, either living with or without family

[1] The scope of this report does not include a literature review demonstrating the elevated need among these special population youth.

[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] 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

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

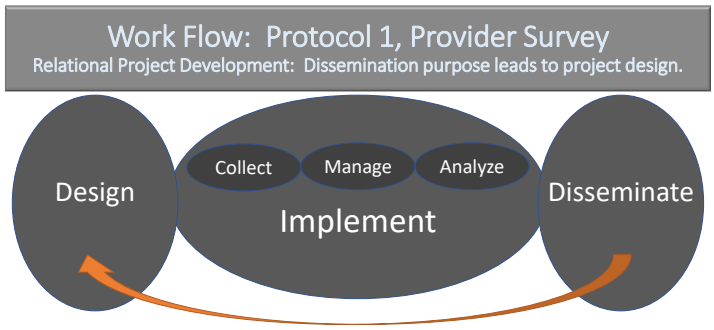
County	Island	Complex Area	Complex	Rural	Native Hawaiian %	CoFA Nation Ancestry/ Micronesian %	Total Enrollment
Kauai	Kaua`i	Kapa`a-Kaua`i-Waimea	Kapa`a	Yes	28*†	1	3,162
			Kaua`i	Yes	22	3	3,794
			Waimea	Yes	36*†	2	2,314
	Ni`ihau		Ni`ihau	Yes	100*†	0	9
Maui	Maui	Baldwin-Kekaulike-Maui	Baldwin	Yes	32*†	6*	4,359
			Kekaulike	Yes	33*†	2	4,275
			Maui	Yes	16	7*	7,328
		Lahainaluna-Hana-Lanai-Molokai	Lahainaluna	Yes	19	1	3,210
			Hana	Yes	78*†	0	348
	Lanai		Lanai	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-Waianae	Nanakuli	Yes	70*†	3	2,196
			Waianae	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. The DoP Research Division uses a relational approach to project development in which the client (ADAD) is engaged in discussions about the intended use and purpose of a project (dissemination). In collaboration, both groups define what will be disseminated and how, which then informs the project design accordingly, as depicted by the arrow in Figure 1. ADAD staff and DoP faculty collaboratively identified the health disparity groups through a series of meetings from August through November 2018.

Figure 1. Relational Project Design.



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, and a special populations needs assessment. Therefore, in addition to the 2019-2020 ATOD Youth Needs Assessment Study[6], which uses a quantitative design, this Special Populations Needs Assessment was designed using qualitative methods.

Statewide Youth Needs Assessment. Youth who are perceived to be most in need of ADAD-funded treatment services may be less likely to complete a school-based survey than youth who are unlikely to need adolescent treatment services, and/or their unique circumstances may be overlooked in standard survey techniques designed to protect anonymity. To compensate for this short-coming, DoP and ADAD collaboratively created 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 school age population in the State of Hawai`i, this qualitative needs assessment study was designed to highlight the unique needs of specific "special" populations of youth, their families, and professionals with experience caring for them. Together, the quantitative school-based surveillance and this in-depth qualitative study will provide a robust picture of youth substance use needs in the State of Hawai`i[7].

This "Interim Report" has been designed to capture the views of the professionals working with special populations of youth and their family as an initial step. The findings presented in this report have been shared with ADAD staff (November 2019 - March 2020) to gain clarity and to identify potential implications. This report collates these findings and implications prior to public dissemination. A community friendly report will be disseminated to participating agencies via email and in live community forums (virtual and live site visits to coincide with Protocol 2 data collection). ADAD may subsequently post these public materials for broader public use.

[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.

[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.

2. Project Design – Protocol 1

Design Overview. This youth needs assessment uses a two-protocol qualitative design (Table 3). This Interim Report presents findings from Protocol 1, in which professional views of 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). 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 - per agreement with ADAD.

An important step in gaining an understanding of the youth experience of the continuum of care and the system of care is to learn from the professionals who care for these youth across the continuum and system of care. We conducted a rapid needs assessment by quickly collecting professionals' views using a short answer response online survey in summer 2019. The results of which will be used to guide the in-depth needs assessment for Protocol 2 using face-to-face interviews. Protocol 2 is scheduled to occur in 2020-2021, and will use both virtual and live data collection techniques, pending covid19 safety guidelines.

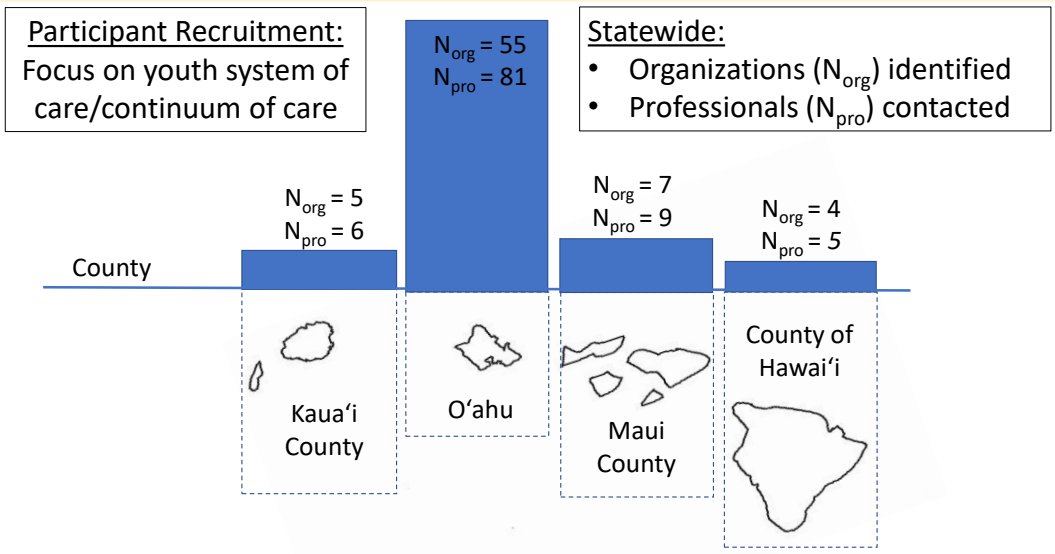
IRB Approval. This Needs Assessment was deemed "Not Human Subjects Research" by the University of Hawai`i Human Studies Program (HSP) because the primary purpose of the project was to fulfill a service contract with the state, as opposed to generalizable knowledge (refer to Appendix A for HSP letter).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

Statewide Sampling Framework. For each of the five special populations groups, a list was generated of 20-30 statewide service provider agencies from current (Spring 2019) and recent past ADAD-funded organizations, as well as other state, municipal, and private non-profit organizations. Organizations across the State of Hawai`i were identified as a means to ensure the inclusion of people working in rural contexts of care (i.e. neighbor island organizations). A total of 71 organizations were included in the sampling frame: 55 (77%) O`ahu organizations and 16 (23%) neighbor island organizations (Figure 2). Note that some organizations were large, with branches in multiple communities and sometimes on more than one island, and encompassing a large staff. Other organizations were small and served very specific geographic areas with a small staff. For the larger organizations, it was often the case that more than one staff participated, particularly if there were branches on more than one island. Ultimately, the statewide sampling framework resulted in a list of 101 potential participants, most of whom were affiliated with O`ahu-based organizations (74%).

Table 3. Project Design – Two Protocols.

Protocol 1: Rapid Needs Assessment	Protocol 2: In-depth Needs Assessment
Online Anonymous Survey	Face-to-Face Interviews
obtain the views of *professionals* who provide care to youth in one or more of the special populations groups	obtain the views of *youth* in each of the special populations groups and their *caregivers* (e.g. parents, *professionals)*

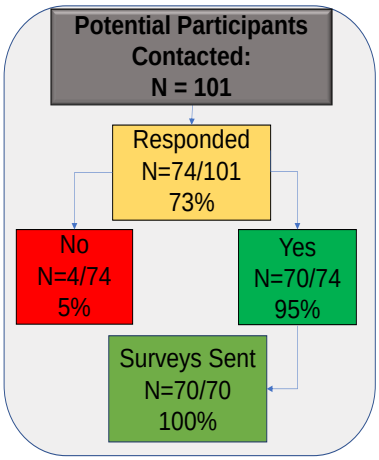
Figure 2. Statewide Sampling Framework



Participant Recruitment and Sample Description. Each organization's Executive Director was contacted via email by the Principal Investigator. The email included a letter of purpose from ADAD (refer to Appendix B for sample email and letter), and indicated that a DoP Special Populations project staff would follow up by email and phone to describe the project and elicit their organization's voluntary participation.

Of the 101 people contacted, 74 (73%) responded. Among the respondents, the majority (N=70, 95%) agreed to complete a survey. Those who agreed to complete the survey were offered a $25 gift card (some declined the gift card). Each of the 70 people who agreed to participate were sent a link to an anonymous online survey. A total of 50 surveys were completed and used in the analysis (Figure 3). Although DoP staff knew to whom the survey link was sent, responses were anonymous and no demographic data were collected.

Figure 3. Participant Recruitment & Sample Description.



Sample Size
Surveys Completed
N=50/70
71% completed

Special Population	N	%
Substance Use	10	20%
Mental Health	10	20%
Juvenile Justice	10	20%
Homelessness	9	18%
Foster Care	11	22%
Total	50	100%

Ten people completed the substance use version of the survey, 10 people completed the mental health version, 10 people completed the juvenile justice use version of the survey, 9 people completed homelessness version, and 11 people completed the foster care version.

Data Collection. The survey items were constructed collaboratively with ADAD staff to address five basic questions (Table 5), each with additional probing questions as well as questions regarding intersecting health disparities - rural, Native Hawaiian, CoFA Nation ancestry/Micronesian, and SGM populations. Five versions of the survey were created; one for each of the special populations (Appendix C). Participants were sent a link to a specified survey version based on their primary professional role in substance use, mental health, juvenile justice, foster care, or homelessness. Survey items were constructed as open-ended short answer responses (20 lines of 100 characters per line). Responses were downloaded to a word document to contain each participant's responses in a unique "transcript." Each transcript was single-spaced with size 10 Arial font and one-inch margins. A typical transcript was just over one page in length.

Table 5. Survey Questions

1	Needs	What are the substance use service <u>needs</u> among special populations youth?
2	Supports	What kinds of <u>support</u> is available to special populations youth?
3	Barriers	What are the <u>barriers</u> to accessing and using substance use prevention and treatment services?
4	Gaps	What are the <u>systemic gaps</u> in services?
5	Improvements	What are other <u>areas for improvement</u>?

Data were collected from June 2019 through August 2019. Upon agreeing to complete the survey, a link to the survey was emailed to the participant. The link remained active for one month. During that month a reminder/thank you email was sent each week. After one month, the link was deactivated and data were downloaded. Data collection occurred in seven waves staggered across seven weeks to ensure each special population group was represented evenly in the data collection, and that organizations serving the entire state were represented.

Data Management. Data management emphasized: a) ensuring responses were not identifiable to an individual, organization, or location; and b) creating uniformity in spelling and grammar for ease of analysis. Once these basic data management tasks were complete, the de-identified transcripts were content analyzed using a computer assisted qualitative data analysis software (NVivo, version 12).

Data Analysis: Group/Item and Eco-Developmental Domains. Each transcript was content analyzed by coding for group/item and eco-developmental domains. Then these codes were explored for overarching themes, as presented in the findings section.

Groups included the special population group to which the transcript belonged; the entire transcript was coded for a single group based on the participant's recruitment category. Within each transcript, each response was coded for the item to which it belonged. Content analysis by special population group allows for within group and cross group analysis to reveal trends or distinctions among the special population groups. Content analysis by item allows for each set of responses to be explored for a specified survey item, as well as within or across special population groups.

Each transcript also was coded by eco-developmental domains, as proposed. A brief background on eco-developmental domains is provided here as it relates to the field of youth substance use prevention and treatment services. The youth substance use services field has relied on a risk and protective factors (RPF) approach for over two decades. The RPF model is grounded in the theory of

human ecology.[8] The field of public health refers to this as the social ecological model, while developmental scientists refer to this as the eco-developmental model.[9] The main point is that individuals are embedded within multiple socio-cultural contexts: micro, meso, exo, macro, chrono. The influence of these contexts changes over time as a result of human growth and development.

Micro-level: The immediate systems and settings in which individuals find themselves. When applied to adolescence, the usual focus is one or more micro-level system or setting domain, e.g. family, peers, neighborhood, school.

Meso-level: Encompasses the dynamic interaction between a set of two or more micro settings, such as the school as a site for substance use service delivery.

Exo-level: Institutions that govern or structure micro and meso levels through policy, law, or other rules and guidelines.

Macro-level: Societal, philosophical, and cultural influences, such as democracy, capitalism, humanism, aloha āina, individualism, etc.

Chrono-level. Historical eras that represent qualitative change over time, such as the destigmatization of mental health, or reframing addiction as a chronic disease.

For the content analysis, micro and meso level settings of the individual, family, peer, school, and community, were coded. At the macro-level, geo-spatial (rural) and cultural assets and barriers were coded. These data were not coded for chrono-level issues, as a preliminary review of the transcripts indicated a lack of data in this category. At the meso and exo-level, the continuum of care and the system of care were coded. Among these, access to care is focal point for the meso and exo level regarding the continuum of care and the system of care. Access to health care is multidimensional and involves dynamic interactions between health services (supply) and population characteristics (demand)[10]. Seven key dimensions of access are acceptability, accommodation, affordability, availability, awareness, geography, and, timeliness.

Acceptability. The service and provider must be socially and culturally acceptable to consumers.

Accommodation. How health care resources are organized; and the ease of consumers to contact, gain entry to, and navigate the system.

Affordability. Consumers' ability to meet incurred costs for health care.

Availability. Volume and types of services match population needs.

Awareness. The communication of health and health system information to consumers; and the consumers' understanding of their health needs and knowledge of how to have these needs met.

Geography. Proximity of services and providers and ease of mobility to services by consumers.

Timeliness. Time until care can be received by consumers.

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

[9] 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.

[10] Russell, D. J., Humphreys, J. S., Ward, B., Chisholm, M., Buykx, P., Mcgrail, M., & Wakerman, J. (2013). Helping policy-makers address rural health access problems. *Australian Journal of Rural Health, 21*(2), 61-71. doi:10.1111/ajr.12023

3. Findings – Protocol 1

Overview. Findings are presented as five inter-related themes that emerged from the content analysis. For each theme, there is a narrative description along with one or more data visualization graphics. For some themes, there is an accompanying quote or set of quotes excerpted from the transcripts (indented, italicized, narrow font). It should be noted that professionals' responses highlighted youth treatment as opposed to prevention activities.

- ***Theme 1****: Pathways to Accessing Services.*
- ***Theme 2****: The School as a Partner.*
- ***Theme 3****: Continuum of Care, System of Care.*
- ***Theme 4****: Health Disparity Groups-Hawaiian, Micronesian, Sexual & Gender Minorities.*
- ***Theme 5****: Rural Health Disparities.*

Theme 1: Pathways to Accessing Services

This project was designed to explore unique and common experiences delineated by the five special population groups. It was expected that participating professionals would identify unique experiences based on the youths primary concern - substance use (SU); mental health; homelessness (HO); juvenile justice (JJ); or foster/kinship care (FC). The analysis of professionals' responses indicated that youth may be distinguished by the pathway in which they are able to access substance use prevention and treatment services, as opposed to whether the youth's primary concern was substance use, mental health, juvenile justice, foster care, or homelessness. Professionals' responses indicated that there are two pathways. One pathway appears to apply to youth involved in public sector services. The second pathway appears to apply to youth who are reliant on the school referrals to access adolescent treatment. Regardless of the pathway, professionals described numerous systemic barriers to accessing treatment (Figure 4).

> *How does a young person tell an adult, especially one they see once a month, that they need help? How does a young person tell a foster parent something that may get them kicked out of their home. Where is it safe to have these conversations? How does a young person feel comfortable seeking out substance abuse treatment at school, surrounded by all of their peers, on top of already being the foster kid in class…. And where are the adults trained to help the kids struggling with their substance use?*

Pathway 1: Public Sector Involvement. *Included in this pathway are youth with cases in the juvenile justice or foster/kinship care systems, and to a certain extent youth with more serious mental health care needs such as those receiving care with CAMHD.*

These youth were perceived by professionals to fear punitive action if they were to disclose their substance use, and thus would be filtered out of or delayed in accessing treatment. Youth may be concerned that their self-disclosed substance use may result in lengthy or severe juvenile justice involvement, foster placement problems, or further mental health stigmatization. Among youth who disclose their need or whose need is disclosed for them, accessing substance use services appears to depend on their state appointed case manager to refer them for services. In contrast to youth who are perceived to rely on the school-based referral pathway, youth involved in public sector services may benefit from their existing case management. Youth involved with juvenile justice, the foster and kinship system, or under CAMHD supervision for mental health concerns were perceived to access resources

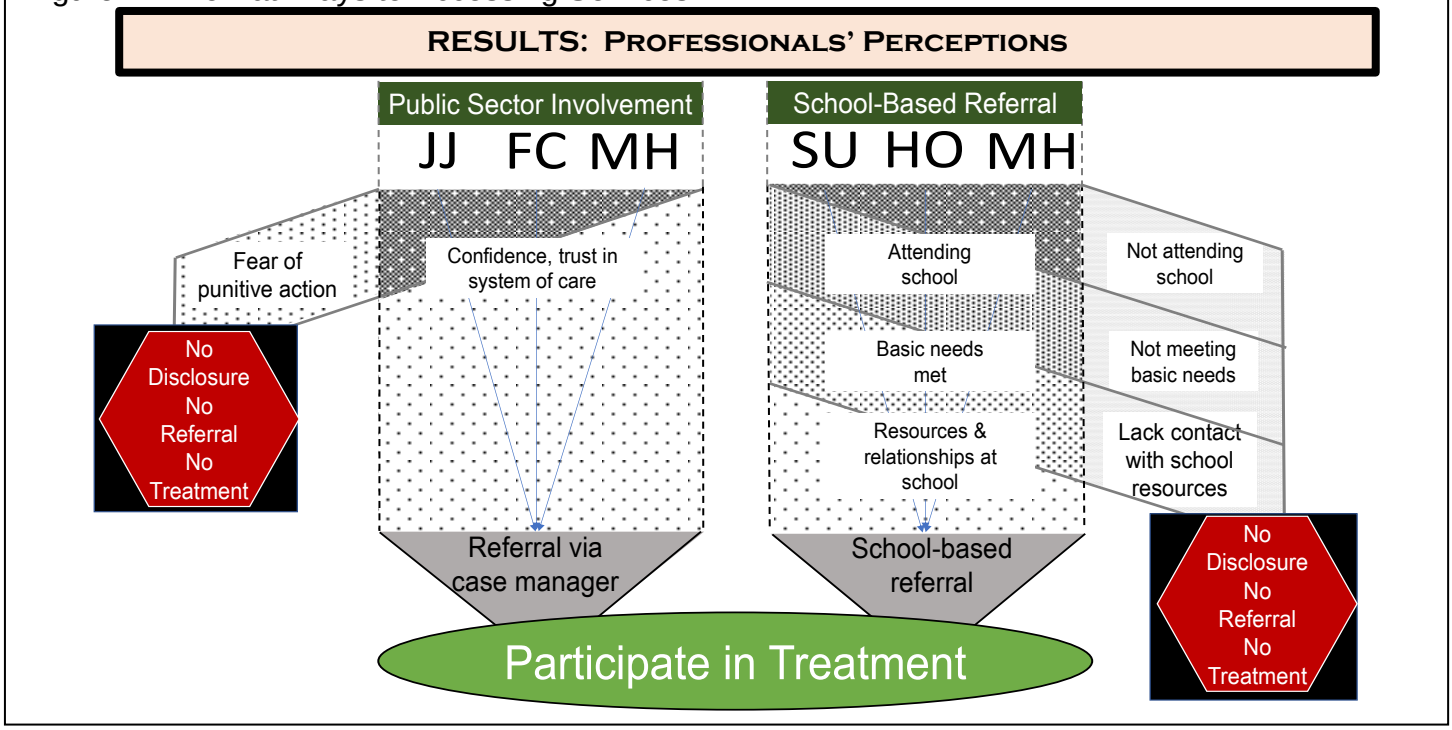
through caseworkers, drug court, or other judiciary representatives. Professionals perceived that these youth were receiving necessary services, though not necessarily in a timely manner.

Pathway 2: School-Based Referral. *Included in this pathway are youth who are not involved in public sector services and therefore rely on school referrals, such as youth with elevated substance use service needs, youth living in unstable housing or homeless conditions, and youth with less serious mental/behavioral health problems.*

This pathway begins with being identified at school, according to professionals. Youth were perceived to access ADAD-funded adolescent treatment services through a school referral. However, there were several obstacles in the school referral pathway.

Some youth may not attend school or may not attend regularly in part due to their elevated need for substance use services, mental/behavioral health status, or unstable housing. Youth not attending school (regularly) likely will not be referred to school-based services, simply because they are not noticed. Another obstacle pertains to basic needs, such as unstable housing. Among youth whose basic needs are not being met, the concern for their basic needs may supersede a concern for referral to drug treatment. These youth may not be referred or the referral may be put on hold. Among youth who attend school regularly and whose basic needs are not in question, self-referral or referral by a peer or other person at the school may be impeded when school-based resources regarding substance use prevention and treatment are not clear. School-based health education and school-based services were perceived to be important but somewhat elusive and idiosyncratic – at what point does one refer, to whom does one refer a youth, how does one refer a youth.

Figure 4. Two Pathways to Accessing Services.



Theme 2: The School as a Partner

Nearly half of professionals expressed ideas about "The School" as a partner in the substance use continuum of care and system of care (*N*=24, 48%). Related to the school being perceived as one of two pathways to accessing services as noted in Theme 1, the school was perceived to be a resource for anti-drug norms and activities, and thus a place where self-referral may be a viable option. Note that professionals did not distinguished between services that were delivered by ADAD-funded community providers co-located at the school or if the school itself was delivering a service. Similarly, professionals referred to "counselors," but did not distinguish between counselors employed by ADAD-funded community providers or counselors employed by the Department of Education or other counselor that may be working at the school.

***The School as a Resource*.** The most prominent issue about The School concerned youths' exposure to resources for drug prevention and treatment (*N*=21, 42%; Figure 5). Generally, The School was idealized as a resource hub, and professionals expressed both high expectations as well as numerous barriers. The School was expected to be a place in which substance use prevention education occurs in the form of classroom curricula and by providing information regarding related resources. The School was expected to be a place in which adults are aware of the signs of adolescent substance use and thus would be able and willing to reach out to students in need. However, professionals expressed concern for students who are not in school due to inconsistent attendance, home schooling, drop-out, or suspension. Similarly, when students do not attend school, adults (e.g. teachers, counselors) and peers on campus are not aware of potential substance use issues and are thus unable to extend assistance to those youths in particular.

> *Kids not coming to school. Though we have truancy laws and educational neglect rules, they aren't enforced. Some of that is caused by a lack of funding. The Judiciary tried to address truancy in the DOE a few years ago, but not much has changed. When kids drop out of sight, it's hard to help them. And when they are in school, teachers need to be willing to release them in order for them to be seen. Addressing their substance use disorders will help them improve in school, but it's hard for teachers to see that at times. … There seems to be a lack of awareness that our state-funded SU treatment programs are evidence-based and use group curriculum that has shown to be effective in treating SUD. We are fortunate to have law in Hawaii that allows minors to access substance use disorder treatment without parental consent - it's a huge help in reducing barriers.*

> *Youth are suspended/expelled from school for violating substance free policy and DOE does not refer to outpatient or allow youth to attend school level services.*

***The School as a Site for Self-Referral*.** Professionals described The School as a site for self-referral albeit self-referral was perceived to be a barrier to care (*N*=7, 14%). Self-referral not only would require school attendance, it also would require the presence of well-trained and attentive school-based staff. Even when present at school, youth were perceived to be disincentivized from self-reporting due to stigma and shame surrounding help-seeking, a lack of counseling personnel whom youth can trust, and fear of punitive action toward substance use (Figure 6). Professionals believe that youth favor maintaining confidentiality and avoiding family and school disciplinary action over self-referral.

> *Youths will not seek help and will only get treatment when they are caught. Very few will self-evaluate themselves and realize they have an issue. We believe that it's about information and education, then providing*

youths with a safe place to get help, ongoing youth support to the entire school, not just for those with the issues. So many kids hide their mental illness and substance use until it is too late.

The Rural School. The School is perceived to be a fundamental system partner in rural communities, both explicitly (*N*=3, 6%) and implicitly (*N*=22, 44%). While relatively few professionals mentioned schools in a rural context, nearly half of the professionals implicitly emphasized the role of the school in rural communities by referencing transportation (Figure 7; *N*=22, 44%). Professionals commented that rural areas are unlikely to have youth substance use resources except those provided at their school. In contrast, urban areas were perceived to have dense service availability beyond those which were co-located on school campuses. Professionals emphasized the combination of rural geography (distance) and limited public transportation impeded access, unless services were co-located at The Rural School.

Transportation is major barrier for youth to access care. Many youth do not have the means to be able to attend appointments or programs, and resources are not offered within the school system.

System-Level Communication Problems. Nearly half of the professionals considered The School to be a crucial partner in the youth substance use continuum of care and system of care, yet the partnership was characterized as fraught with communication and related problems (Figure 8; *N*=9, 18%). A general lack of communication produced confusion about contract expectations and the role of the ADAD-funded community-provider at the school. Professionals noted miscommunication regarding how The School learns about community services (ADAD-funded or otherwise), including those which may be co-located at the school. Professionals expressed frustration about miscommunication leading to service duplication as well as service gaps. Professionals stressed the need for interagency contact between the Department of Health and the Department of Education, such as data-sharing.

… the substance use prevention program is available to the school, yet either the decision makers are not getting back to the service provider with a yes or no answer. The services are free, yet there is not communication from the school.

The collaboration between DOE, DOH, and CWS needs to be much stronger. … Sometimes there are disagreements about who should pay for needed treatment between the agencies.

Figure 5. The School as a Resource.

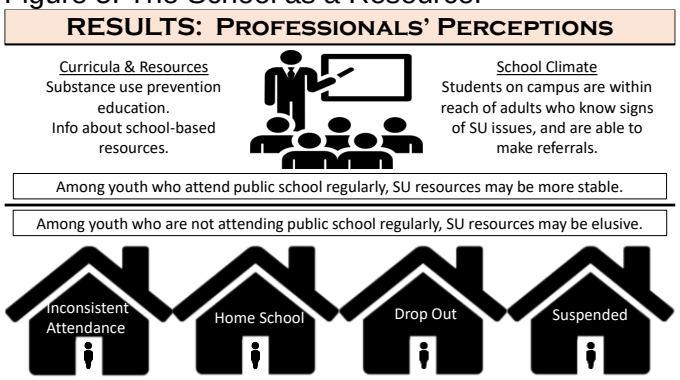


Figure 6. Impediments to Self-Referral.

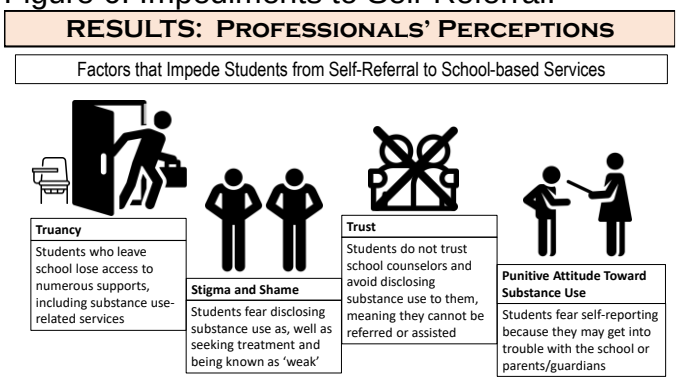


Figure 7. The Rural School.

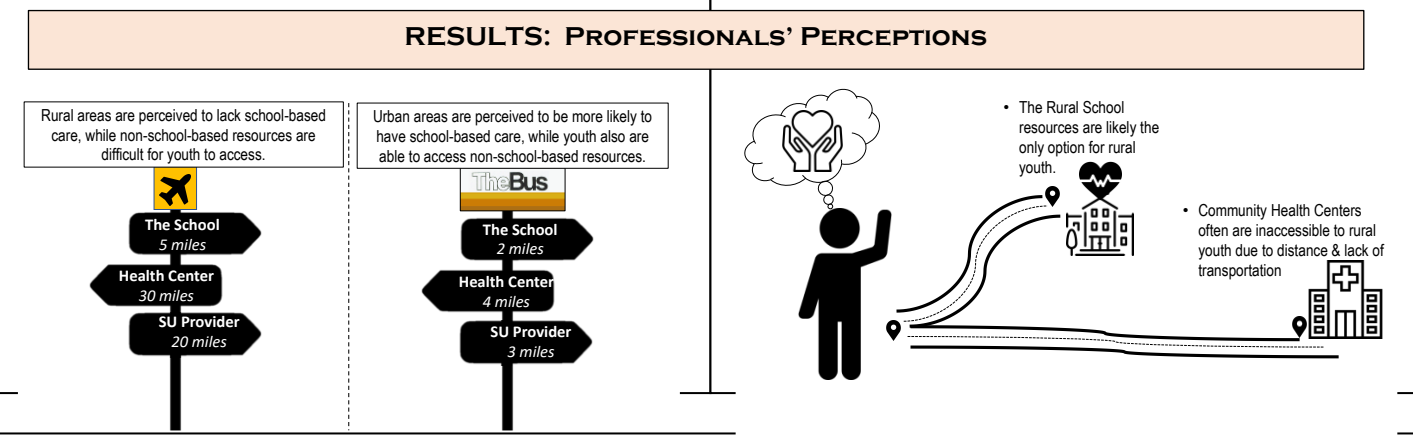
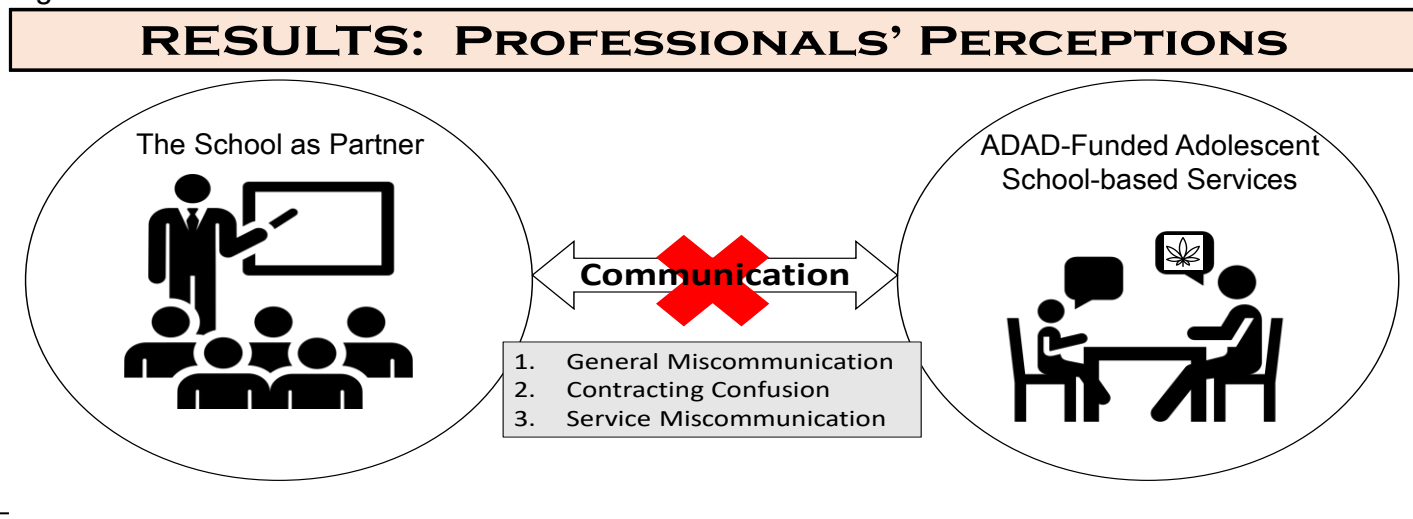


Figure 8. Communication Problems.



Theme 3: Continuum of Care, System of Care

Moving beyond The School as Partner, broader issues were expressed about the continuum of care and system of care. The most prominent perception was that the continuum of care is marred by a variety of service gaps. Furthermore, nearly a fifth of professionals noted problems with navigating and accessing existing services in the ADAD system of care (which may intersect with other youth care systems.

Service Gaps in the Continuum of Care. Service gaps across the continuum of care emerged as a major theme. With the exception of one respondent, participating professionals mentioned issues with service availability and gaps in the continuum of care (*N*=49, 98%). Reflecting the perceptions of professionals, Figure 9 depicts the continuum of care as a triangle. The points below the triangle indicate service types along the continuum of care in ascending order of treatment intensity as referenced by professionals; moving from health promotion to prevention, to early intervention, then outpatient treatment, and finally to intensive outpatient and residential care. Notably, these service types align well with ASAM placement levels, though not exactly. The peak of the triangle indicates greater service availability and the base suggests service gaps. Beginning with health promotion, such as afterschool sports or mentorship, these programs were perceived to exist albeit in need of funding. Prevention efforts were seen as more abundant than other types of programs, but beyond the reach of some youth due to cultural, geographic, and economic factors. Further along the continuum of care where services are deemed to be treatment, resources were perceived as less accessible. Both early intervention and outpatient services were discussed as lacking. Finally, professionals (*N*=16, 32%) identified major service gaps for intensive inpatient and residential treatment services.

> *Prevention and education is currently very limited. While our agency is working with our community outreach team to provide education for youth in regard to vaping, it is our understanding that other substance use issues are not being addressed.*
>
> *There aren't early interventions in place. Prevention education is great, but there isn't a confidential way for a youth who has just started using, or uses inconsistently, to receive services. Also, the after care for teens is non-existent.*
>
> *Some of the barriers are lack of outreach workers for that specific group of clients, residential treatment centers specifically for youth, funding for said treatment centers so service are free for participants, and continued support for youth that have completed treatment, including but limited to life skills, job training, and continuing education. There is definitely a need for affordable residential treatment services that can also provide follow-up care for an extended period of time. Our students who have participated in residential treatment services "graduated" and received no support thereafter.*

Navigating Referrals and Accessing Existing Services in the System of Care. In addition to challenges related to the continuum of care, other factors were perceived to make the service system hard to navigate for both youth and professionals (Figure 10). Close to one-fifth (*N*=9, 18%) of the survey participants described navigational problems, such that making referrals is perceived as a lengthy and overly complicated process due to idiosyncratic factors with the various state agencies and community providers. Referral problems included a lack of knowledge among professionals regarding programs, services, and other resources; the need for referrals to occur earlier; and that system navigation requires time and funds.

Youth often become bitter once they are involved in the juvenile justice system, which makes it more difficult for substance abuse/misuse counselors to build trust with youth as they feel like they are being punished by the system, their Probation Officers, or their parents. Once they are at this point, the substance use services are mandated by those coordinating their care and youth are less receptive than perhaps they would have been had there been intervention earlier. There needs to be more early intervention and providing services/referrals in the community to youth/families before they are in involved with the JJ system; increase in preventative services. The solution lies in being Proactive, not Reactive.

Figure 9. Service Gaps in the Continuum of Care.

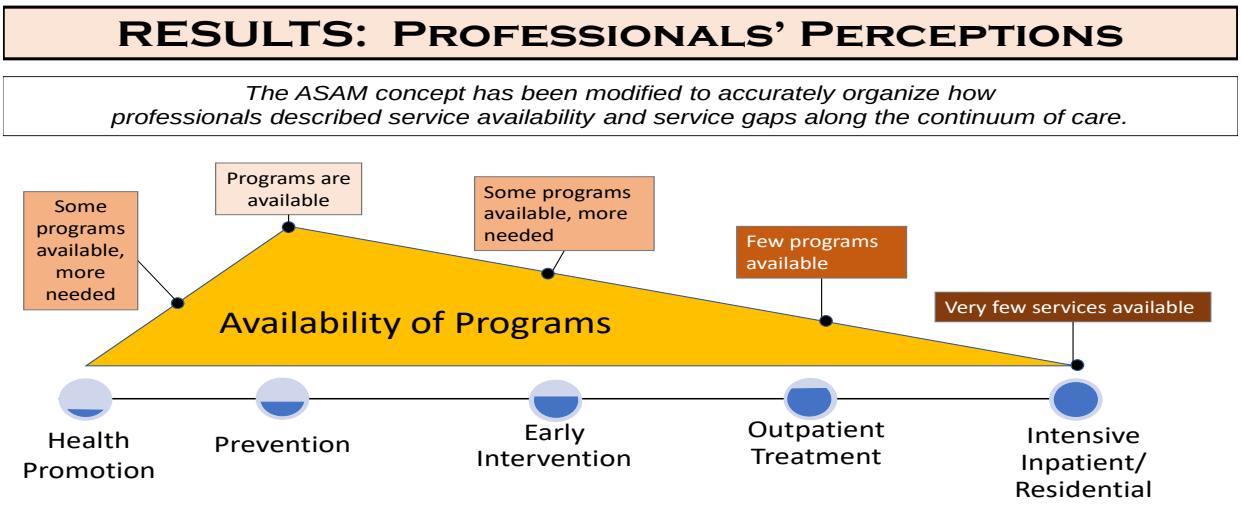
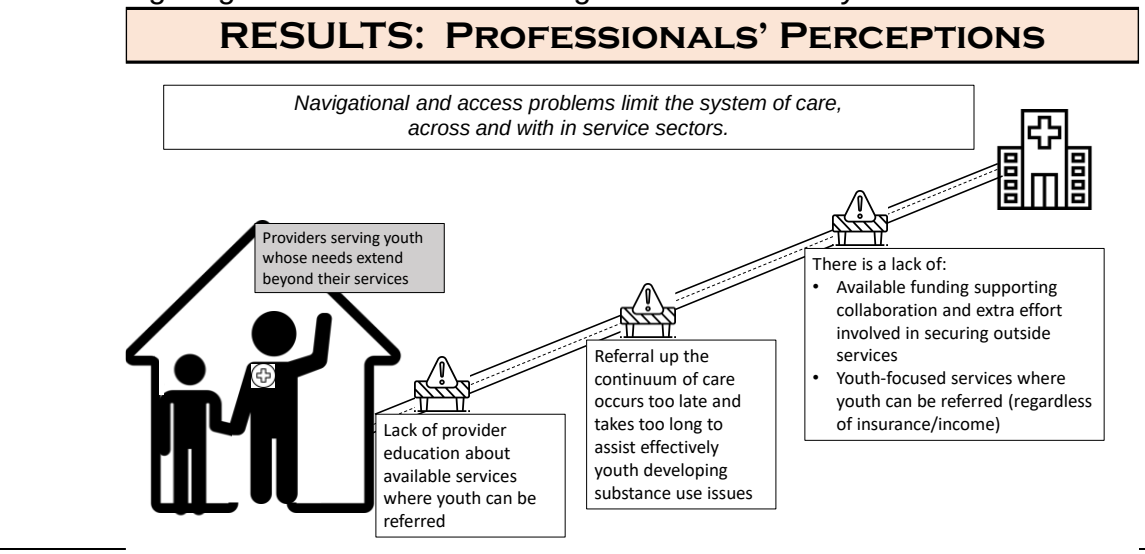


Figure 10. Navigating Referrals and Accessing Services in the System of Care.



Theme 4: Health Disparity Groups - Hawaiian, Micronesian, Sexual & Gender Minorities

This project was designed to gain insights about youth substance use disparity populations in Hawai`i, specifically youth of Native Hawaiian and CoFA Nation/Micronesian ancestry, as well as youth who identify as sexual or gender minorities. Professionals described both facilitators and barriers to care.

Regarding facilitators, professionals highlighted the benefit of having providers who were of the same population as the youth they serve, referred to as cultural matching. Cultural competence training in Native Hawaiian and Micronesian issues, as well as training in SGM issues were considered important. Specific to Native Hawaiians, professionals suggested building programs into existing cultural systems. Specific to SGM youth, professionals stated the need to eradicate heteronormative attitudes among staff.

Regarding barriers (Figure 11), 29 professionals (58%) described gaps related to Native Hawaiian youth, 20 professionals (40%) identified gaps related to Micronesian youth, and 27 professionals (54%) singled out gaps related to SGM youth. Professionals believed that among Native Hawaiian communities, there is a general lack of trust for state-based institutions, stemming in part from historical and on-going cultural traumas. They also noted a lack of cultural relevant programs. Micronesian youth were perceived to be faced with a health care system that is incomprehensible and does not serve them in their preferred language, causing additional barriers. For SGM youth, the cisnormative and heteronormative service system is characterized as the main barrier, with specific issues due to the lack of transgender and gender non-conforming services, such as residential substance use services.

> On Native Hawaiian Disparities:
> *…historical trauma in the case of NH children and a high rate of family members who use/misuse substances.*
>
> *There are Native Hawaiian substance abuse treatment services for adults, but the offerings are slim to almost non-existent for youth.*
>
> *[Native Hawaiian] families may prefer cultural practices rather than formal evidence based interventions. These families may also be at higher risk of poverty. This may make it more difficult to access insurance based services.*
>
> *[regarding Native Hawaiians] Lack of cultural competency among providers- we need to do more to understand their values. Cultural trauma-losing land and water rights, gentrification. Very few NH men serving in social service positions to serve as role models.*
>
> On CoFA Nationa/Micronesian Disparities:
> *There is a lack of substance use prevention and treatment services for all kids in Hawaii, this is made even more difficult with the language challenges and cultural differences between CoFA nations and western practice. While people know that there are entities available…there are not resources specific to SUD prevention and treatment for this population.*
>
> *There is a lack of education/training about how to better serve this population. We have been trying to find trainers to talk about CoFA issues and haven't been able to find anyone to provide education to help us more effectively serve this population. Translation, particularly for parents, and transportation are issues. Even when there is a rate to pay for these, it rarely covers the actual cost.*

Barriers to mental health care apply to all Micronesians: language, cultural, racism and discrimination (structural and individual), stigma against Micronesians, health literacy, lack of insurance, lack of affordability. For Micronesian youth, in addition to above, bullying from students, and racism, discrimination, and ignorance of Micronesian cultural norms from teachers, counselors, and school administrators.

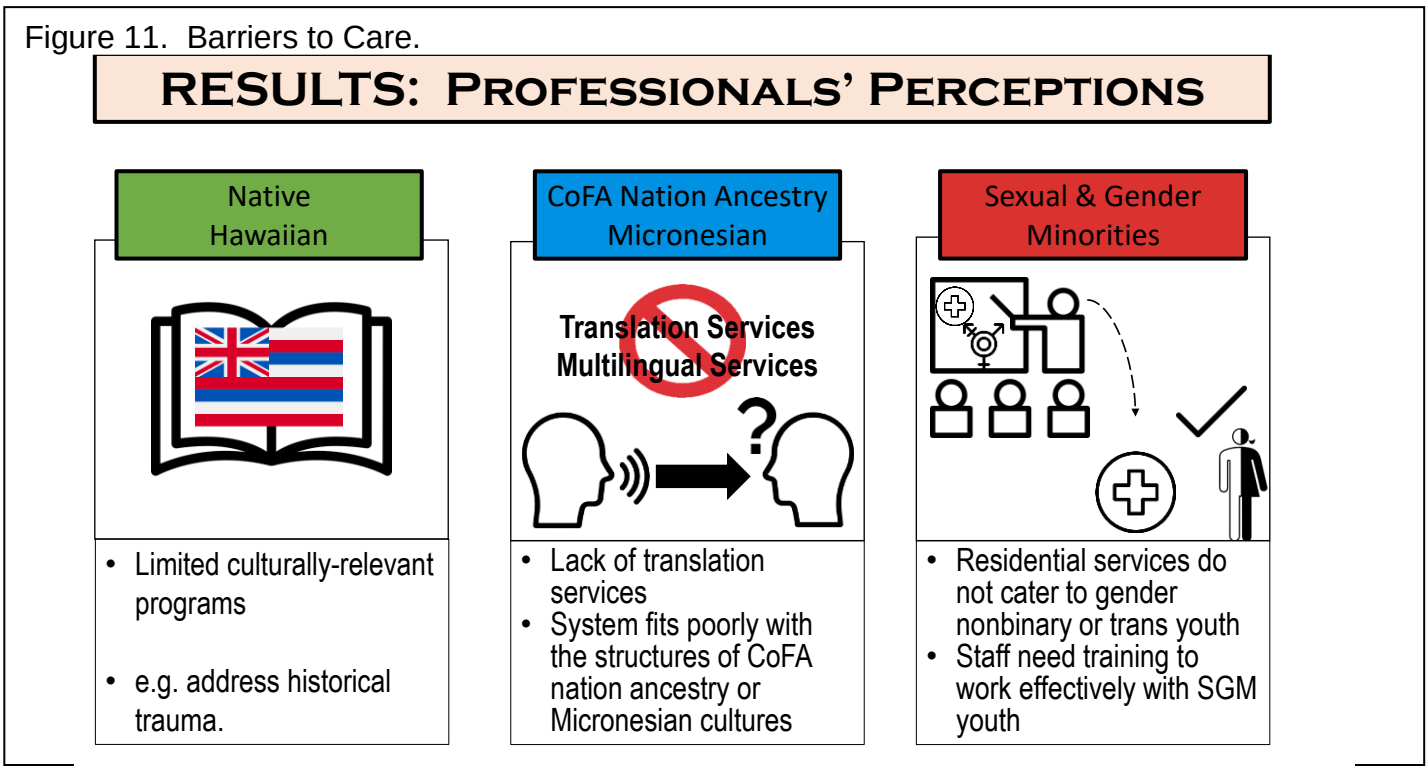
On Sexual & Gender Minority Disparities:

For starters, transgender medicine is a field that is not addressed nearly enough in the majority of medical schools. There are not enough transgender navigators in health care. There are gender defined substance abuse centers, facilities, shelter (such as woman's way) that do GREAT work but do not always have policies in place to care for gender minorities or youth. I recently was listening to a podcast that estimated transgender youth was anywhere from 4-6x more likely to attempt suicide and at much greater risk of substance abuse. I think part of the problem is linkage to care. If there were more providers who were comfortable with the general medical needs of sexual and gender minorities and that rapport was built, the mental and substance abuse component could be better addressed. I think we have come a long way in the care of men who identify themselves as homosexual/ MSM but there are still so many barriers for transgender males and females.

Youth who are LGBTQ+ do not have access to LGBTQ+ specific treatment and I think the closest that we come is substance abuse treatment in conjunction with gender-specific or identity-specific counseling which is extremely hard to find.

Providers need to be comfortable with their own feelings and beliefs about sexual and gender minorities and need constant support from supervisors.

Figure 11. Barriers to Care.



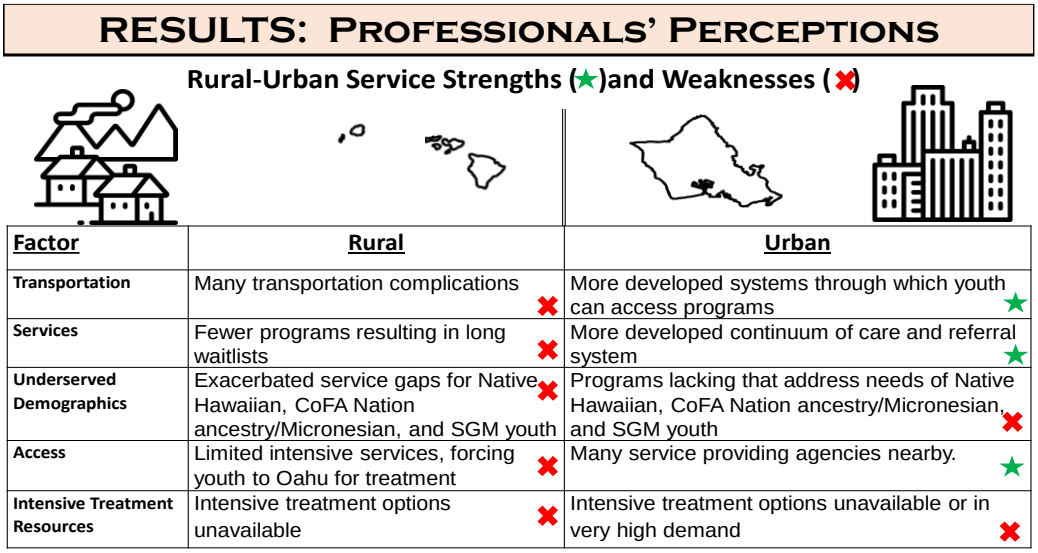
Theme 5: Rural Health Disparities

Nearly half (*N*=21, 42%) of the professionals noted that the rural and urban continuum of care and system of care differ. A rural-urban divide is perceived to result in two continua of care and two systems of care (Figure 12). Rural areas were characterized as having poor public transportation options and difficult transportation situations, few youth-oriented programs, access to care complications resulting from limited availability, and little to no options for "higher-end" intensive treatment. Furthermore, these rural conditions were perceived to exacerbate service gaps for Native Hawaiian, CoFA Nation ancestry/Micronesian, and SGM youth, for whom culturally relevant services already are lacking. Urban areas were perceived to have easier-to-access transportation, better developed networks of programs, and a closer proximity to provider agencies. However, urban areas were still perceived to lack adequate programming for Native Hawaiian, CoFA Nation ancestry/Micronesian, and SGM youth, as well as a lack of sufficient "higher-end" treatment options for young people in general.

Nearly one-fifth of professionals (*N*=9, 18%) noted isolation as a common experience among neighbor island youth (Figure 13), primarily due to their perception that most services are located on O`ahu. Professionals explained that youth residing in under-resourced rural counties (Kaua`i, Maui, and Hawai`i), must travel to O`ahu for care and therefore feel cut off from their social support systems. Professionals also perceived that aftercare or recovery services are lacking for neighbor island youth who return from O`ahu. Feelings of isolation while accessing services, coupled with a lack of aftercare support, were perceived as a strain on youths' recovery process.

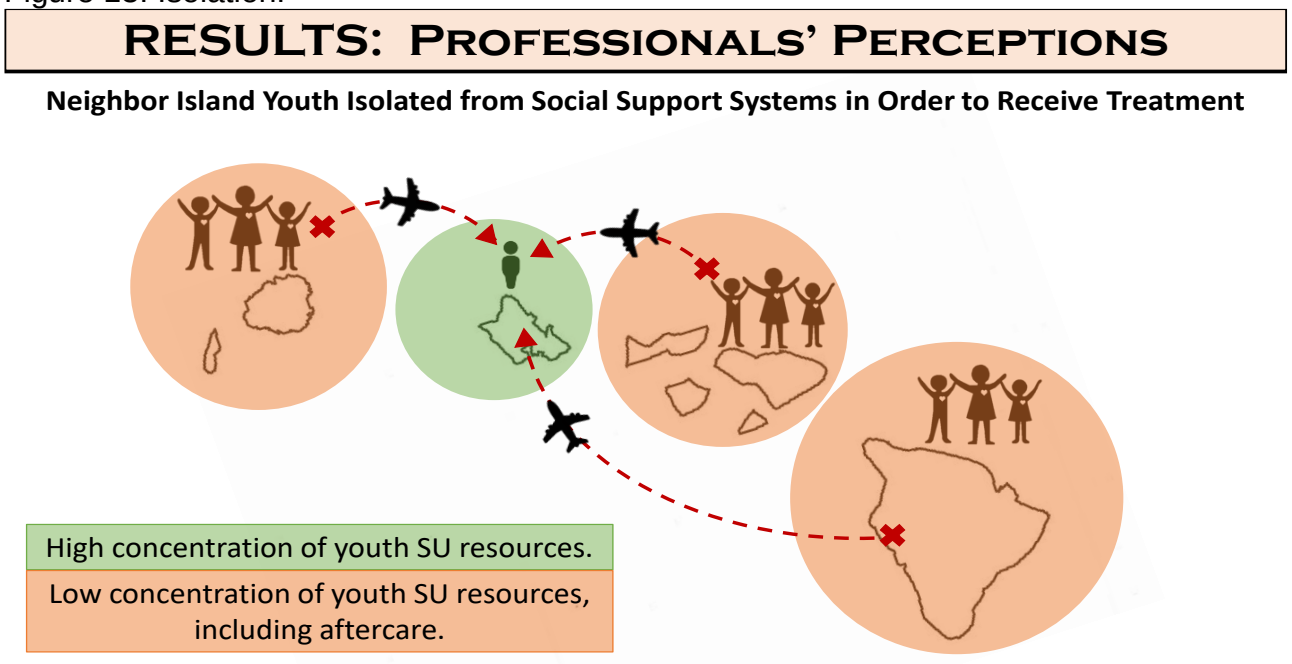
> *Lack of treatment in community, attending and transporting to programs which are 1-2 hours away from home.*
>
> *Neighbor islands access to services is very limited. In East and West Hawai`i, which has the second largest population of children in foster and kinship care, treatment programs are very limited and wait lists are long.*
>
> *Rural areas have specific needs in these communities vs. urban areas. Many services that are available are widely concentrated in urban areas, lack a presence in rural areas. Counties-Maui and Kaua'i that have smaller islands i.e. Molokai, Lana'i, and Ni'ihau don't have enough services! Programs that are specific to and cater to high-risk populations are also lacking. Lack of training made available to outer-islands to build prevention workforce. Skilled staff prevention & treatment specialists that are qualified & willing to work with populations living in rural areas. Incentives for qualified & skilled prevention & treatment staff to work in rural areas. Most individuals work in the areas that they do because they have a passion to do so rather than the pay.*
>
> *When someone is sent to Oahu for treatment, they also feel more isolated and disconnected, exacerbating the problems.*

Figure 12. Rural-Urban Divide.



Factor	Rural	Urban
Transportation	Many transportation complications ✖	More developed systems through which youth can access programs ★
Services	Fewer programs resulting in long waitlists ✖	More developed continuum of care and referral system ★
Underserved Demographics	Exacerbated service gaps for Native Hawaiian, CoFA Nation ancestry/Micronesian, and SGM youth ✖	Programs lacking that address needs of Native Hawaiian, CoFA Nation ancestry/Micronesian, and SGM youth ✖
Access	Limited intensive services, forcing youth to Oahu for treatment ✖	Many service providing agencies nearby. ★
Intensive Treatment Resources	Intensive treatment options unavailable ✖	Intensive treatment options unavailable or in very high demand ✖

Figure 13. Isolation.



4. Summary & Implications

Summary. The fifty professionals who participated in this anonymous online survey shared keen insights on substance use service continuum of care and system of care for youth with elevated need for substance use treatment, experiencing mental health issues, involved in juvenile justice or foster care systems, or living in homeless contexts. Surveys were deidentified and content analyzed to shed light on needs and supports, as well as barriers, gaps, and areas for improvement. Five interrelated themes emerged from the content analysis. In this section, implications corresponding to each theme are briefly described. Implications are meant to inform ADAD practice and policy, both internally with respect to ADAD-funded community providers, and externally with its partner organizations. Partner organizations include public sector agencies at the federal, state, or county level, as well as private entities.

Implications, Theme 1: Pathways to Accessing Services.

ADAD Policy & Practice. Access to health care is multidimensional and involves dynamic interactions between health services (supply) and population characteristics (demand)[11]. Each of the seven key dimensions of access may be addressed with a youth-focus at the forefront, both for the various services along the continuum of care that are supported by ADAD, as well as navigating in and around the system of care supported by ADAD.

ADAD-Funded Community Providers Policy & Practice. Results indicated that services provided by ADAD-funded community providers through the adolescent school-based treatment program may be best-suited for youth attending school regularly. It may be useful to determine the accuracy of this perception using the WITS database to examine the extent to which school-based services are provided to youth who attend school regularly, who may have been suspended, and who are involved with public sector agencies.

ADAD Partner Organizations Policy & Practice. Results indicated that among youth involved with public sector agencies, a fear of punitive action may impede them from seeking a referral to substance use services. It may be especially important for ADAD to work with other state and county level public sector providers in juvenile justice, foster care, and mental health to assess and align the ways in which these systems are organized in support of adolescent sobriety.

Implications, Theme 2: The School as Partner.

ADAD Policy & Practice. Considering The School is the main partner in the youth substance use continuum of care and system of care, a more formalized structure of partnership may need to be made clear between ADAD and the Department of Education at the state level, as well as with each of

[11] Russell, D. J., Humphreys, J. S., Ward, B., Chisholm, M., Buykx, P., Mcgrail, M., & Wakerman, J. (2013). Helping policy-makers address rural health access problems. *Australian Journal of Rural Health, 21*(2), 61-71. doi:10.1111/ajr.12023

the complex areas and schools. Special attention must be given to rural communities, bearing in mind that the largest proportion of student enrollment in most rural schools is youth of native Hawaiian ancestry.

ADAD-Funded Community Providers Policy & Practice. Although community providers may obtain letters of support from their host school(s) when applying for ADAD funding, there does not appear to be a template for the partnership in terms of roles and responsibilities. It would be beneficial for ADAD and the DoE to establish broad and transparent guidelines, so that the specific actions may be tailored to the assets with in the community provider and school relationship.

ADAD Partner Organizations Policy & Practice. The State of Hawai`i is unique in the nation in that it is the only state with a unified school district. While there is significant school autonomy, the structure of the State DoE as a single governing body may lend itself well to interagency alignment. By creating systems level interagency alignment between the DoE and ADAD, the burden will be lifted from community providers and their respective school partners from having to create this synergy.

Implications, Theme 3: Continuum of Care and System of Care.

ADAD Policy & Practice. There are gaps in service availability along the continuum of care, as well as problems navigating the system of care. These issues are exacerbated among health disparity groups. A more equitable approach to locating services in rural communities is called for, as well as expanding services access along the continuum, and creating synergies across referral agencies. It will be important to make improvements that account for a youth focused system, as opposed to replicating an adult oriented system.

ADAD-Funded Community Providers Policy & Practice. ADAD may benefit from increasing its one-on-one and regionally-grouped technical assistance among its community providers. This type of technical assistance and workforce development may best be facilitated in coordination with ADAD partners in mental health, juvenile justice, foster care, homelessness, and education.

ADAD Partner Organizations Policy & Practice. In addition to public sector alignment between ADAD and other state, federal, and county agencies; these agencies (especially the State DoE) may participate actively in technical assistance and workforce development on behalf of ADAD-funded community providers.

Implications, Theme 4: Health Disparity Groups – Hawaiian, Micronesian, SGM

ADAD Policy & Practice. Results indicated a series of barriers and gaps in service access among Native Hawaiian, CoFA Nation Ancestry/Micronesian, and sexual and gender minority youth. ADAD may bolster these barriers and gaps with the variety of facilitators mentioned by participating professionals: workforce development for cultural matching, cultural competency and humility trainings, embracing sexual and gender fluidity. Furthermore, ADAD likely will need to invest in the development and diffusion of evidence-based Native Hawaiian culturally grounded practices.

ADAD-Funded Community Providers Policy & Practice. Implementing culturally relevant services appears to be a priority, especially among Native Hawaiian communities. ADAD may consider increasing dispensations both for cultural matching and cultural humility trainings to incentivize community providers. Similarly, translation and health literacy services for providers working with CoFA Nation ancestry/Micronesian populations will need to be incentivized, particularly in communities where large numbers of Micronesian youth reside (see Table 4).

ADAD Partner Organizations Policy & Practice. ADAD may need to establish new partnerships and reframe existing partnerships to eliminate health disparities.

Implications, Theme 5: Rural Health Disparities

ADAD Policy & Practice. A rural-urban divide is perceived to result in two continua of care and two systems of care, such that services are O`ahu-centric and are built on the resources available in the urban context of Honolulu. While the majority of the youth population resides on O`ahu[12], a majority rule philosophy is insufficient reasoning for continuum of care and system of care problems. ADAD may need to convene a rural task force with members from among its cadre of community providers and partner organizations located in rural areas of the state. Furthermore, a rural solution must account for Hawaiian self-determination, given the intersection of rurality with Hawaiian community residency.

ADAD-Funded Community Providers Policy & Practice. Rural youth appear to be especially vulnerable due to limited service access, which seems to be most usefully co-located on school campuses due to transportation issues in rural communities. Rural providers are impeded by the distance they must travel to provide services, which cuts into the time they have available for direct care.

ADAD Partner Organizations Policy & Practice. ADAD may need to establish new partnerships with public transportation and school transportation to ameliorate service access problems experienced by rural youth.

[12] 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

5. Appendices.

Appendix A. HSP Letter.
Appendix B. Sample Invite - DoP Email and ADAD Letter.
Appendix C. Glossary of Terms & Abbreviations.
Appendix D. Survey Template.

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.

1960 East-West Road
Biomedical Sciences Building B104
Honolulu, Hawai'i 96822
Telephone: (808) 956-5007
Fax: (808) 956-8683
An Equal Opportunity/Affirmative Action Institution

Appendix B. Sample invite – DoP email and ADAD Letter

Helm, Susana

From: Helm, Susana
Sent: Sunday, June 16, 2019 1:39 AM
To: XXX
Cc: Special Populations
Subject: youth substance use needs assessment - special populations
Attachments: ADAD.Letter.to.Providers.pdf; ProjectOverview_FAQ_190527.pdf

Aloha XXX.

The State of Hawai`i Department of Health, Alcohol and Drug Abuse Division (ADAD) is interested in learning from service providers and other state and local agencies about the substance use prevention and treatment needs among vulnerable youth, which we are referring to as "special populations" (refer to attached letter and project overview).

ADAD is working with our team at the University of Hawai`i, Department of Psychiatry Research Division to gather the views of professionals who work with youth in the public and private non-profit sectors to identify areas of need and support, barriers and gaps in services, and areas for systems improvement via an online survey.

My colleague, Mr. Robin Zeller (SpecialPopulations@dop.hawaii.edu) will send you a follow-up email regarding the special populations needs assessment survey, and to invite you or one of your colleagues to participate.

Mahalo,
--susana

Susana Helm, PhD
Professor, Department of Psychiatry
John A. Burns School of Medicine
University of Hawai `i at Manoa
Honolulu, HI 96813

DAVID Y. IGE
GOVERNOR OF HAWAII

BRUCE S. ANDERSON, Ph.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
ALCOHOL AND DRUG ABUSE DIVISION
KAKUHIHEWA BUILDING
601 Kamokila Boulevard, Room 360
Kapolei, Hawaii 96707
PH: (808) 692-7506
FAX: (808) 692-7521

In reply, please refer to:
File: DOH/ADAD

May 31, 2019

Aloha!

The State of Hawai`i Department of Health, Alcohol and Drug Abuse Division (ADAD) is partnering with the University of Hawai`i, Department of Psychiatry's Research Division (DoP Research) to conduct a set of youth substance use needs assessments. DoP Research will be administering the Alcohol Tobacco, and Other Drug Use (ATOD) Survey in collaboration with the Department of Education during the 2019-2020 academic year.

However, vulnerable youth who are most in need of substance use prevention and treatment services often are not in school to participate in surveys and/or their vulnerabilities are not identified in school-based surveys. ADAD is particularly interested in learning about the needs of these "special populations" of vulnerable youth who may have substance use or mental health problems, and/or may be involved with the juvenile justice or foster care systems, and/or may be living in homeless or unsheltered conditions.

Therefore, we are working with DoP Research this summer to gather information about special populations youth from service providers, and later this 2019-2020 year DoP Research will interview youth and caregivers. ADAD is kindly asking assistance from your organization. DoP Research will be contacting you in June 2019 regarding an online survey for gathering provider views. For more information or to provide your immediate support, please contact Dr. Helm or Mr. Zeller.

Dr. Susana Helm
Principal Investigator, Special Populations Needs Assessment
HelmS@dop.hawaii.edu
Toll free: 855.641.2914

Mr. Robin Zeller
Needs Assessment Program Associate
SpecialPopulations@dop.hawaii.edu
692.1906

Sincerely,

John Valera, AICP
Acting Chief, Alcohol and Drug Abuse Division

Youth Substance Use Prevention and Treatment Services
Needs Assessment, 2019-2020
Special Populations

Introduction:

The State of Hawai`i Department of Health, Alcohol and Drug Abuse Division (ADAD) is interested in learning from service providers about the substance use prevention and treatment needs among vulnerable youth, which we are referring to as "special populations".

The majority of what we know about youth substance use is garnered from school-based surveys. However, vulnerable youth who are most in need of substance use prevention and treatment services often are not in school to participate in surveys and/or their vulnerabilities are not identified in school-based surveys.

ADAD is particularly interested in learning about the needs of these "special populations" of vulnerable youth who may have substance use or mental health problems, and/or may be involved with the juvenile justice or foster care systems, and/or may be living in homeless or unsheltered conditions.

To address this limitation of school-based needs assessments, ADAD is working with the University of Hawai`i, Department of Psychiatry's Research Division (DoP Research) to gather the views of professionals who work with youth in the public and private non-profit sectors to identify areas of need and support, barriers and gaps in services, and areas for systems improvement.

We are particularly interested in youth with substance use treatment needs, and/or who may be involved with the juvenile justice system, may have mental health issues, and may be living in homeless conditions or in foster care.

Special Population			Description of Youth
1	Substance Use	SU	youth with existing or prior substance use problems
2	Mental Health	MH	youth participating in MH services, including co-occurring substance use disorders
3	Juvenile Justice	JJ	youth involved in/diverted from the juvenile justice system
4	Homeless	HO	youth needing safe, stable, and permanent housing, either living with or without family
5	Foster Care	FC	Youth living in out of home placement in the state foster care or kinship care system

Project Method:

Selecting Participating Organizations. Organizations that provide services to vulnerable youth in one or more of the special populations categories listed above. We aim to include organizations statewide, and to include organizations that emphasize rural, Native Hawaiian, CoFA nation, and sexual or gender minority issues.

Contacting Participating Organizations. A letter from ADAD addressed to youth-serving organizations will be sent via email by Dr. Susana Helm, DoP Research Principal Investigator. Following this, Mr. Robin Zeller will call these youth-serving organizations and agencies to explain the special populations needs assessment project and to invite a representative professional from the youth-serving organization to complete the online survey. A link to the anonymous survey will be emailed. The survey includes a set of 11 short answer items.

Project Report:

Report Content. A summary of the responses will be provided to ADAD, which intends to use the summary to inform their legislative and other reporting requirements, as well as for guiding future youth prevention and treatment services RFPs. DoP Research will also use the summary to develop an interview guide for use when interviewing youth and care-givers later in 2019-2020. In addition, in the future DoP Research may seek IRB approval to share information gathered from your responses at conferences or in journal articles.

Confidentiality. Only the DoP Research team will have access to data. Data will be de-identified prior to analyses. Reports will include summaries of responses, with brief excerpted quotes.

Anonymity. Your organization name will not be included in any reports. Rather, a general description of participants will be used, e.g. professionals in the fields of substance use, juvenile justice, mental health, child welfare, and homelessness.

Appendix C. Glossary of Terms and Abbreviations

Glossary of Terms

Cisnormative	The assumption that a person's gender identity matches their biological sex/sex assigned at birth.
Heteronormative	Of or relating to a world view that promotes heterosexuality as the normal or preferred sexual orientation.

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
DoP-R	Department of Psychiatry – Research
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

Appendix D. Survey Templates

SURVEY VERSION: SUBSTANCE USE

Aloha

The Youth Substance Use Needs Assessment Team at the University of Hawai`i Psychiatry Research Division, and the Hawai`i State Department of Health's Alcohol and Drug Abuse Division (ADAD) thank you for agreeing to complete this online survey.

Your opinions are greatly appreciated. Your responses will help ADAD and community organizations involved in substance use prevention and treatment to improve their systems of care, and assist ADAD to create future plans for wider reaching services and support.

Below are three sets of questions related to: 1) *needs & support*, 2) *barriers and systemic gaps*, 3) *areas for improvement*.

We encourage you to discuss the questions in this survey with your colleagues. If you prefer, you may write your responses in a Word document, then cut-and-paste into the box provided. Please note the text boxes in this survey are limited to 200 words.

We understand the demanding nature of your work, and respectfully ask that you complete this survey ***within 30 days***. **(We will send weekly reminders)**

The survey is anonymous. Although the Needs Assessment Team will de-identify survey responses before analysis and reporting, please do not use your name or your organizations' name in your responses. Your answers will be compiled with the responses of other care-providers in order to highlight needs, sources of support, barriers and gaps, as well as areas for improvement, in addition to any other themes that respondents may find important.

A report will be provided to ADAD and to the organizations that participated. In the future, the Needs Assessment Team may share the information gathered from your responses at conferences or in journal articles.

If you have any questions, please contact us via email: SpecialPopulations@dop.hawaii.edu.

By clicking "next" you are agreeing to participate in The 2019 Special Populations Needs Assessment, and you will proceed to the survey.

SUPPORT & NEEDS

We are interested in your experiences in providing prevention and treatment to youth with elevated risk. We define youth with elevated risk as individuals who have experienced problems relating to their substance use. They likely qualify for treatment services but may or may not be participating in them.

Some examples of services, policies, and practices include intensive outpatient, residential services, detox services, regional/rural services, school-based services, individual and or family, etc.

We also are interested in how different care-providers connect across sectors (e.g. youth with elevated risk and substance use), as well as the role developmental age transitions (e.g. child and adolescent service sector to adult service sector) might play in how services are given to youth with elevated risk.

1. SUPPORT

These two questions address how youth with elevated risk with substance use prevention and/or treatment needs are *supported* to reduce or eliminate substance use and manage recovery.

Regarding youth with elevated risk, what services does your organization provide that *support* their substance use prevention and/or treatment needs?

Among youth with elevated risk in Hawai`i, what services or resources are available to *support* them to reduce or eliminate substance use?

2. NEEDS

These questions address substance use prevention and treatment care *needs* among youth with elevated risk.

For youth with elevated risk who **are** currently participating in your organization's services, what are their substance use/misuse *needs*?

Regarding youth with elevated risk **who are not** currently enrolled in your organization's program, what are their *needs* regarding substance use/misuse?

BARRIERS AND GAPS

We are interested in learning about the barriers and systemic gaps in accessing and utilizing services.

3. BARRIERS

What are the barriers to accessing and using substance use prevention and treatment services that are currently offered?

From your view as a professional, what are the barriers for youth with elevated risk to access and utilize substance use services?

From the viewpoint of youth with elevated risk, what are barriers to accessing and using the services provided by your organization?

4. GAPS

We are interested in learning about the systemic gaps in service, practice, or policy regarding youth with elevated risk. These questions address factors which keep individuals from receiving a continuity of care, a term referring to care which extends from inpatient to outpatient contexts, including prevention and health promotion services.

Systemic gaps may include: Interagency collaboration, school-based, community-based, one-stop shop for accessing services, time from intake to care, service intensity match intensity of need, etc.

What are the systemic gaps in substance use prevention and treatment services, practices, or policies regarding youth with elevated risk which keep them from receiving a continuity of care?

Please highlight your answer with examples.

* Are you familiar with substance use issues among rural populations?

- Yes
- No

For youth with elevated risk who **live in rural areas**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among Native Hawaiian populations?

- Yes
- No

For youth with elevated risk who are **Native Hawaiian**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among sexual and gender minority (LGBTQIA+) populations?

- Yes
- No

For youth with elevated risk who identify as **sexual and gender minorities**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among CoFA (Compact of Free Association) populations?

CoFA nations include: The Federated States of Micronesia, The Republic of the Marshall Islands, and Palau.

- ◯ Yes
- ◯ No

For youth with elevated risk from **CoFA** nations, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

Areas for Improvement

The following questions pertain to your ideas for improving the system of care for substance use inclusive of youth with elevated risk (and their families, schools, and communities).

These questions ask for your suggestions regarding improvement on the individual level (e.g. ability to access further training), the organizational level (e.g.properly trained staff in sufficient numbers), and the state level (e.g. state and community collaboration).

Please share your thoughts on how to improve your individual capacity/ability to provide a system of care for substance use services inclusive of youth with elevated risk.

Please share your thoughts on how to improve your organization's capacity to provide a system of care for substance use services inclusive of youth with elevated risk.

Please share your thoughts on how to improve the State of Hawai`i's capacity to provide a system of care for substance use services inclusive of youth with elevated risk.

Thank You!

The Youth Substance Use Needs Assessment Team at the University of Hawai`i and the Hawai`i State Department of Health's Alcohol and Drug Abuse Division thank you for your time and effort to complete this survey. It is our hope that the information provided by yourself and others will make substance use prevention and treatment more accessible, equitable, and successful in Hawai`i.

Mahalo

SURVEY VERSION: MENTAL HEALTH

Aloha

The Youth Substance Use Needs Assessment Team at the University of Hawai`i Psychiatry Research Division, and the Hawai`i State Department of Health's Alcohol and Drug Abuse Division (ADAD) thank you for agreeing to complete this online survey.

Your opinions are greatly appreciated. Your responses will help ADAD and community organizations involved in substance use prevention and treatment to improve their systems of care, and assist ADAD to create future plans for wider reaching services and support.

Below are three sets of questions related to: 1) *needs & support*, 2) *barriers and systemic gaps*, 3) *areas for improvement*.

We encourage you to discuss the questions in this survey with your colleagues. If you prefer, you may write your responses in a Word document, then cut-and-paste into the box provided. Please note the text boxes in this survey are limited to 200 words.

We understand the demanding nature of your work, and respectfully ask that you complete this survey ***within 30 days.*** **(We will send weekly reminders)**

The survey is anonymous. Although the Needs Assessment Team will de-identify survey responses before analysis and reporting, please do not use your name or your organizations' name in your responses. Your answers will be compiled with the responses of other care-providers in order to highlight needs, sources of support, barriers and gaps, as well as areas for improvement, in addition to any other themes that respondents may find important.

A report will be provided to ADAD and to the organizations that participated. In the future, the Needs Assessment Team may share the information gathered from your responses at conferences or in journal articles.

If you have any questions, please contact us via email: SpecialPopulations@dop.hawaii.edu.

By clicking "next" you are agreeing to participate in The 2019 Special Populations Needs Assessment, and you will proceed to the survey.

SUPPORT & NEEDS

We are interested in your experiences in providing prevention and treatment to youth with mental health problems.

Some examples of services, policies, and practices include intensive outpatient, residential services, detox services, regional/rural services, school-based services, individual and or family, etc.

We also are interested in how different care-providers connect across sectors (e.g. mental health and substance use), as well as the role developmental age transitions (e.g. child and adolescent service sector to adult service sector) might play in how services are given to youth with mental health problems.

1. SUPPORT

These two questions address how youth with mental health problems with substance use prevention and/or treatment needs are *supported* to reduce or eliminate substance use and manage recovery.

Regarding youth with mental health problems, what services does your organization provide that *support* their substance use prevention and/or treatment needs?

Among youth with mental health problems in Hawai`i, what services or resources are available to *support* them to reduce or eliminate substance use?

2. NEEDS

These questions address substance use prevention and treatment care *needs* among youth with mental health problems.

For youth with mental health problems who **are** currently participating in your organization's services, what are their substance use/misuse *needs*?

Regarding youth with mental health problems **who are not** currently enrolled in your organization's program, what are their *needs* regarding substance use/misuse?

BARRIERS AND GAPS

We are interested in learning about the barriers and systemic gaps in accessing and utilizing services.

3. BARRIERS

What are the barriers to accessing and using substance use prevention and treatment services that are currently offered?

From your view as a professional, what are the barriers for youth with mental health problems to access and utilize substance use services?

From the viewpoint of youth with mental health problems, what are barriers to accessing and using the services provided by your organization?

4. GAPS

We are interested in learning about the systemic gaps in service, practice, or policy regarding youth with mental health problems. These questions address factors which keep individuals from receiving a continuity of care, a term referring to care which extends from inpatient to outpatient contexts, including prevention and health promotion services.

Systemic gaps may include: Interagency collaboration, school-based, community-based, one-stop shop for accessing services, time from intake to care, service intensity match intensity of need, etc.

What are the systemic gaps in substance use prevention and treatment services, practices, or policies regarding youth with mental health problems which keep them from receiving a continuity of care?

Please highlight your answer with examples.

* Are you familiar with substance use issues among rural populations?

- Yes
- No

For youth with mental health problems who **live in rural areas**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among sexual and gender minority (LGBTQIA+) populations?

- Yes
- No

For youth with mental health problems who identify as **sexual and gender minorities**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among Native Hawaiian populations?

- Yes
- No

For youth with mental health problems who are **Native Hawaiian**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among CoFA (Compact of Free Association) populations?

CoFA nations include: The Federated States of Micronesia, The Republic of the Marshall Islands, and Palau.

- ◯ Yes
- ◯ No

For youth with mental health problems from **CoFA** nations, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

Areas for Improvement

The following questions pertain to your ideas for improving the system of care for substance use inclusive of youth with mental health problems (and their families, schools, and communities).

These questions ask for your suggestions regarding improvement on the individual level (e.g. ability to access further training), the organizational level (e.g.properly trained staff in sufficient numbers), and the state level (e.g. state and community collaboration).

Please share your thoughts on how to improve your individual capacity/ability to provide a system of care for substance use services inclusive of youth with mental health problems

Please share your thoughts on how to improve your organization's capacity to provide a system of care for substance use services inclusive of youth with mental health problems

Please share your thoughts on how to improve the State of Hawai`i's capacity to provide a system of care for substance use services inclusive of youth with mental health problems

Thank You!

The Youth Substance Use Needs Assessment Team at the University of Hawai`i and the Hawai`i State Department of Health's Alcohol and Drug Abuse Division thank you for your time and effort to complete this survey. It is our hope that the information provided by yourself and others will make substance use prevention and treatment more accessible, equitable, and successful in Hawai`i.

Mahalo

SURVEY VERSION: JUVENILE JUSTICE

Aloha

The Youth Substance Use Needs Assessment Team at the University of Hawai`i Psychiatry Research Division, and the Hawai`i State Department of Health's Alcohol and Drug Abuse Division (ADAD) thank you for agreeing to complete this online survey.

Your opinions are greatly appreciated. Your responses will help ADAD and community organizations involved in substance use prevention and treatment to improve their systems of care, and assist ADAD to create future plans for wider reaching services and support.

Below are three sets of questions related to: 1) *needs & support*, 2) *barriers and systemic gaps*, 3) *areas for improvement*.

We encourage you to discuss the questions in this survey with your colleagues. If you prefer, you may write your responses in a Word document, then cut-and-paste into the box provided. Please note the text boxes in this survey are limited to 200 words.

We understand the demanding nature of your work, and respectfully ask that you complete this survey ***within 30 days***. **(We will send weekly reminders)**

The survey is anonymous. Although the Needs Assessment Team will de-identify survey responses before analysis and reporting, please do not use your name or your organizations' name in your responses. Your answers will be compiled with the responses of other care-providers in order to highlight needs, sources of support, barriers and gaps, as well as areas for improvement, in addition to any other themes that respondents may find important.

A report will be provided to ADAD and to the organizations that participated. In the future, the Needs Assessment Team may share the information gathered from your responses at conferences or in journal articles.

If you have any questions, please contact us via email: SpecialPopulations@dop.hawaii.edu.

By clicking "next" you are agreeing to participate in The 2019 Special Populations Needs Assessment, and you will proceed to the survey.

SUPPORT & NEEDS

We are interested in your experiences in providing prevention and treatment to youth involved with juvenile justice.

Some examples of services, policies, and practices include intensive outpatient, residential services, detox services, regional/rural services, school-based services, individual and or family, etc.

We also are interested in how different care-providers connect across sectors (e.g. juvenile justice and substance use), as well as the role developmental age transitions (e.g. child and adolescent service sector to adult service sector) might play in how services are given to youth involved with juvenile justice.

1. SUPPORT

These two questions address how youth involved with juvenile justice with substance use prevention and/or treatment needs are *supported* to reduce or eliminate substance use and manage recovery.

Regarding youth involved with juvenile justice, what services does your organization provide that *support* their substance use prevention and/or treatment needs?

Among youth involved with juvenile justice in Hawai`i, what services or resources are available to support them to reduce or eliminate substance use?

2. NEEDS

These questions address substance use prevention and treatment care *needs* among youth involved with juvenile justice.

For youth involved with juvenile justice who **are** currently participating in your organization's services, what are their substance use/misuse *needs*?

Regarding youth involved with juvenile justice **who are not** currently enrolled in your organization's program, what are their *needs* regarding substance use/misuse?

BARRIERS AND GAPS

We are interested in learning about the barriers and systemic gaps in accessing and utilizing services.

3. BARRIERS

What are the barriers to accessing and using substance use prevention and treatment services that are currently offered?

From your view as a professional, what are the barriers for youth involved with juvenile justice to access and utilize substance use services?

From the viewpoint of youth involved with juvenile justice, what are barriers to accessing and using the services provided by your organization?

4. GAPS

We are interested in learning about the systemic gaps in service, practice, or policy regarding youth involved with juvenile justice. These questions address factors which keep individuals from receiving a continuity of care, a term referring to care which extends from inpatient to outpatient contexts, including prevention and health promotion services.

Systemic gaps may include: Interagency collaboration, school-based, community-based, one-stop shop for accessing services, time from intake to care, service intensity match intensity of need, etc.

What are the systemic gaps in substance use prevention and treatment services, practices, or policies regarding youth involved with juvenile justice which keep them from receiving a continuity of care?

Please highlight your answer with examples.

* Are you familiar with substance use issues among Native Hawaiian populations?

- Yes
- No

For youth involved with juvenile justice who are **Native Hawaiian**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among CoFA (Compact of Free Association) populations?

CoFA nations include: The Federated States of Micronesia, The Republic of the Marshall Islands, and Palau.

- ◯ Yes
- ◯ No

For youth involved with juvenile justice from **CoFA** nations, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among rural populations?

- Yes
- No

For youth involved with juvenile justice who **live in rural areas**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among sexual and gender minority (LGBTQIA+) populations?

- Yes
- No

For youth involved with juvenile justice who identify as **sexual and gender minorities**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

Areas for Improvement

The following questions pertain to your ideas for improving the system of care for substance use inclusive of youth involved with juvenile justice (and their families, schools, and communities).

These questions ask for your suggestions regarding improvement on the individual level (e.g. ability to access further training), the organizational level (e.g.properly trained staff in sufficient numbers), and the state level (e.g. state and community collaboration).

Please share your thoughts on how to improve your individual capacity/ability to provide a system of care for substance use services inclusive of youth involved with juvenile justice

Please share your thoughts on how to improve your organization's capacity to provide a system of care for substance use services inclusive of youth involved with juvenile justice

Please share your thoughts on how to improve the State of Hawai`i's capacity to provide a system of care for substance use services inclusive of youth involved with juvenile justice

Thank You!

The Youth Substance Use Needs Assessment Team at the University of Hawai`i and the Hawai`i State Department of Health's Alcohol and Drug Abuse Division thank you for your time and effort to complete this survey. It is our hope that the information provided by yourself and others will make substance use prevention and treatment more accessible, equitable, and successful in Hawai`i.

Mahalo

SURVEY VERSION: FOSTER CARE

Aloha

The Youth Substance Use Needs Assessment Team at the University of Hawai`i Psychiatry Research Division, and the Hawai`i State Department of Health's Alcohol and Drug Abuse Division (ADAD) thank you for agreeing to complete this online survey.

Your opinions are greatly appreciated. Your responses will help ADAD and community organizations involved in substance use prevention and treatment to improve their systems of care, and assist ADAD to create future plans for wider reaching services and support.

Below are three sets of questions related to: 1) *needs & support*, 2) *barriers and systemic gaps*, 3) *areas for improvement*.

We encourage you to discuss the questions in this survey with your colleagues. If you prefer, you may write your responses in a Word document, then cut-and-paste into the box provided. Please note the text boxes in this survey are limited to 200 words.

We understand the demanding nature of your work, and respectfully ask that you complete this survey ***within 30 days***. **(We will send weekly reminders)**

The survey is anonymous. Although the Needs Assessment Team will de-identify survey responses before analysis and reporting, please do not use your name or your organizations' name in your responses. Your answers will be compiled with the responses of other care-providers in order to highlight needs, sources of support, barriers and gaps, as well as areas for improvement, in addition to any other themes that respondents may find important.

A report will be provided to ADAD and to the organizations that participated. In the future, the Needs Assessment Team may share the information gathered from your responses at conferences or in journal articles.

If you have any questions, please contact us via email: SpecialPopulations@dop.hawaii.edu.

By clicking "next" you are agreeing to participate in The 2019 Special Populations Needs Assessment, and you will proceed to the survey.

SUPPORT & NEEDS

We are interested in your experiences in providing prevention and treatment to youth in foster and kinship care.

Some examples of services, policies, and practices include intensive outpatient, residential services, detox services, regional/rural services, school-based services, individual and or family, etc.

We also are interested in how different care-providers connect across sectors (e.g. foster care and substance use), as well as the role developmental age transitions (e.g. child and adolescent service sector to adult service sector) might play in how services are given to youth in foster and kinship care.

1. SUPPORT

These two questions address how youth in foster and kinship care with substance use prevention and/or treatment needs are *supported* to reduce or eliminate substance use and manage recovery.

Regarding youth in foster and kinship care, what services does your organization provide that *support* their substance use prevention and/or treatment needs?

Among youth in foster and kinship care in Hawai`i, what services or resources are available to *support* them to reduce or eliminate substance use?

2. NEEDS

These questions address substance use prevention and treatment care *needs* among youth in foster and kinship care.

For youth in foster and kinship care who **are** currently participating in your organization's services, what are their substance use/misuse *needs*?

Regarding youth in foster and kinship care **who are not** currently enrolled in your organization's program, what are their *needs* regarding substance use/misuse?

BARRIERS AND GAPS

We are interested in learning about the barriers and systemic gaps in accessing and utilizing services.

3. BARRIERS

What are the barriers to accessing and using substance use prevention and treatment services that are currently offered?

From your view as a professional, what are the barriers for youth in foster and kinship care to access and utilize substance use services?

From the viewpoint of youth in foster and kinship care, what are barriers to accessing and using the services provided by your organization?

4. GAPS

We are interested in learning about the systemic gaps in service, practice, or policy regarding youth in foster and kinship care. These questions address factors which keep individuals from receiving a continuity of care, a term referring to care which extends from inpatient to outpatient contexts, including prevention and health promotion services.

Systemic gaps may include: Interagency collaboration, school-based, community-based, one-stop shop for accessing services, time from intake to care, service intensity match intensity of need, etc.

What are the systemic gaps in substance use prevention and treatment services, practices, or policies regarding youth in foster and kinship care which keep them from receiving a continuity of care?

Please highlight your answer with examples.

* Are you familiar with substance use issues among Native Hawaiian populations?

- Yes
- No

For youth in foster and kinship care who are **Native Hawaiian**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment? In some cases these services may be inclusive of the youth's family.

* Are you familiar with substance use issues among sexual and gender minority (LGBTQIA+) populations?

- ◡ Yes
- ◯ No

For youth in foster and kinship care who identify as **sexual and gender minorities**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment? In some cases these services may be inclusive of the youth's family.

* Are you familiar with substance use issues among CoFA (Compact of Free Association) populations?

CoFA nations include: The Federated States of Micronesia, The Republic of the Marshall Islands, and Palau.

- ◯ Yes
- ◯ No

For youth in foster and kinship care who are from **CoFA** nations, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment? In some cases these services may be inclusive of the youth's family.

* Are you familiar with substance use issues among rural populations?

- Yes
- No

For youth in foster and kinship care who **live in rural areas**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment? In some cases these services may be inclusive of the youth's family.

Areas for Improvement

The following questions pertain to your ideas for improving the system of care for substance use inclusive of youth in kinship and foster care (and their families, schools, and communities).

These questions ask for your suggestions regarding improvement on the individual level (e.g. ability to access further training), the organizational level (e.g.properly trained staff in sufficient numbers), and the state level (e.g. state and community collaboration).

Please share your thoughts on how to improve your individual capacity/ability to provide a system of care for substance use services inclusive of youth in foster and kinship care

Please share your thoughts on how to improve your organization's capacity to provide a system of care for substance use services inclusive of youth in foster and kinship care

Please share your thoughts on how to improve the State of Hawai`i's capacity to provide a system of care for substance use services inclusive of youth in foster and kinship care

Thank You!

The Youth Substance Use Needs Assessment Team at the University of Hawai`i and the Hawai`i State Department of Health's Alcohol and Drug Abuse Division thank you for your time and effort to complete this survey. It is our hope that the information provided by yourself and others will make substance use prevention and treatment more accessible, equitable, and successful in Hawai`i.

Mahalo

SURVEY VERSION: HOMELESSNESS

Aloha

The Youth Substance Use Needs Assessment Team at the University of Hawai`i Psychiatry Research Division, and the Hawai`i State Department of Health's Alcohol and Drug Abuse Division (ADAD) thank you for agreeing to complete this online survey.

Your opinions are greatly appreciated. Your responses will help ADAD and community organizations involved in substance use prevention and treatment to improve their systems of care, and assist ADAD to create future plans for wider reaching services and support.

Below are three sets of questions related to: 1) *needs & support*, 2) *barriers and systemic gaps*, 3) *areas for improvement*.

We encourage you to discuss the questions in this survey with your colleagues. If you prefer, you may write your responses in a Word document, then cut-and-paste into the box provided. Please note the text boxes in this survey are limited to 200 words.

We understand the demanding nature of your work, and respectfully ask that you complete this survey ***within 30 days***. **(We will send weekly reminders)**

The survey is anonymous. Although the Needs Assessment Team will de-identify survey responses before analysis and reporting, please do not use your name or your organizations' name in your responses. Your answers will be compiled with the responses of other care-providers in order to highlight needs, sources of support, barriers and gaps, as well as areas for improvement, in addition to any other themes that respondents may find important.

A report will be provided to ADAD and to the organizations that participated. In the future, the Needs Assessment Team may share the information gathered from your responses at conferences or in journal articles.

If you have any questions, please contact us via email: SpecialPopulations@dop.hawaii.edu.

By clicking "next" you are agreeing to participate in The 2019 Special Populations Needs Assessment, and you will proceed to the survey.

SUPPORT & NEEDS

The term "homeless situation" is meant to describe youth who are "houseless", have run away from home, or who are "couch surfing". We are interested in your experiences in providing prevention and treatment to youth in homeless situations.

Some examples of services, policies, and practices include intensive outpatient, residential services, detox services, regional/rural services, school-based services, individual and or family, etc.

We also are interested in how different care-providers connect across sectors (e.g. homelessness and substance use), as well as the role developmental age transitions (e.g. child and adolescent service sector to adult service sector) might play in how services are given to youth in homeless situations.

1. SUPPORT

These two questions address how youth in homeless situations with substance use prevention and/or treatment needs are *supported* to reduce or eliminate substance use and manage recovery.

Regarding youth in homeless situations, what services does your organization provide that *support* their substance use prevention and/or treatment needs?

Among youth in homeless situations in Hawai`i, what services or resources are available to *support* them to reduce or eliminate substance use?

2. NEEDS

These questions address substance use prevention and treatment care *needs* among youth in homeless situations

For youth in homeless situations who **are** currently participating in your organization's services, what are their substance use/misuse *needs*?

Regarding youth in homeless situations **who are not** currently enrolled in your organization's program, what are their *needs* regarding substance use/misuse?

BARRIERS AND GAPS

We are interested in learning about the barriers and systemic gaps in accessing and utilizing services.

3. BARRIERS

What are the barriers to accessing and using substance use prevention and treatment services that are currently offered?

From your view as a professional, what are the barriers for youth in homeless situations to access and utilize substance use services?

From the viewpoint of youth in homeless situations, what are barriers to accessing and using the services provided by your organization?

4. GAPS

We are interested in learning about the systemic gaps in service, practice, or policy regarding youth in homeless situations. These questions address factors which keep individuals from receiving a continuity of care, a term referring to care which extends from inpatient to outpatient contexts, including prevention and health promotion services.

Systemic gaps may include: Interagency collaboration, school-based, community-based, one-stop shop for accessing services, time from intake to care, service intensity match intensity of need, etc.

What are the systemic gaps in substance use prevention and treatment services, practices, or policies regarding youth in homeless situations which keep them from receiving a continuity of care?

Please highlight your answer with examples.

* Are you familiar with substance use issues among sexual and gender minority (LGBTQIA+) populations?

- Yes
- No

For youth in homeless situations who identify as **sexual and gender minorities**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among CoFA (Compact of Free Association) populations?

CoFA nations include: The Federated States of Micronesia, The Republic of the Marshall Islands, and Palau.

- ◯ Yes
- ◯ No

For youth in homeless situations who are from **CoFA** nations, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among Native Hawaiian populations?

- Yes
- No

For youth in homeless situations who are **Native Hawaiian**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

* Are you familiar with substance use issues among rural populations?

- Yes
- No

For youth in homeless situations who **live in rural areas**, what service, practice, and policy gaps make it difficult to access a continuity of care for substance use prevention and treatment?

Areas for Improvement

The following questions pertain to your ideas for improving the system of care for substance use inclusive of youth in homeless situations (and their families, schools, and communities).

These questions ask for your suggestions regarding improvement on the individual level (e.g. ability to access further training), the organizational level (e.g.properly trained staff in sufficient numbers), and the state level (e.g. state and community collaboration).

Please share your thoughts on how to improve your individual capacity/ability to provide a system of care for substance use services inclusive of youth in homeless situations

Please share your thoughts on how to improve your organization's capacity to provide a system of care for substance use services inclusive of youth in homeless situations

Please share your thoughts on how to improve the State of Hawai`i's capacity to provide a system of care for substance use services inclusive of youth in homeless situations

Thank You!

The Youth Substance Use Needs Assessment Team at the University of Hawai`i and the Hawai`i State Department of Health's Alcohol and Drug Abuse Division thank you for your time and effort to complete this survey. It is our hope that the information provided by yourself and others will make substance use prevention and treatment more accessible, equitable, and successful in Hawai`i.

Mahalo

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