

**SERVICES TO CONDUCT A NEEDS ASSESSMENT FOR  
SUBSTANCE USE PREVENTION AND TREATMENT SERVICES  
AMONG SPECIAL YOUTH POPULATIONS  
USING QUALITATIVE METHODS:  
PROTOCOL 2,  
IN-DEPTH INTERVIEWS WITH  
PROFESSIONALS REGARDING  
THE SYSTEM OF CARE**

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

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

## **THIS REPORT MAY BE USED FOR PUBLIC DISSEMINATION.**

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# 1. Project Overview

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

Five special populations were identified through discussions with ADAD in Fall 2018 regarding substance use disparities, which mirror state and national public sector services (Table 1). In addition to the five special populations of youth, other health disparity subgroups are included in this Needs Assessment. Youth from medically underserved populations include a) Native Hawaiians, b) CoFA Nation/Micronesian ancestry youth, and c) sexual and gender minorities. Youth from medically underserved areas also were a focus, specifically d) rural youth. The state population<sup>2</sup> 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<sup>3</sup>, Hawaiian students generally account for the largest proportion of rural school enrollment. While often identified as demographic descriptors, the health disparities manifested by these groups may be attributed to institutionalized policies and practices that disadvantage them<sup>4</sup>.

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

Table 1. Special Populations – Service Systems and Health Disparities

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

<sup>1</sup> The scope of this contract does not include a literature review demonstrating the elevated need among these special population youth.

<sup>2</sup> 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://histeagis.maps.arcgis.com/apps/MapSeries/index.html?appid=dff86c08e0894d2c8d205a177d72b9cd>

<sup>3</sup> 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>

<sup>4</sup> 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**

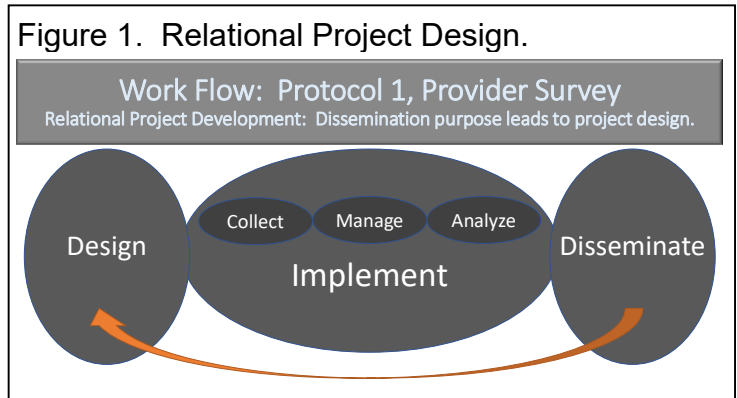
County	Island	Complex Area	Complex	Rural	Native Hawaiian %	CoFA Nation Ancestry/ Micronesian %	Total Enrollment
Kauai	Kaua'i	Kapa'a-Kaua'i-Waimea	Kapa'a	Yes	28*†	1	3,162
			Kaua'i	Yes	22	3	3,794
			Waimea	Yes	36*†	2	2,314
	Ni'ihau		Ni'ihau	Yes	100*†	0	9
Maui	Maui	Baldwin-Kekaulike-Maui	Baldwin	Yes	32*†	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	Yes	16	7*	560
	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 this collaboration, both groups define what will be disseminated and how, which then informs the project design, as depicted by the arrow going from dissemination to design (Figure 1). ADAD staff and DoP faculty collaboratively identified the health disparity groups through a series of meetings in 2018.

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



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

**Professionals Report.** This *Professionals Report* has been designed to capture the views of the professionals working with special populations of youth and their family through in-depth interviews. This report builds upon a prior phase of the project, which was a rapid assessment using an online data capture technique. Generated from the results of the rapid assessment<sup>8</sup>, interview questions were identified from the most prominent themes, as described in the methods section.

The rapid assessment results also were used to guide interviews with youth. A set of eight focus group interviews were conducted from August to December 2020 with 26 youth. The youth report is forthcoming in 2021.

<sup>5</sup> <https://health.hawaii.gov/substance-abuse/files/2013/05/2007StatewideReport.pdf>

<sup>6</sup> 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.

<sup>7</sup> 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.

<sup>8</sup> Helm S, Onoye J, Wilczek K, Zeller TR, Monick B. (2020). *Services to conduct a needs assessment for substance use prevention and treatment services among special populations youth using qualitative methods. Interim Report – Protocol 1, Professionals' Views.* Department of Psychiatry, University of Hawai'i at Mānoa. 4/27/20. [https://health.hawaii.gov/substance-abuse/files/2020/05/19-239\\_InterimReport\\_Helmetal\\_2020\\_200427.pdf](https://health.hawaii.gov/substance-abuse/files/2020/05/19-239_InterimReport_Helmetal_2020_200427.pdf)



## 2. Project Design – Protocol 2, Professionals

**Design Overview.** This youth needs assessment uses a two-protocol qualitative design (Table 3). This *Professionals Report* presents findings from Protocol 2, 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). By agreement with ADAD, all data are owned by the Department of Psychiatry and will not be given to ADAD or any other entity at any time, as a way to protect anonymity of participants, organizations, and communities.

An important step in gaining an understanding of the youth experience of the continuum of care and the system of care is learning from the professionals who care for these youth across the continuum and system of care. For protocol 1, we had conducted a rapid needs assessment by quickly collecting professionals' views using a short-answer response online survey in summer 2019. The results<sup>9</sup> of the rapid assessment were used here in protocol 2 to guide the in-depth needs assessment, specifically as interview prompts.

**Table 3. Project Design – Two Protocols.**

Protocol 1: Rapid Needs Assessment	Protocol 2: In-depth Needs Assessment
Online Anonymous Survey	Face-to-Face Interviews via zoom
obtain the views of <i>professionals</i> who provide care to youth in one or more of the special populations groups	obtain the views of <i>youth</i> in each of the special populations groups and <i>professionals</i>

**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.** Organizations that provide services to youth across the special population groups were invited to participate. Participant recruitment was announced in a variety of ways, for example during the annual spring Hawai‘i Addictions Conference<sup>10</sup>, during monthly Hawaii Interagency Statewide Youth Network of Care meetings<sup>11</sup>, and in a set of webinars we provided in collaboration with Hawai‘i Youth Services Network in Spring and Summer 2020<sup>12,13</sup>. The target sample included executive directors, clinical directors, and program supervisors of these organizations.

**Participant Recruitment and Sample Description.** Professionals were contacted directly through email by the Principal Investigator, with an invitation to participate in a one-hour interview using

<sup>9</sup> Helm S, Onoye J, Wilczek K, Zeller TR, Monick B. (2020). *Services to conduct a needs assessment for substance use prevention and treatment services among special populations youth using qualitative methods. Interim Report – Protocol 1, Professionals' Views.* Department of Psychiatry, University of Hawai‘i at Mānoa. 4/27/20.

<sup>10</sup> Monick B, Zeller Robin T, Wilczek K, Helm S (2020). *Underserved populations and substance use health disparities. A Qualitative needs assessment among youth-serving professionals in Hawai‘i.* Poster, Hawai‘i Addiction Conference, Honolulu, HI. 4/17/20.

<sup>11</sup> Helm S & Onoye J. (2020). *Innovations in Youth Substance Use Prevention & Treatment System of Care, Continuum of Care.* Invited Talk: Hawaii Interagency, State Youth Network of Care, annual meeting. Honolulu HI 7/2/20.

<sup>12</sup> Helm S, Onoye, J, Wilczek K, Zeller RT, Monick B. (2020). *Statewide youth substance use needs assessment. Results 2019.* Webinar for Executive Directors, Program Directors, Administrators, Policy Makers; hosted by Hawai‘i Youth Services Network, Honolulu, HI. 6/8/20.

<sup>13</sup> Helm S, Onoye, J, Wilczek K, Zeller RT, Monick B. (2020). *Statewide youth substance use needs assessment. Results 2019.* Webinar for Youth Services Professionals; hosted by Hawai‘i Youth Services Network, Hono, HI. 7/13/20.



zoom. Interview logistics were managed by our needs assessment team at DoP, with the goal of recruiting professionals whose work represented the special population groups of youth from across the State. Interviews began in mid-June 2020 and concluded at the end of July 2020. A total of twenty-one individual or small group discussions occurred and included the expert views of 25 professionals providing care to youth in the State of Hawai'i.

**Data Collection.** Professionals participated in one-hour interviews, via zoom due to the pandemic. Interview questions were grounded in protocol 1, in which survey results collected from an online survey of 50 professionals indicated five important themes (Table 4). An orientation was conducted prior to initiating the interview (See Figure 2). The Principal Investigator served as the lead interviewer, while project associates served as notetakers and observers. Refer to Appendix B for the interview guide, which was “screen shared” during the zoom interview.

Table 4. Interview Questions based on Prominent Themes	
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 – Native Hawaiian, COFA Nation/Micronesian, sex & gender minoritized youth.
Theme 5	Rural health disparities.

Figure 2. Interview Orientation

Mahalo!	The Youth Substance Use Needs Assessment Team at the University of Hawai'i Psychiatry Research Division, and the Hawai'i State Department of Health Alcohol and Drug Abuse Division (ADAD) thank you for agreeing to contribute to this Youth Needs Assessment.
Youth System of Care	Your views and expertise will help ADAD and community organizations involved in substance use/abuse prevention & treatment improve their systems of care, and help create future plans for wider reaching services and support.
Special Population Team	Attending your interview on behalf of the Special Populations team are the interviewer, a notetaker, and for some interviews there is an observer learning how to conduct interviews. Once the interview begins, the notetaker and observer will close their video and mute their audio.
Audio Record Transcript De-ID	The notetaker is making an audio recording using our own recorders (not using the zoom record feature). The recording will be converted to a transcript. Your transcript will be de-identified, meaning your name will not be attached to the transcript, and references to people, places, and organizations will be given pseudonyms.
Strengths Improvements	Your interview transcript will be compiled with the interviews of other professionals in order to highlight strengths and areas for improvement in the youth substance use prevention and treatment system of care and continuum of care.
Reports	A report will be provided to ADAD. In the future, the Special Populations Team may share this information at conferences, workshops, community meetings, webinars, or journal articles.

**Data Management.** Interviews were audio-recorded, transcribed verbatim and checked for accuracy, then de-identified and analyzed. We used our own audio-recorders rather than the zoom audio recording feature to ensure the audio data were secure and compatible with our data management and analysis software. Immediately following the conclusion of the interview, audio data were uploaded to a secure platform, then deleted from the audio recorders. Subsequently, a transcript was typed verbatim by one project associate, then a second project associate checked for accuracy and made any needed edits. A third project associate de-identified the data. The de-identified transcripts were used in the analysis: over 21 hours of interview data yielded 224 pages of data.

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

Data analysis occurred in two steps. First, each transcript was consensus coded for both a priori and emergent themes. Consensus coding is one strategy for ensuring quality in qualitative data analysis. Quality analysis occurs in teams, so that trained coders' views inform the analysis process. This means discrepancies in coding are inherent in high quality coding. In consensus coding, two or more team members code independently, then during consensus coding meetings they compare their analyses. Discrepant views are discussed, and code definitions are updated in the codebook to reflect new meaning. Consensus coding promotes accurate coding by ensuring that discrepancies are not ignored or accounted for by setting an accuracy rate of less than 100%. A priori themes are those that are expected to be in the data as a result of the specific questions asked; in other words these are themes that are established before coding begins. Emergent themes literally emerge from the data, and become evident only upon analyzing the data as a set; in other words these are themes that emerge after coding begins.

Second, the consensus coded data were entered into the computer assisted qualitative data analysis software, [NVivo](#). This software quantified the data in terms of two important metrics – references and files. References are the number of times a theme is mentioned across all of the transcripts. Files refer to the number of transcripts in which a theme was mentioned. Whereas there is no limit to the number of references possible in a data set, the number of files is limited to the number of transcripts, in this case 21. Using these two metrics, the most prominent themes were content analyzed using the NVivo software again. The content analysis is presented in the results section.

### 3. Findings – Protocol 2, Professionals

**Overview.** The youth substance use services field has relied on a risk and protective factors (RPF) approach for over two decades, which is grounded in the theory of human ecology.<sup>14</sup> The field of public health refers to this as the social ecological model, while developmental scientists refer to the ecodevelopmental model.<sup>15</sup> The main point is that individuals are embedded within multiple socio-cultural contexts: micro, meso, exo, macro, chrono (Table 5). The influence of these contexts changes over time as a result of human growth and development. The findings are presented with the higher order levels first (macro, exo levels), then the lower order (micro and meso levels), and finally by era (chrono level). Within these levels, the content analysis identified seven inter-related themes.

Table 5. Findings Organized by Eco-Developmental Systems Theory in Public Health

System	Brief Definition with examples	Level	Findings
Macro	Societal, philosophical, cultural influences, such as democracy, capitalism, hierarchies of human value that contribute to health disparities, etc.	Higher Order	<b>Theme 1:</b> Continuum of Care, System of Care, including Accessing Services.
Exo	Institutions that govern or structure micro and meso levels through policy, law, or other rules and guidelines.		<b>Theme 2:</b> The School. <b>Theme 3:</b> Health Disparity Groups
Meso	Dynamic interaction between a set of two or more micro settings, such as the school as a site for substance use service delivery.	Lower Order	<b>Theme 4:</b> General Issues Regarding Substance Use
Micro	The immediate settings in which individuals live. With youth, the usual focus is one or more micro-level settings - family, peers, school.		<b>Theme 5:</b> Risk & Protective Factors, including Trauma & Youth Advocacy <b>Theme 6:</b> The Role of Peers & Family
Chrono	Historical eras that represent qualitative change over time, e.g. destigmatization of mental health, or reframing addiction as a chronic disease.	Era	<b>Theme 7:</b> Corona Virus 19 Pandemic

#### Ecodevelopmental Systems: Macro & Exo Levels

##### Theme 1: Continuum of Care, System of Care, Accessing Services

The continuum of care and system of care (CoC/SoC) together were the most prominent themes (Figure 3). The continuum was distinguished from the system terms of *what* services may be available in the continuum and *how* services may be accessed in the system. All or nearly all of the interviews highlighted the CoC/SoC which was by design (i.e. Question 3). Put into further context, the continuum of care ranged from health promotion, to prevention and early intervention, to various intensities of treatment and aftercare need. These issues were discussed extensively (Figure 4). The system of care was described in terms of factors that facilitated access or represented a barrier, such as including in the school context as well as how relationships and communication factor into access (Figures 5 & 6)

<sup>14</sup> Bronfenbrenner, U. (1979). *The ecology of human development. Experiments by nature and design*. Cambridge, MA: Harvard University Press.

<sup>15</sup> 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.

Figure 3. Continuum of Care & System of Care

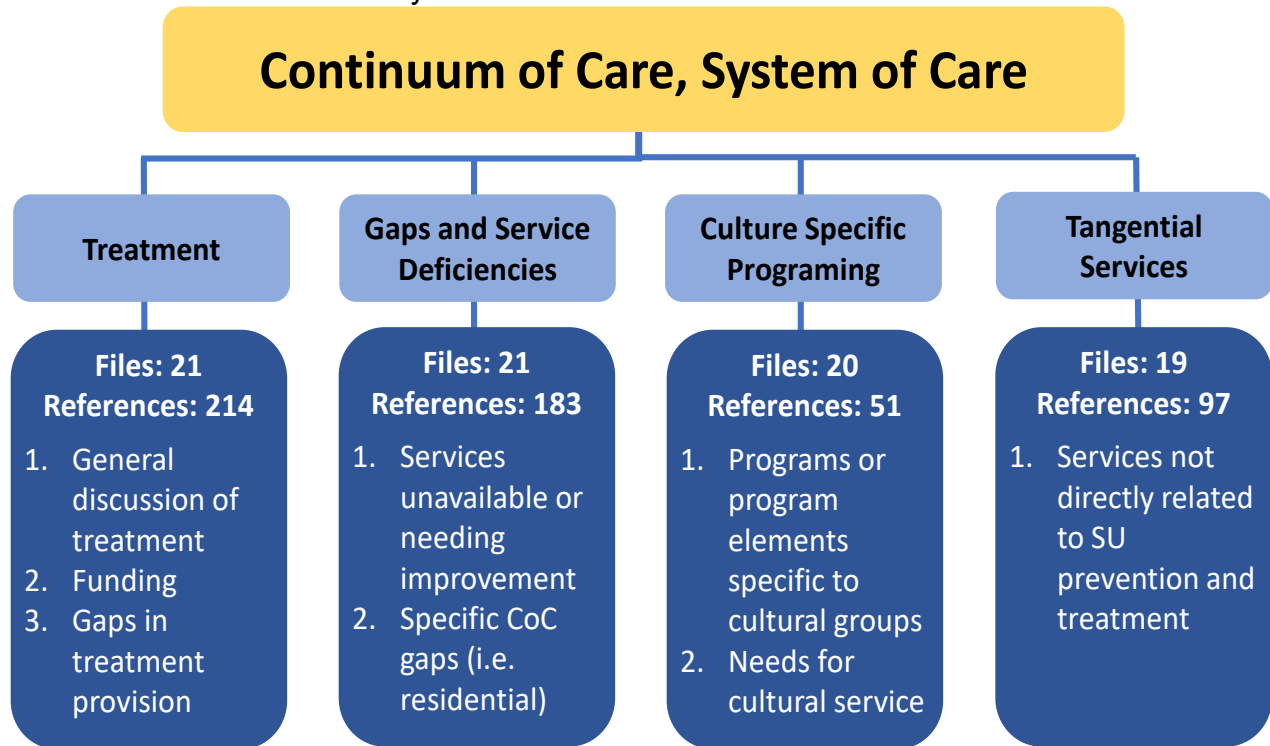


Figure 4. Continuum of Care

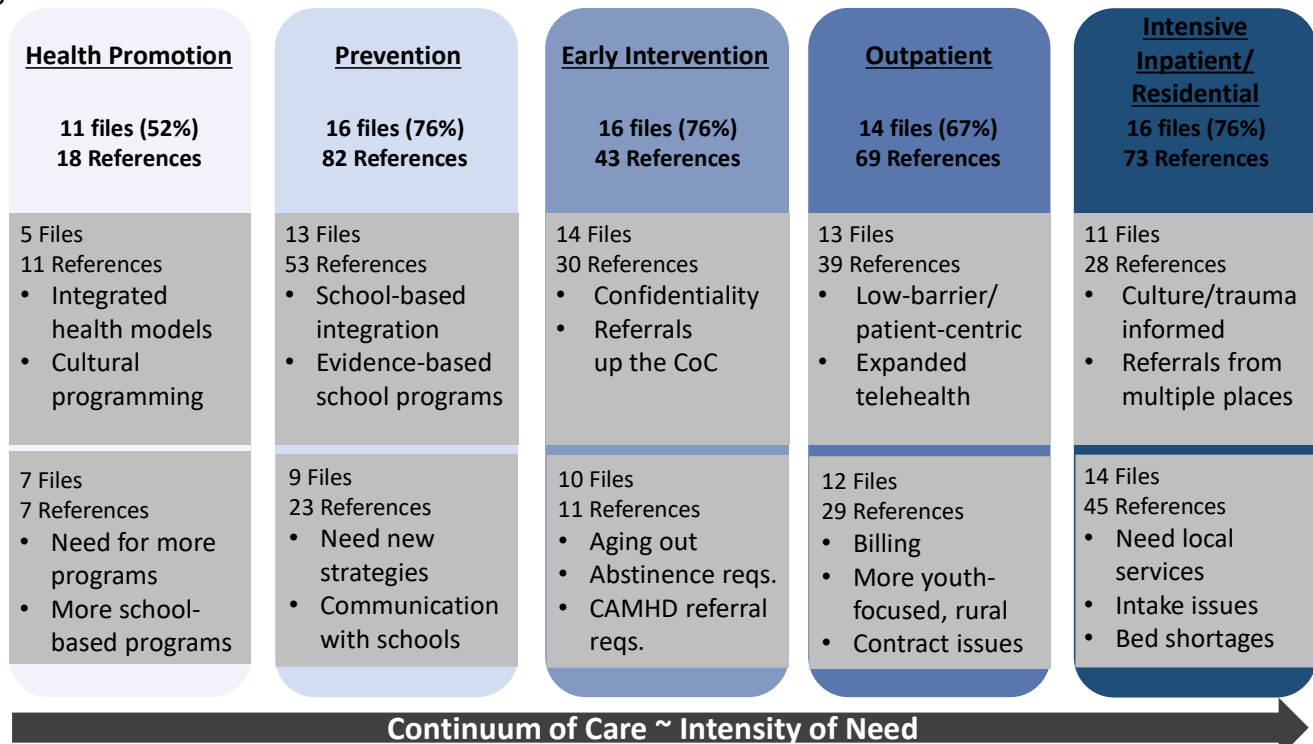


Figure 5. Factors Perceived to Facilitate Access to Care.

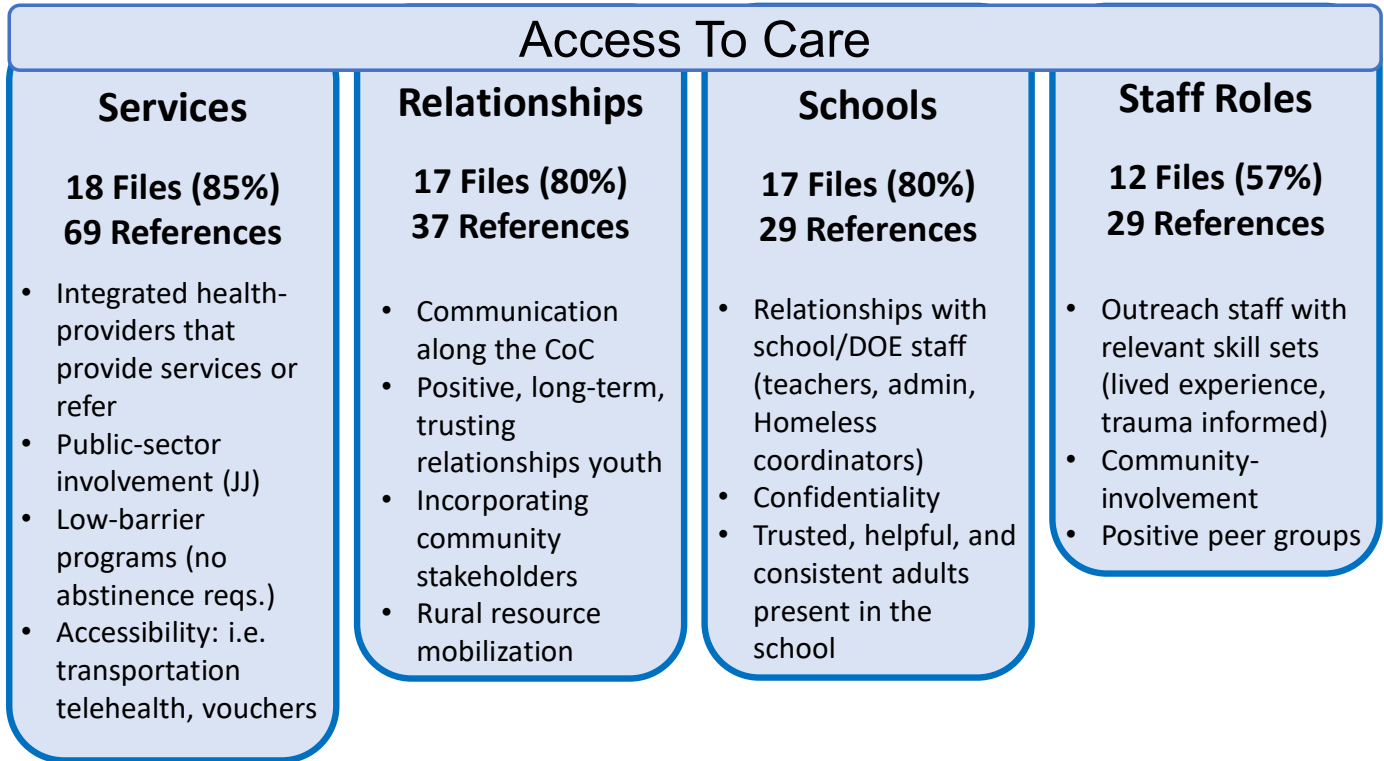
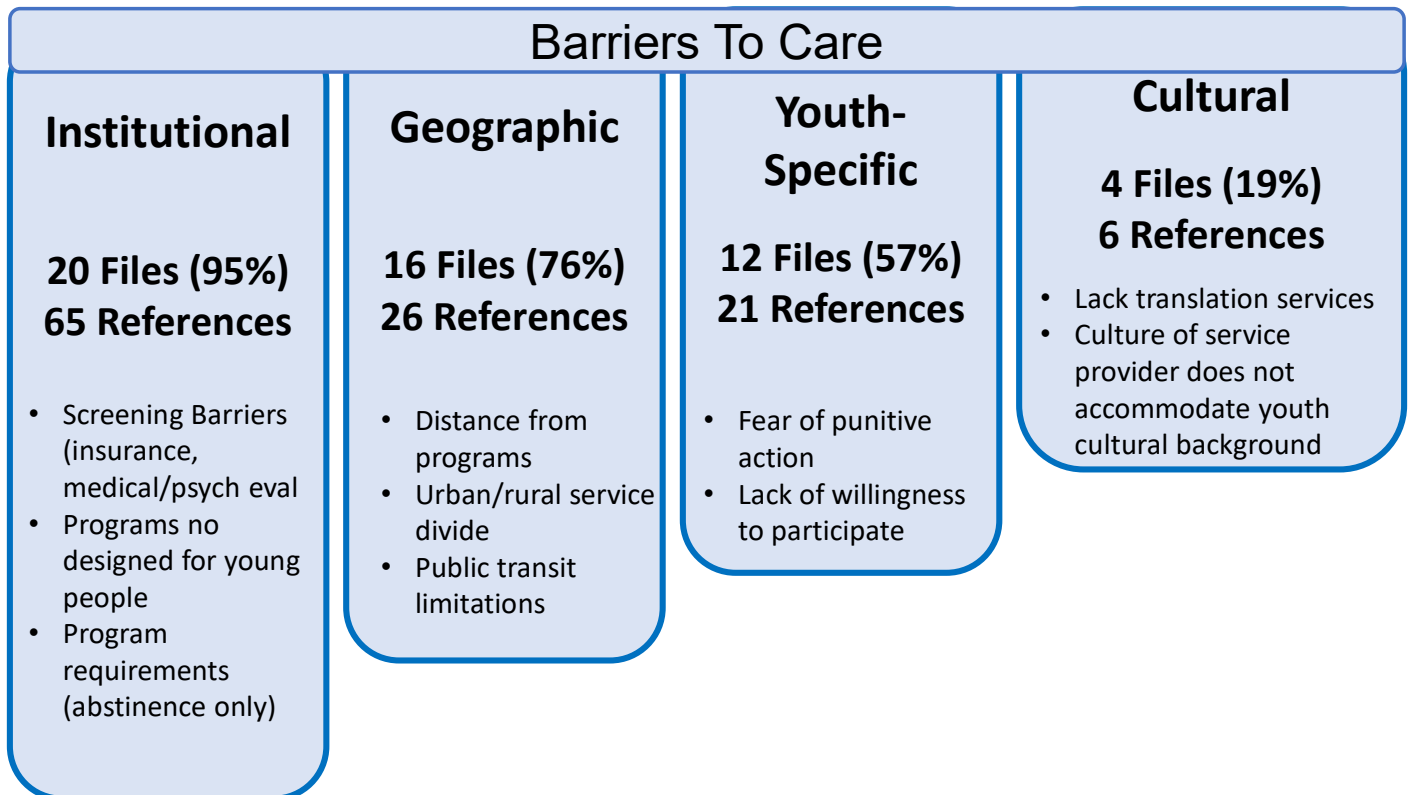


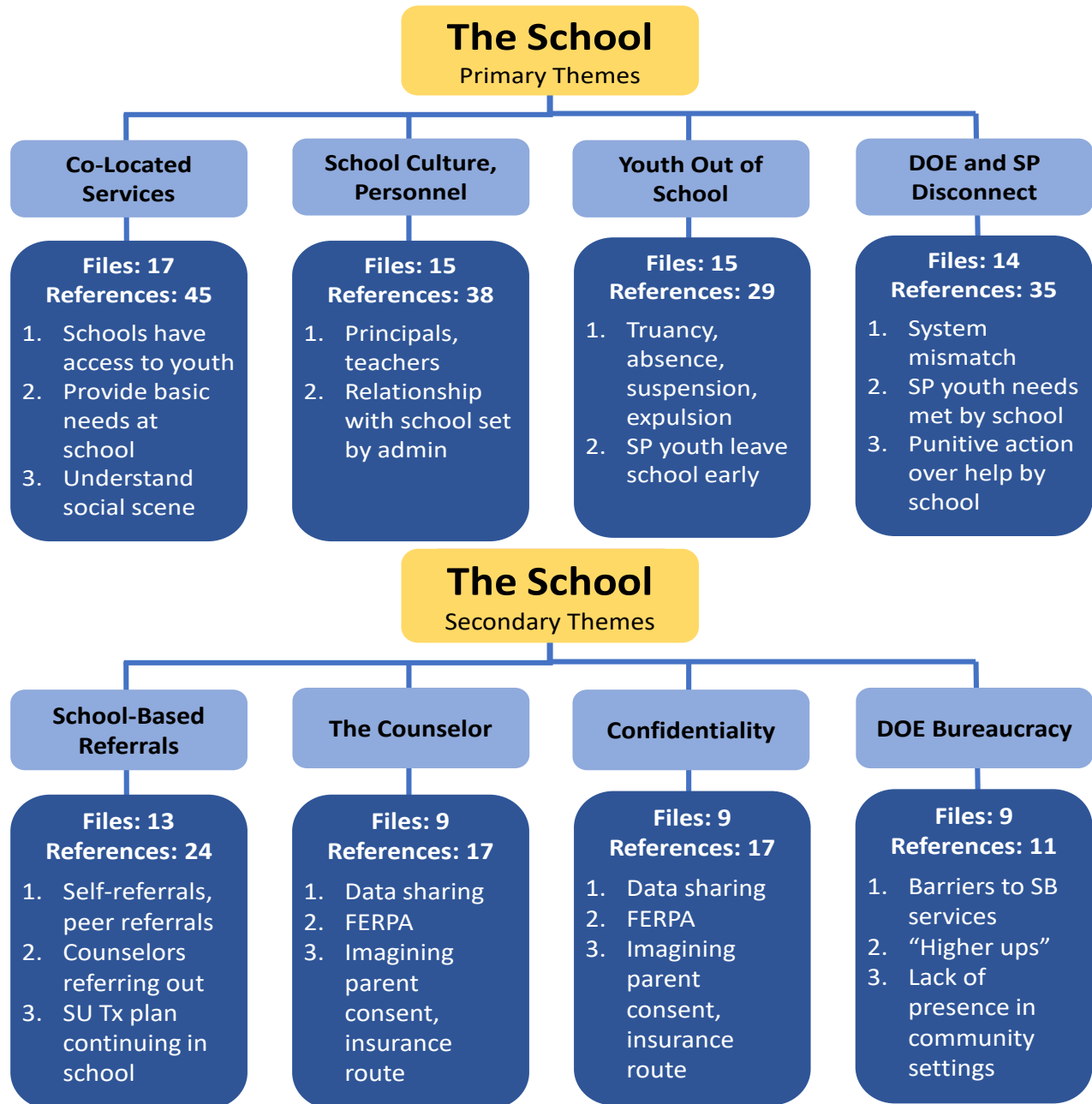
Figure 6. Factors Perceived to Create Barriers to Accessing Care.



## Theme 2: The School

The school was a specific focal point of the interview (Question 2), therefore it was a prominent a priori theme (Figure 7). The more prominent, or primary themes highlighted co-located services, school culture & personnel, concerns about out-of-school youth, limited/no coordination between the Department of Education and Service Provider Systems, school-based referrals, the role of the school counselor, issues with confidentiality, and the DoE bureaucracy (e.g. DoE operational structure to support referrals).

Figure 7. The School as a Partner.



Professionals explained that confidential access to school-based substance use services included challenges, i.e. initiating wrap around services and family engagement, as well FERPA<sup>16</sup>; and opportunities such as youth not needing insurance or parental consent (Figure 8). In spite of the challenges, educators were considered essential assets for creating service access at school (Fig. 9). For example, “Principal A” represents professionals’ perception of “difficult to work with” schools, where there are no designated rooms in which to conduct services, a siloed approach pitting the school against the service, such that the school-based treatment counselor will struggle to engage students. “Principal B” represents professionals’ perception of a “workable” school, where there is adequate space to conduct services, the school culture is supportive of school-based services, and school staff are aware and communicate with the school-based treatment counselor. In the “Principal B” scenario, the counselor is able to build their program and reach students who would benefit from receiving services.

Figure 8. Confidential Access

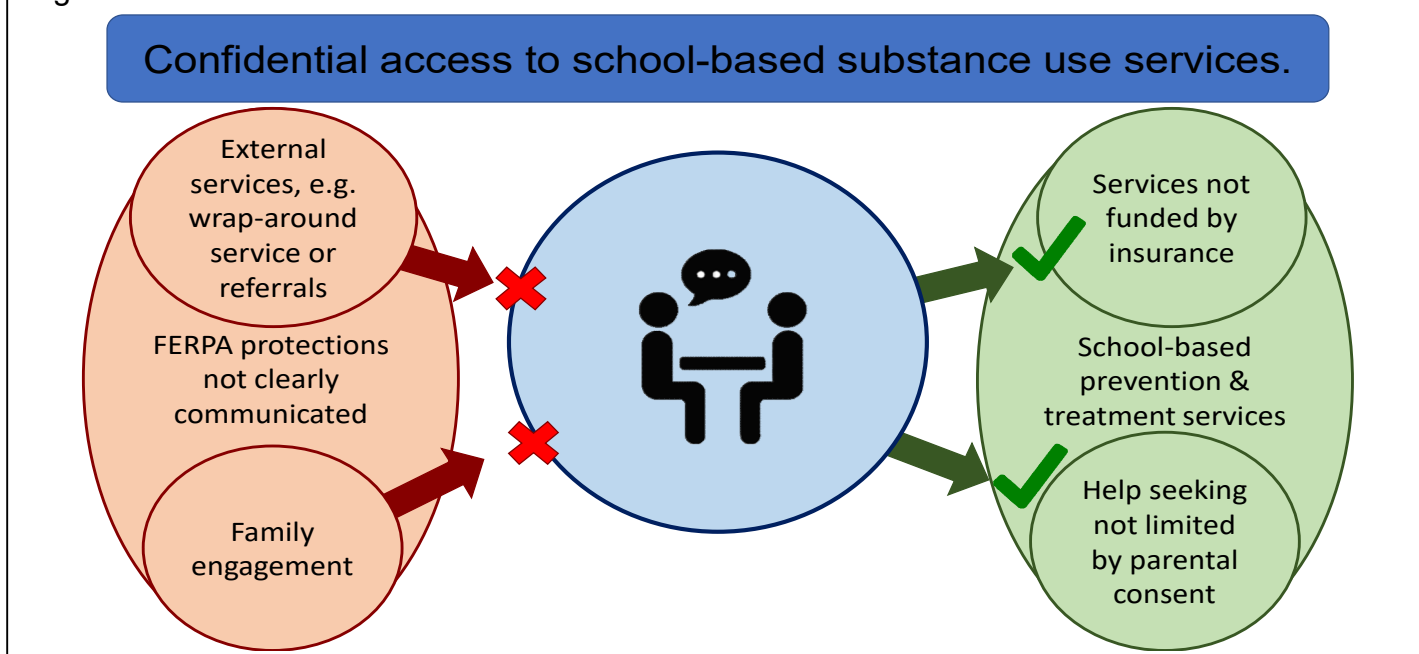
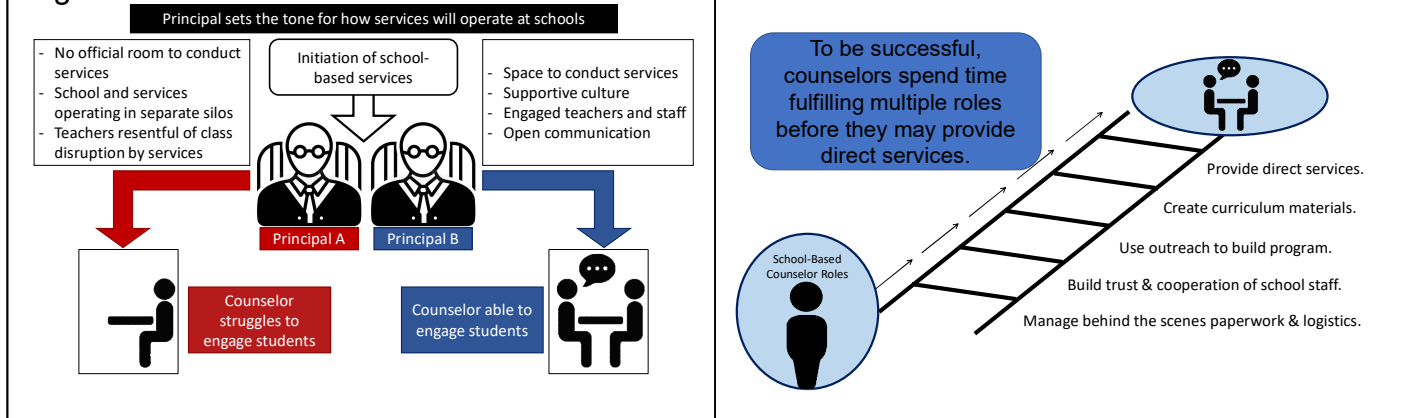


Figure 9. The Role of Educators



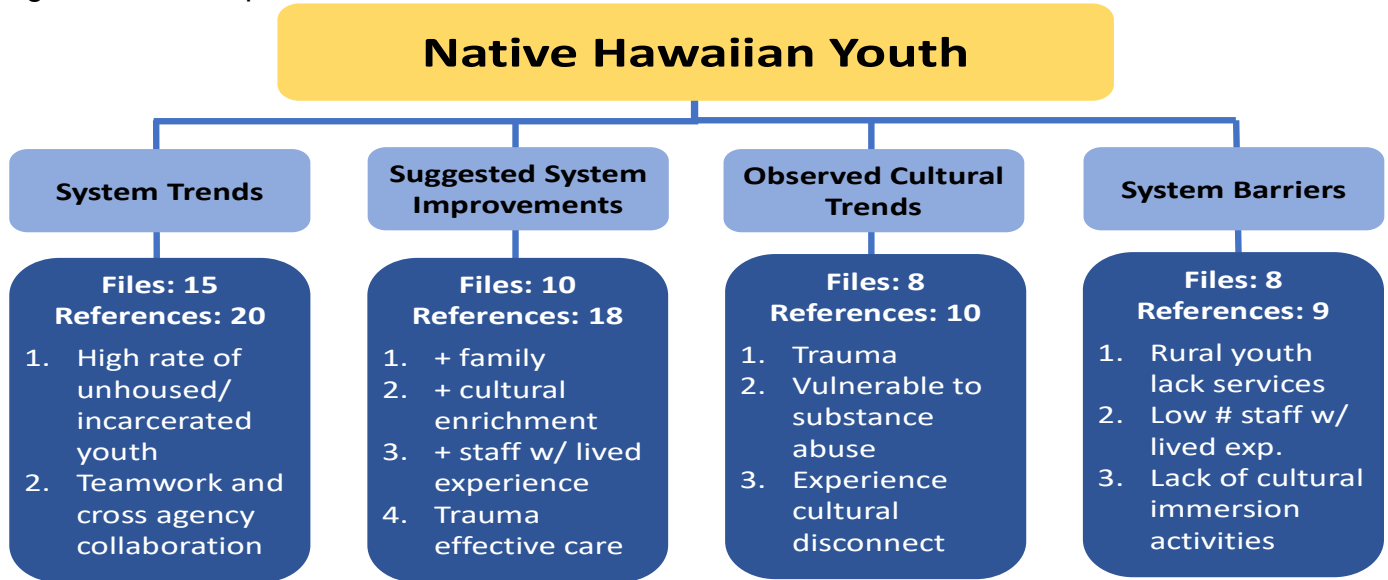
<sup>16</sup> FERPA is a federal law observed in educational systems: Family Educational Rights and Privacy Act (FERPA) is a federal law.  
<http://www.hawaiipublicschools.org/VisionForSuccess/SchoolDataAndReports/StudentPrivacy/Pages/home.aspx>



### Theme 3: Health Disparity Groups

Health disparity groups were a focal point of interview Question 4. Over half of the interviews described substance use issues specific to Native Hawaiian youth (Figure 10) and youth of Micronesian or COFA Nation ancestry (Figure 11). These issues included system trends, barriers, and areas for improvement, as well as cultural insights. Sexual and Gender Minority youth also were a focus of the interview (Figure 12).

Figure 10. Perceptions about Native Hawaiian Youth



Perception of health disparity factors impacting Native Hawaiian youth.

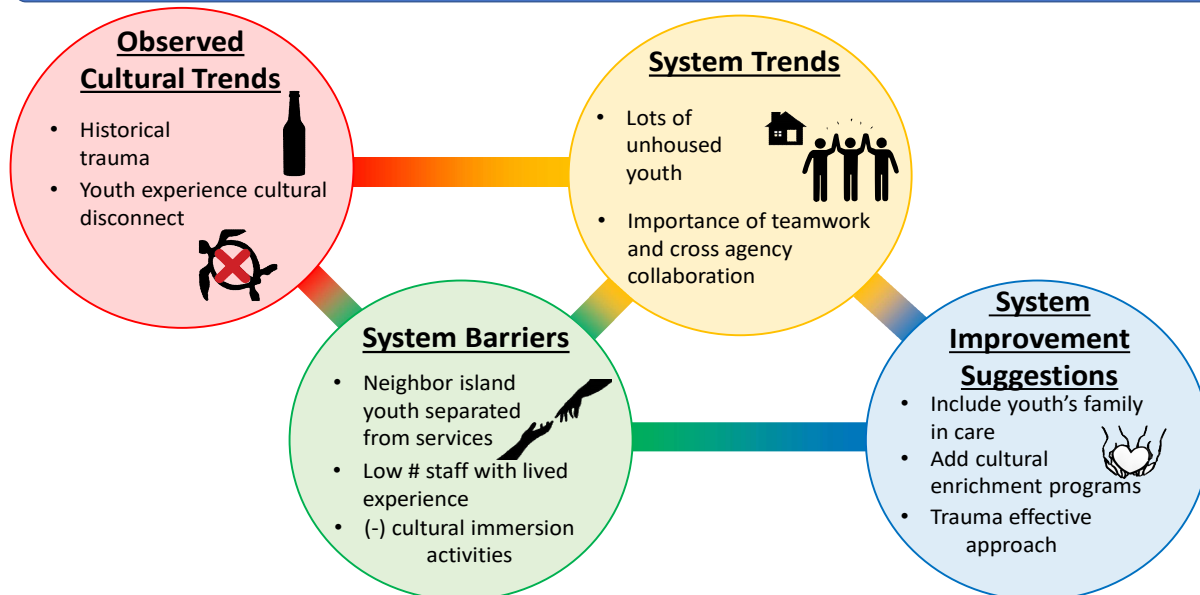
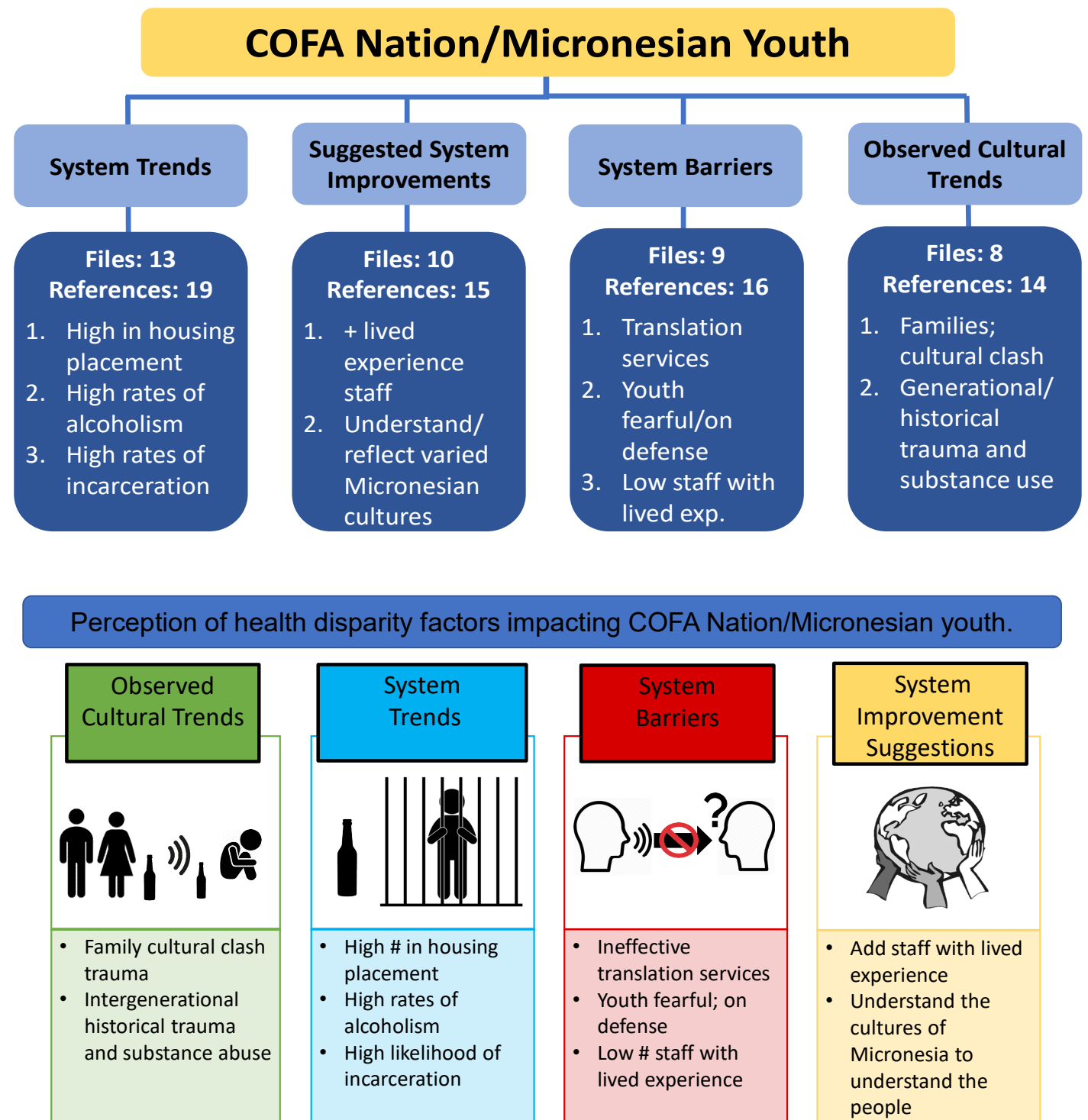
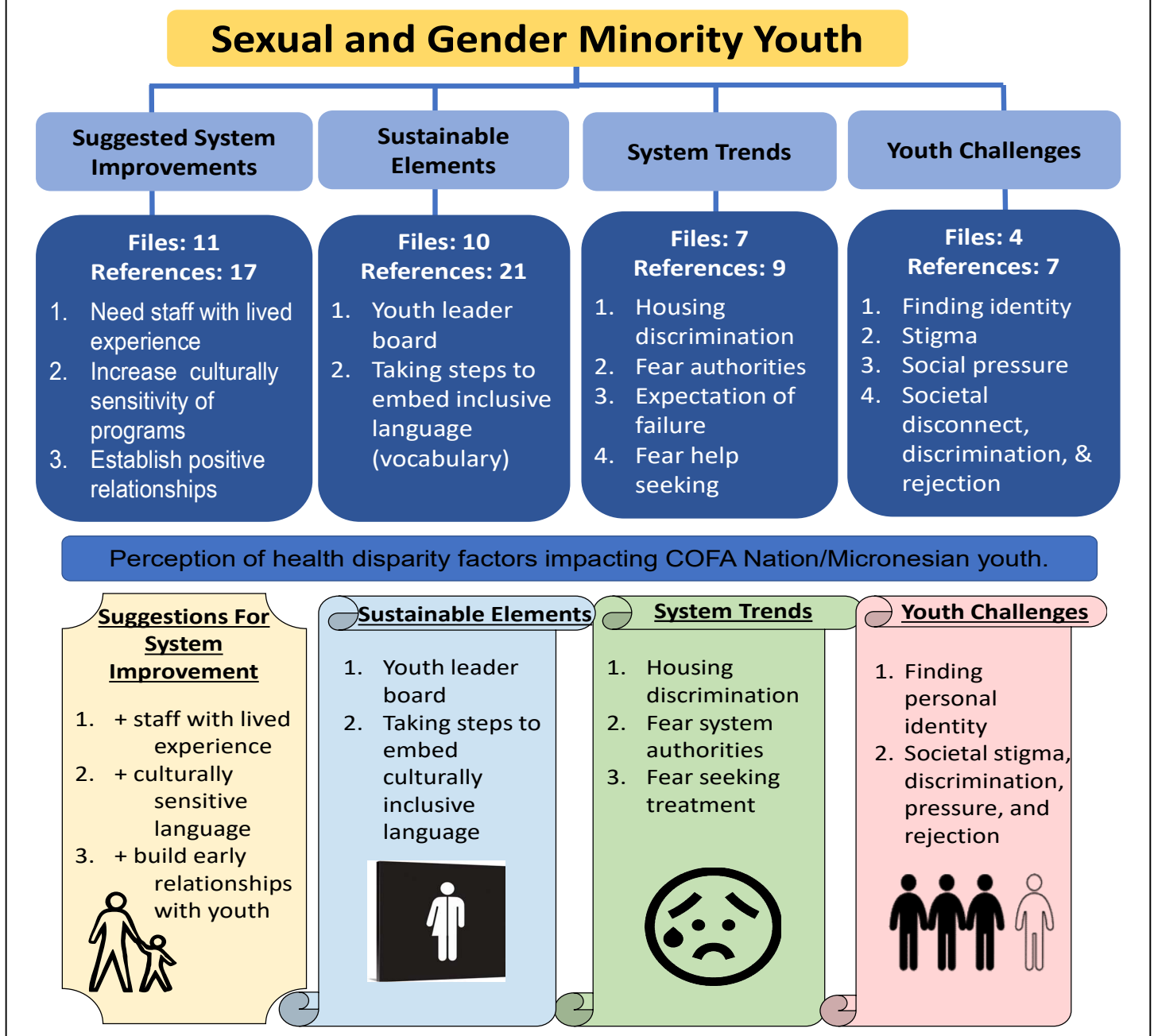


Figure 11. Perceptions about COFA Nation/Micronesia Youth



Professionals throughout the State of Hawai'i identified overlapping themes regarding sexual and gender minority (SGM) youth with respect to the CoC/SoC for substance use (Figure 12). The themes on the scrolls (youth challenges, system trends, and sustainable elements) point to the overall goal of improving SGM youths' access to an array of inclusive services (yellow plaque). Suggestions for system improvement arose from respondents experiences and observations identifying the patterns within their own organization as well as interacting in the broader system of care.

Figure 12. Perceptions about Sexual and Gender Minority Youth

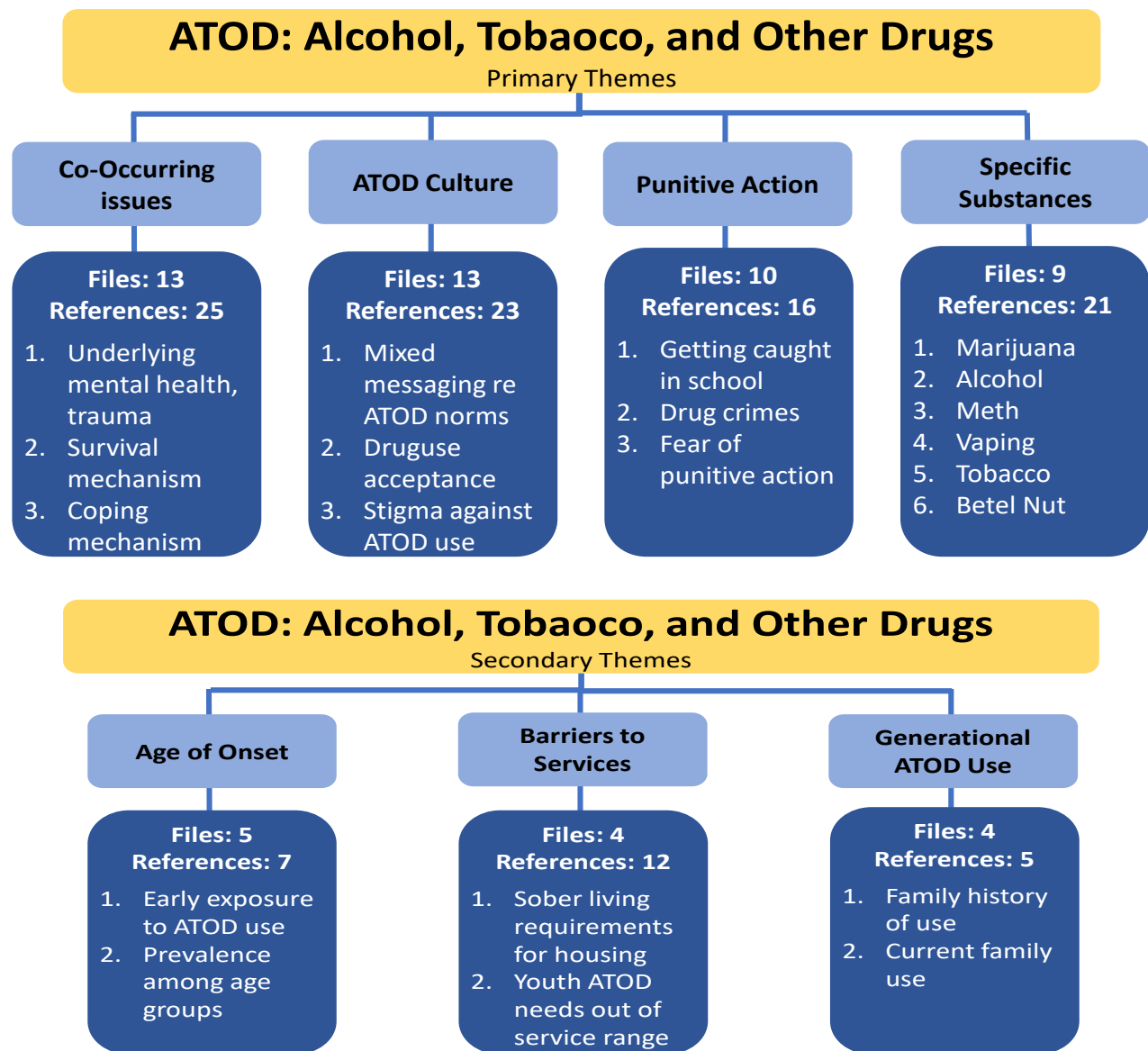


## Ecodevelopmental Systems: Micro & Meso Levels

### Theme 4: General Perceptions Regarding Youth Substance Use

At the micro and meso level, a number of general substance use issues were noted (Figure 13), spanning the use of alcohol, tobacco and vaping, and other drugs including marijuana (ATOD). Based on the most prominent or primary themes, professionals expressed concerns about co-occurring mental health problems, the existence of a “drug culture” or norms supportive of substance use, as well as a system emphasis on punitive action rather than harm reduction. Other secondary themes highlighted age of onset, barriers to care related to sobriety, and intergenerational problems.

Figure 13. General Perceptions of Youth Substance Use.



## Theme 5: Risk & Protective Factors, including Trauma & Youth Advocacy

Risk and protective factors were identified at the micro and meso level. Risk factors included system involvement (e.g. foster care), competing requirements between youth & family needs and service system setting demands, as well as family and school setting issues (Figure 14). Of particular concern was trauma (Figure 15), both in terms of life trauma that may have created vulnerabilities toward substance use, as well as trauma experienced by youth who have become involved in public sector services.

With respect to trauma as a risk factor, professionals perceived that traumatic life experiences may result in substance use as a coping mechanism, both of which are related to the need for public sector services including foster care, juvenile justice, mental health or housing stability services (Figure 16, depicted in the green box in the left). However, these systems were perceived to contribute to new trauma as well as exacerbate existing trauma, thus increasing substance use among some youth (Figure 16, depicted in the blue box in the right). Borrowing from biology and the ecological systems theory, trauma that results from system-involvement is depicted in the blue box as a permeable cell with the youth positioned in the center nucleus. From this view, the youth is vulnerable to trauma both within the cell (e.g. historical trauma, family structure disruption, family substance use, and violence in the home) and beyond the cell (e.g. disrupted community connection, isolation, disruption of close relationships, and disruptions in school attendance).

Figure 14. Risk Factors for Substance Use.

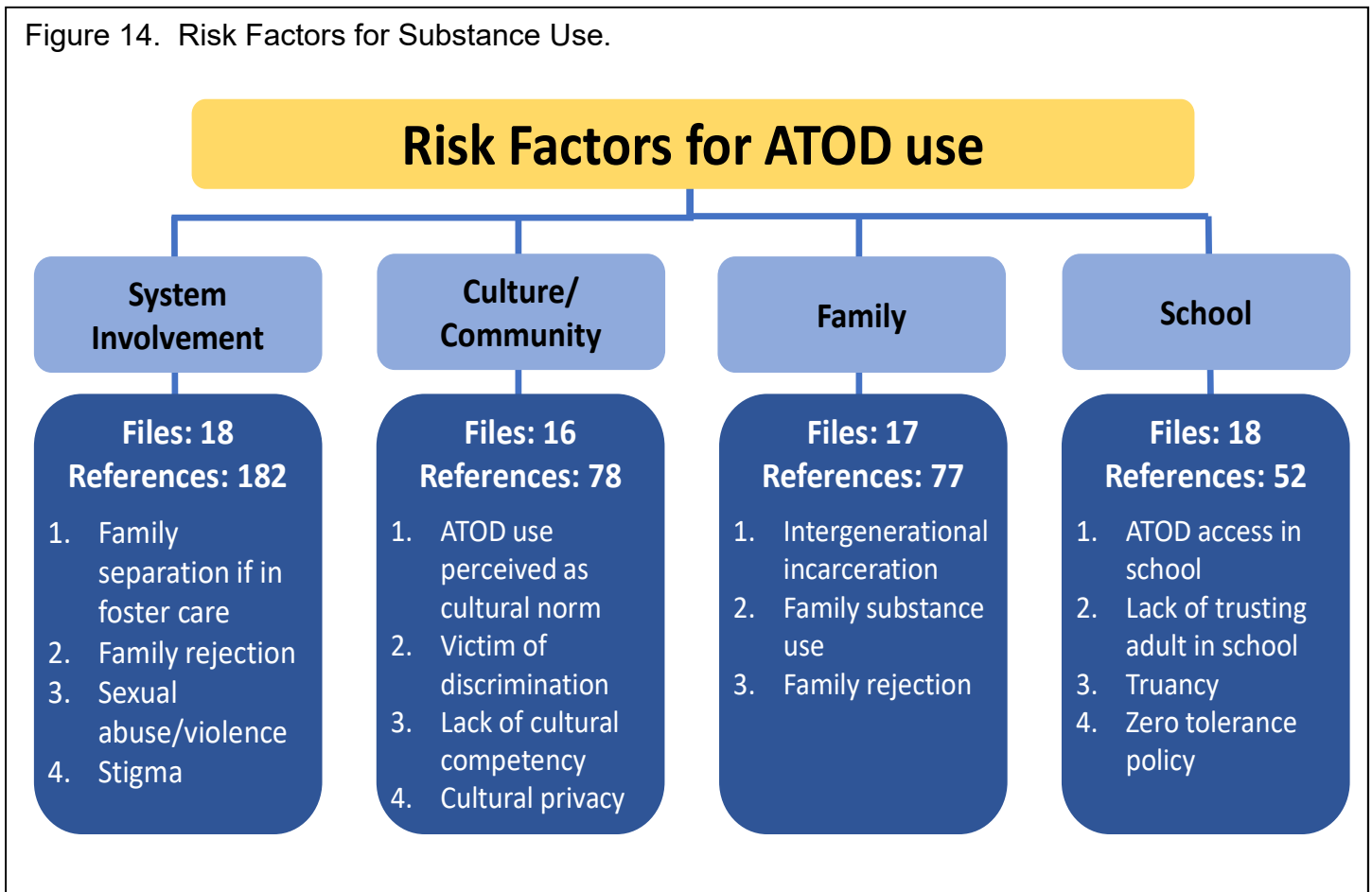


Figure 15. Trauma as a Risk Factor for Substance Use.

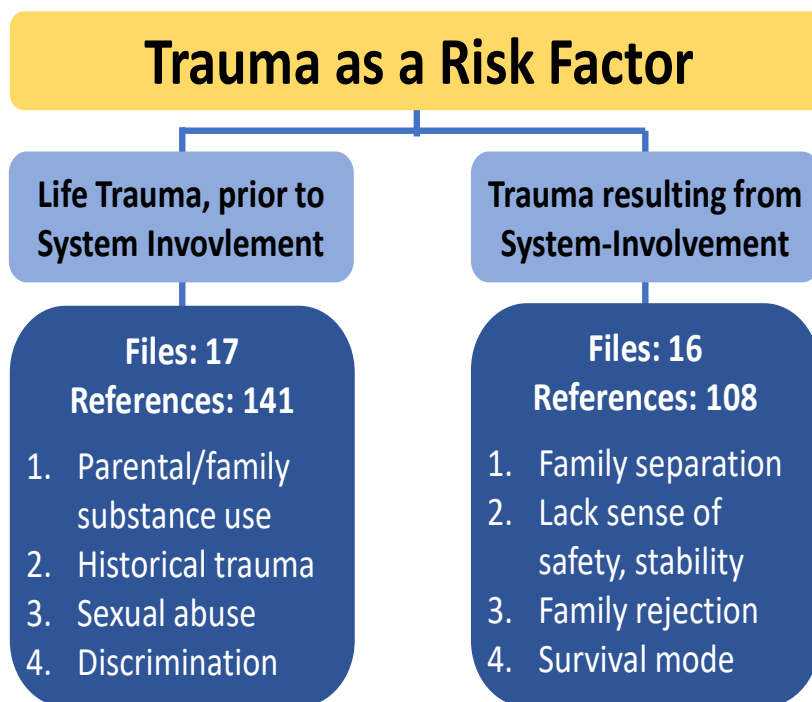
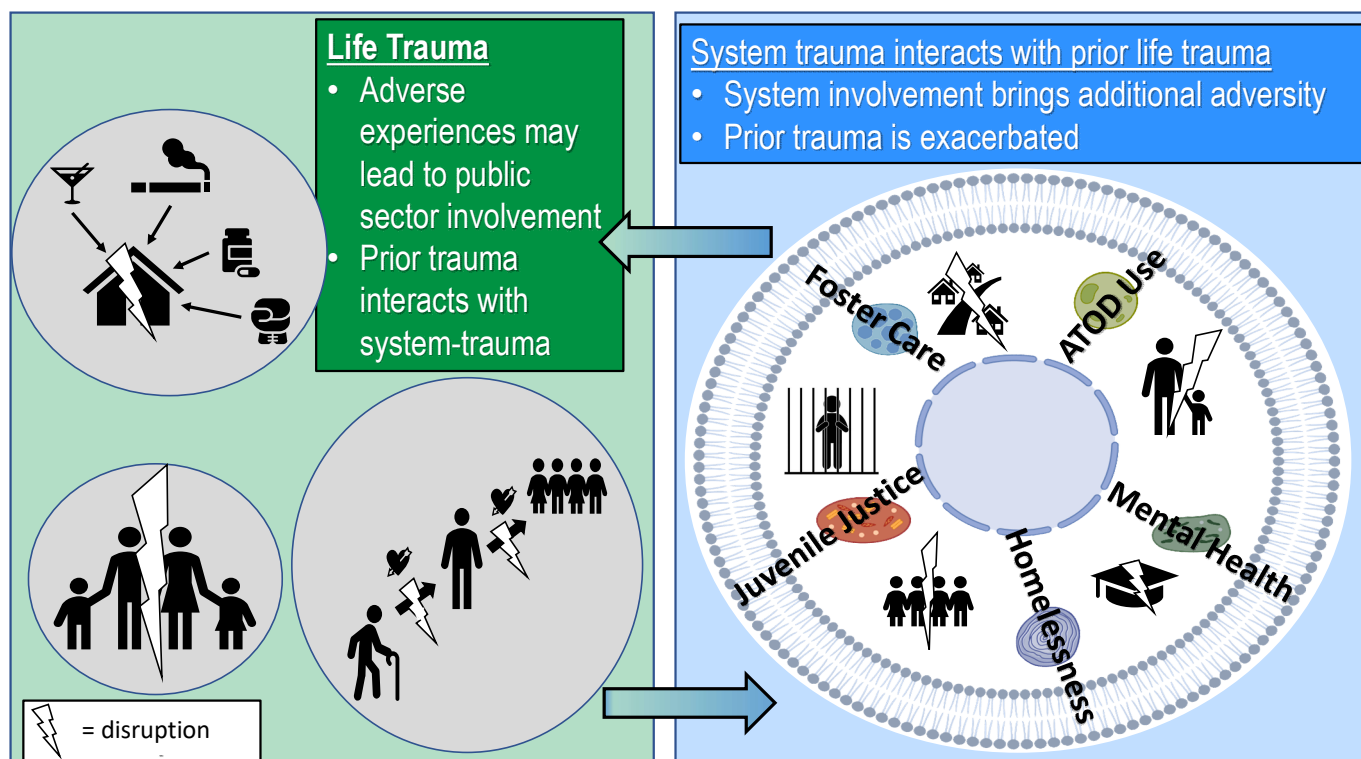


Figure 16. Trauma Cycle and the Cellular Analogy.



Protective factors in the community and culture were noted, as were protective factors in the family and school (Figure 17). As protective factor, youth advocacy included things like youth circles for peer support, youth voice and choice, and other leadership opportunities (Figures 18 & 19). Although not discussed extensively, youth advocacy was described as the heart of a youth centered CoC/SoC.

Figure 17. Protective Factors for Youth Substance Use

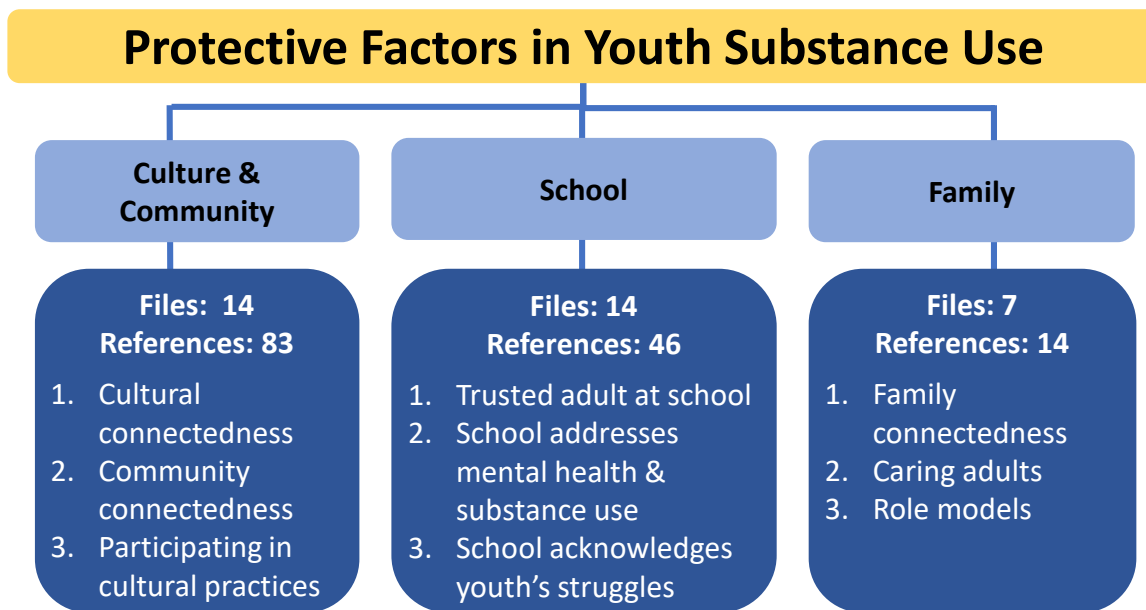


Figure 18. Youth Advocacy is a Protective Factor

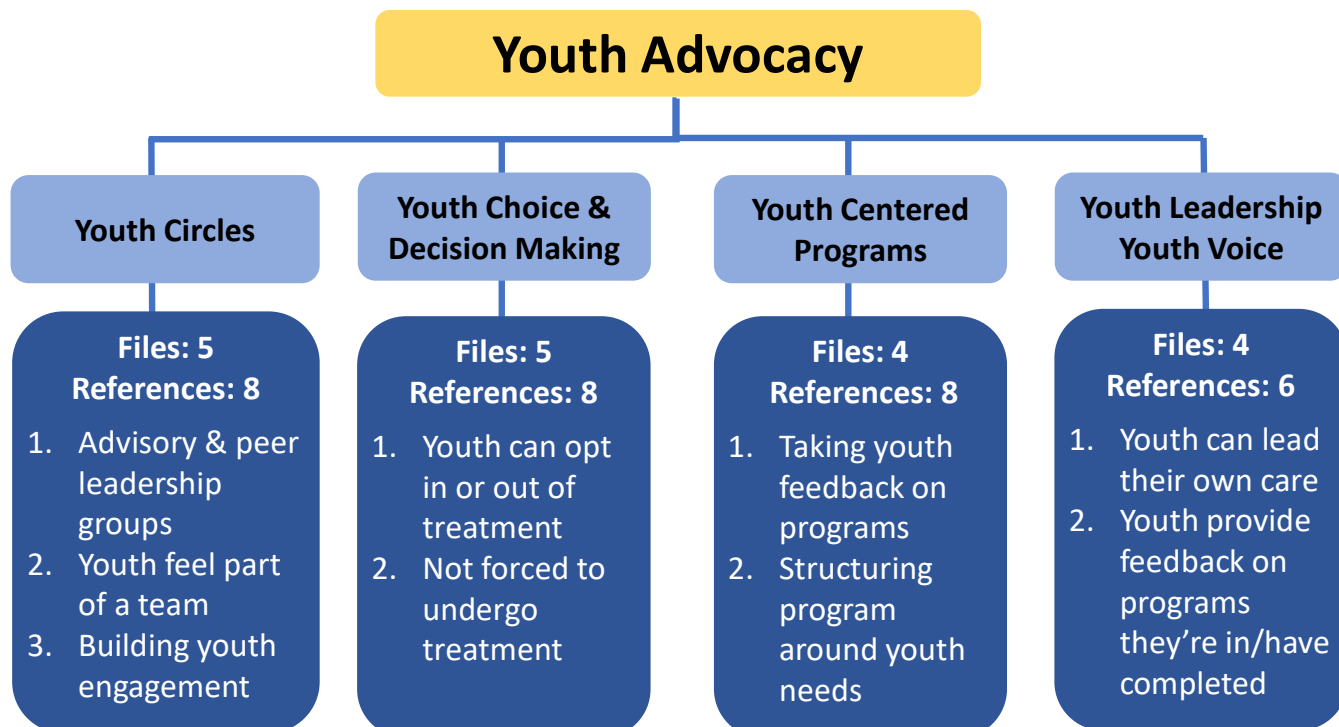
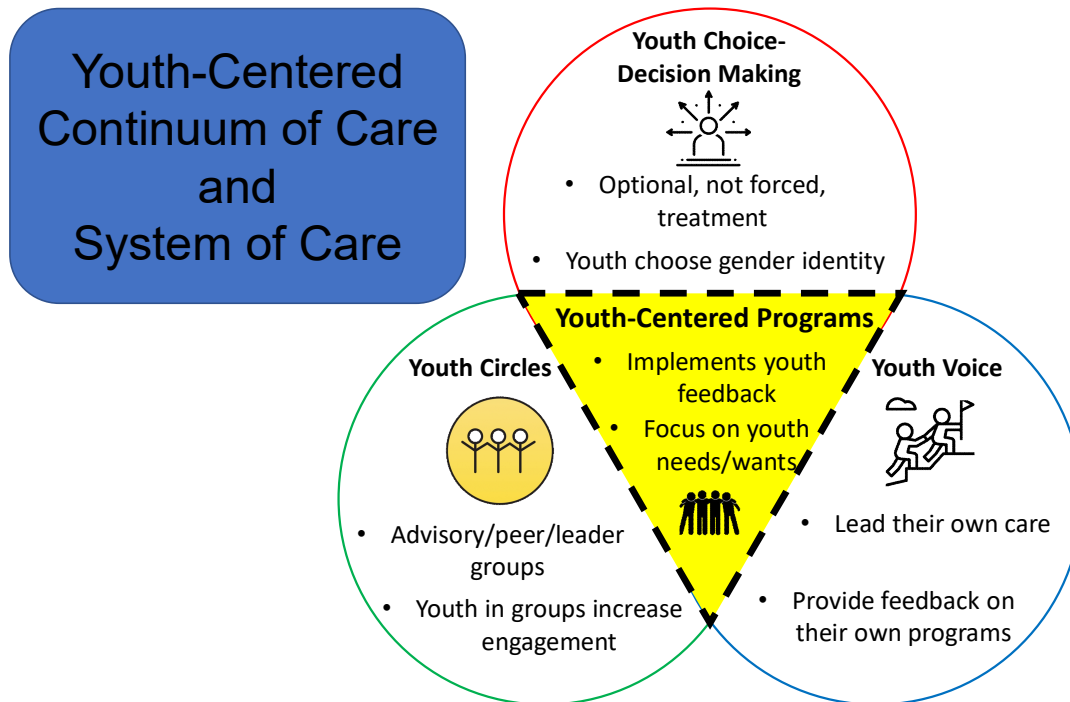




Figure 19. Youth Advocacy: the Heart of a Youth-Centered Continuum of Care & System of Care



## Theme 6: Peers and Family

In approximately half of the interviews, peers and family were mentioned as having an impact on youth substance use. Peers and family were perceived to serve both as risk and protective factors, depending on the situation. For example, professionals acknowledged that peers refer their friends to substance use services, yet there is peer pressure to use drugs. Similarly, some youth may use substances as a coping strategy to combat bullying and other stigmatization experienced among their peers (Figure 20). Regarding families (Figure 21), professionals explained that because some youth may prefer to receive services confidentially, due to a fear of getting into trouble with their parents for using drugs, it's important that youth may access services without parental consent. However, the youth's preference for confidentiality creates challenges for professionals who want to include families in their treatment planning. Several professionals mentioned that family engagement was especially challenging due to insufficient support for multilingual services, particularly when working with COFA nation/Micronesian youth.

Figure 20. Peers & Substance Use: Risk & Protection

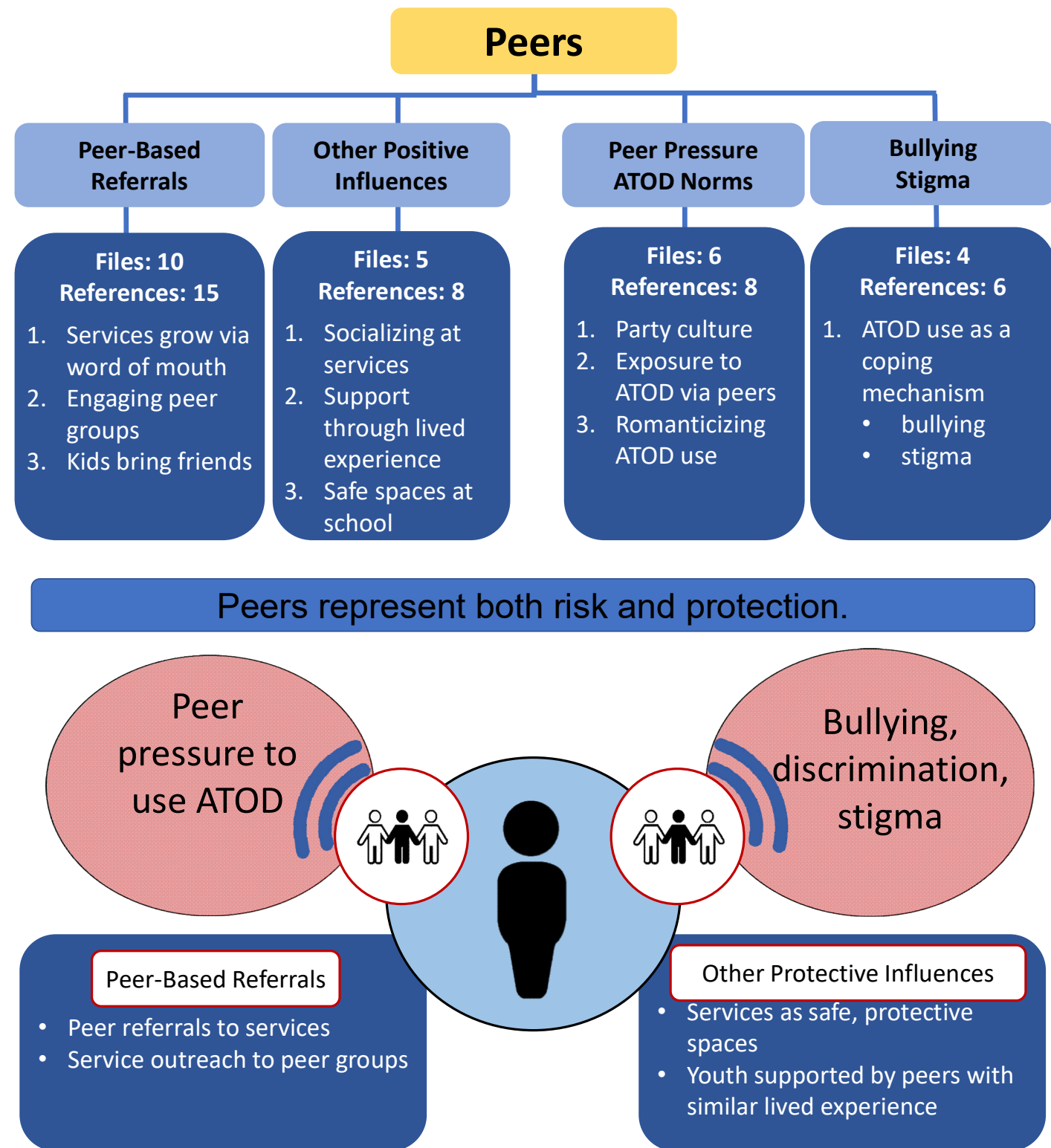
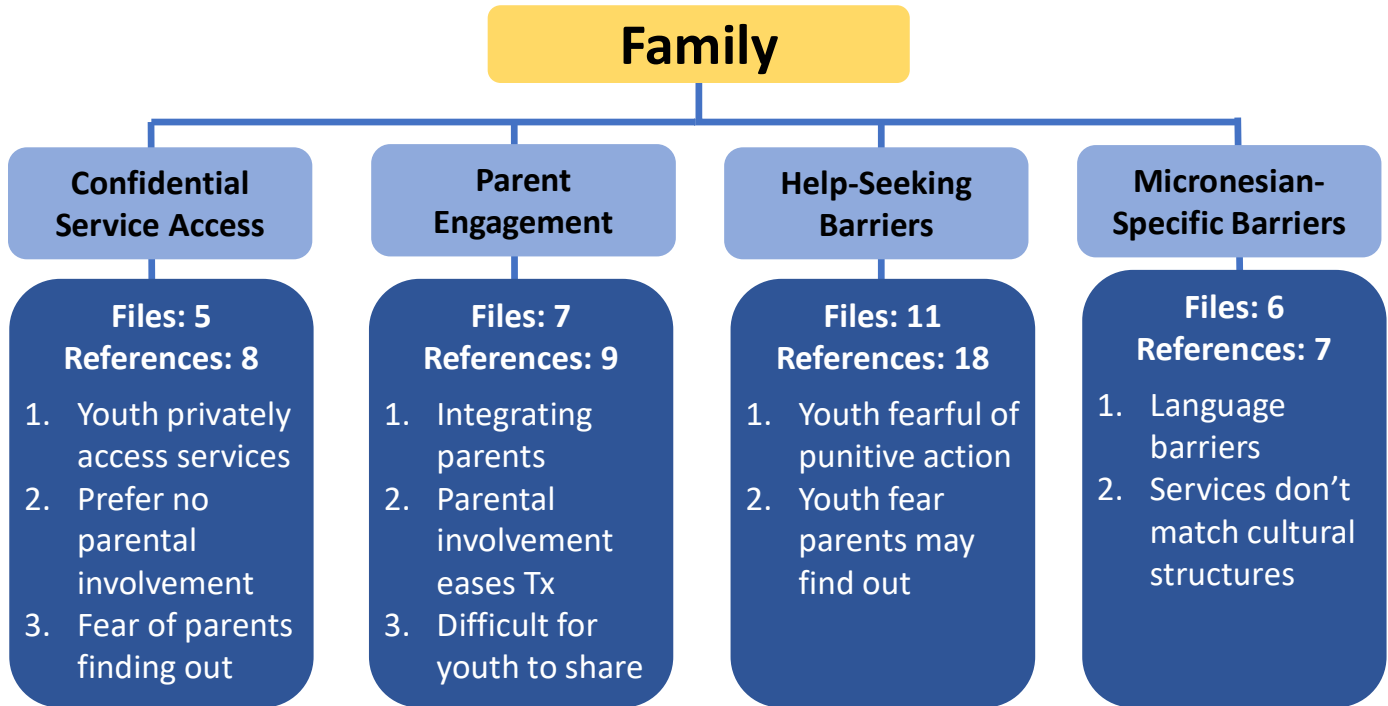
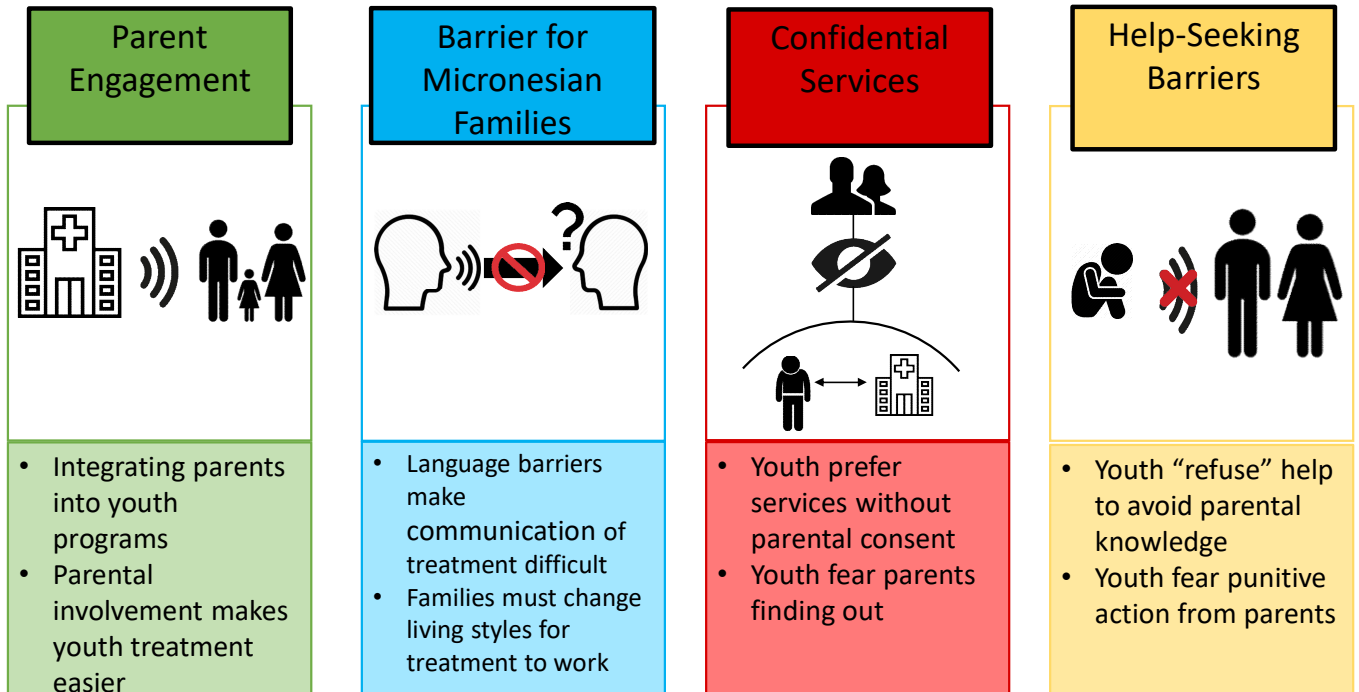


Figure 21. Family & Substance Use: Risk & Protection



The role of family and parents in their child accessing services

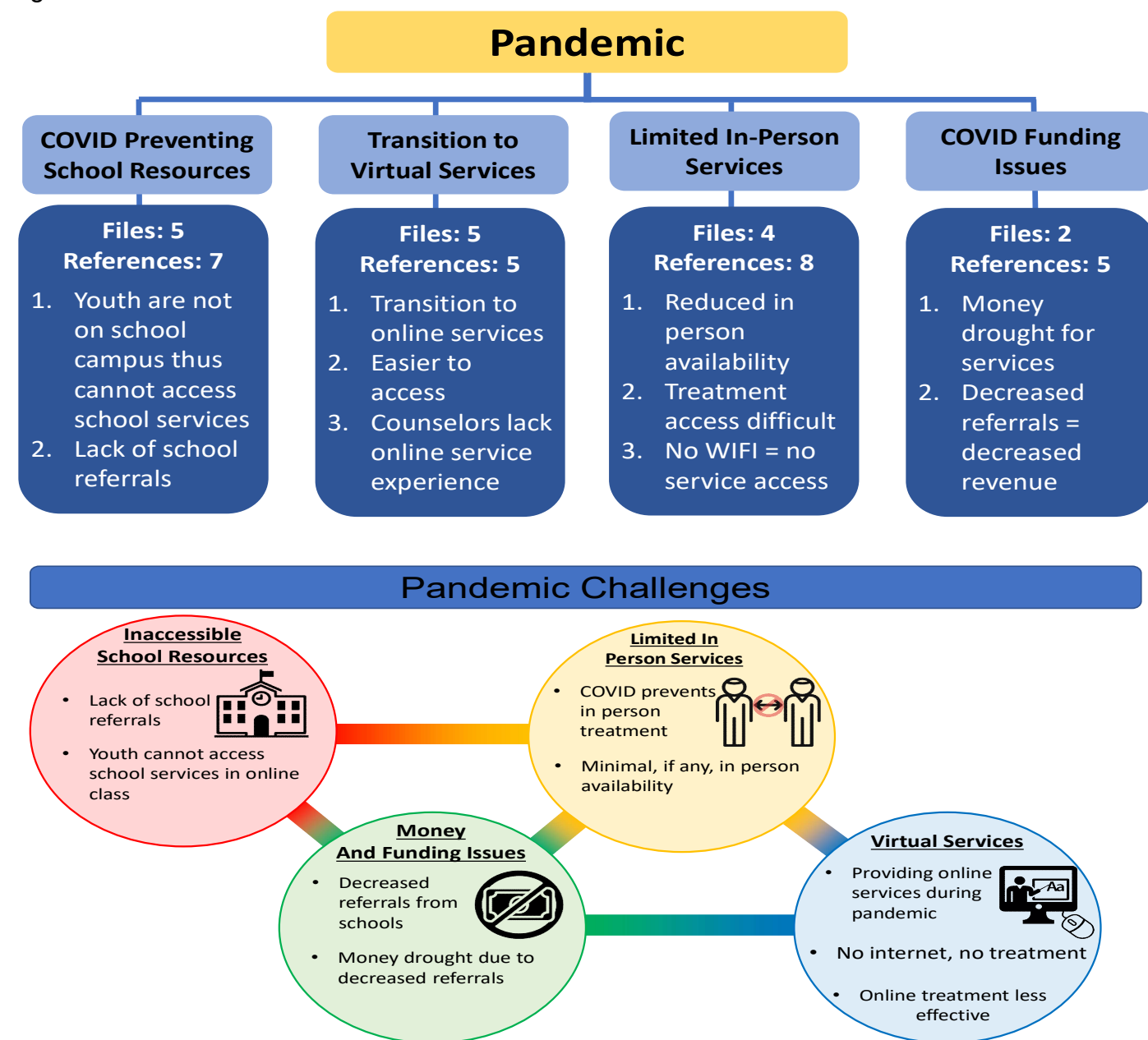


## Ecodevelopmental Systems: Chrono Level

### Theme 7: Corona Virus Pandemic

Although it was not a prominent theme, it is important to note the data for this project were collected during the covid-19 pandemic from mid-June 2020 to the end of July 2020 (Figure 22). The State of Hawai'i initiated a lock down in mid-March 2020, which included school closures or virtual schooling, thereby making access to youth a challenge. Most organizations transitioned to virtual services, and very few in-person services were possible at the early stages of the pandemic. Challenges in maintaining contact with youth created concerns for contract-related funding.

Figure 22. Covid-19 Pandemic



## 4. Conclusion.

**Reflections on the Pandemic.** At the time of this writing (January 2021), the social, economic, and health strains of the pandemic are still with us. Although some feel the [vaccination](#) distribution plans will provide higher levels of COVID immunity statewide by summer 2021, mental health complications and substance use problems experienced by [youth](#) are expected to continue to rise. We interviewed professionals statewide in summer 2020, several months after the state ordered a general lock-down. In a sense, the work-during-pandemic was new still, and the pressure on school-based providers to maintain contact with youth during the summer generally is less than during the academic year. That said, we are confident that the findings from this content analysis continue to apply, even now that we are nearly a year into pandemic living and working.

**Summary of Findings.** As noted in the introduction, this qualitative youth needs assessment is a companion to the quantitative Hawai'i Student Alcohol, Tobacco, and Other Drug (ATOD) Use Survey needs assessment. A benefit of this qualitative approach is that we are able to learn about the system of care and continuum of care for youth substance use from the people who are best acquainted with it – namely the professionals who care for youth and their families. The professionals provided an inside view the system's current capabilities and limitations, as it relates to the youth who are most likely to engage in the substance use service system and the intersecting public sector services.

Much of what the professionals described was confirmatory of our prior rapid assessment [report](#) – the continuum of care, while good, still creates challenges for youth at the extremes of the continuum. Youth may not meet criteria for treatment services or there are no beds available for youth in need of residential care, yet the time and effort spent navigating the system looking for these services may produce frustration among staff. Often times, youth may not be able to enroll in services until their system involvement has elevated, but this defeats the idea of early identification and engagement in services. Furthermore, the youth system continues to orient towards a less effective disciplinary model rather than a coordinated and effective habilitative, prevention- and treatment-oriented, service-oriented, culturally responsive and academically-individualized one.

Among youth from minoritized or disenfranchised populations, the continuum of care was conceptualized as doing the best that it can. A best-that-it-can orientation may be interpreted as the system is not doing enough, but solutions remain elusive. That said, professionals noted solutions for sex and gender minority youth (e.g. staff training, non-binary facilities), COFA Nation/Micronesian youth (e.g. staff recruitment, translation services), and Native Hawaiian youth (acknowledge cultural trauma, culturally relevant interventions).

**Next Steps.** Two areas highlighted in this report pertaining to risk and protective factors are trauma as a risk factor and youth advocacy as a protective factor. Although professionals did not dwell on these topics, they appeared important enough that our next steps include weaving these themes into our report of the in-depth interviews with youth. Based on the analysis of the professionals' interviews, we focused the youth interviews so that youth may share insights on trauma and youth advocacy.

In addition, public dissemination of the results of both the professional and the youth in-depth interview needs assessment results is planned for mid-June 2021. We will be collaborating with the Hawai'i Youth Services Network and their partner, the Hawai'i Interagency Statewide Youth Network of Care. Registration announcements for the webinar will be announced this spring 2021.

## 5. Appendices.

Appendix A. HSP Letter.

Appendix B. Interview Guide.

Appendix C. Glossary of Abbreviations.

## Appendix A. HSP Letter



UNIVERSITY  
of HAWAII®  
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  
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## Appendix B. Interview Guide

### Youth Needs Assessment In-Depth Interview *Substance Use Prevention & Treatment Continuum of Care, System of Care*

*Special Populations ~ high need, low resource*  
substance use  
mental health  
juvenile justice  
foster care or kinship care  
homelessness, unstable housing

#### Mahalo!

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

#### Youth System of Care

Your views and expertise will help ADAD and community organizations involved in substance use/abuse prevention & treatment improve their systems of care, and help create future plans for wider reaching services and support.

#### Special Population Team

Attending your interview on behalf of the Special Populations team are the interviewer, a notetaker, and for some interviews there is an observer learning how to conduct interviews. Once the interview begins, the notetaker and observer will close their video and mute their audio.

#### Audio Record Transcript De-ID

The notetaker is making an audio recording using our own recorders (not using the zoom record feature). The recording will be converted to a transcript. Your transcript will be de-identified, meaning your name will not be attached to the transcript, and references to people, places, and organizations will be given pseudonyms.

#### Strengths Improvements

Your interview transcript will be compiled with the interviews of other professionals in order to highlight strengths and areas for improvement in the youth substance use prevention and treatment system of care and continuum of care.

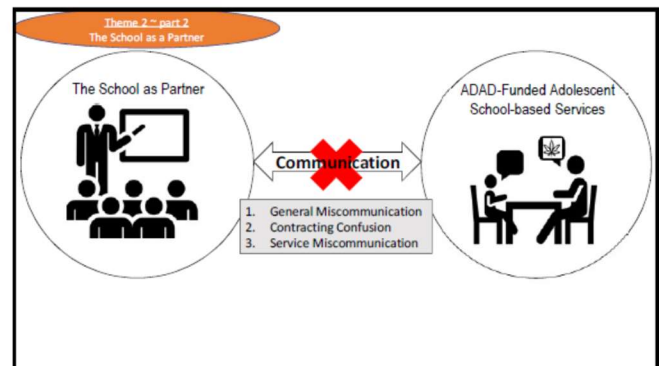
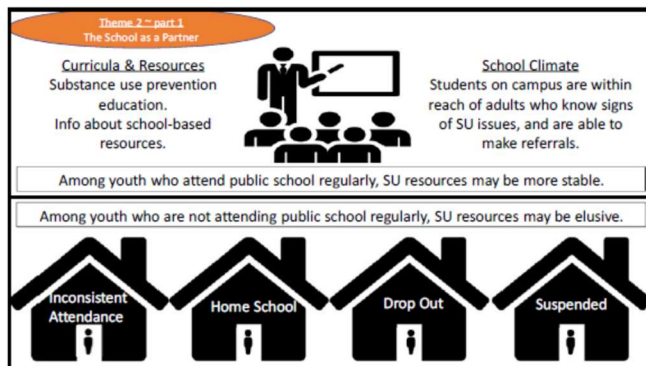
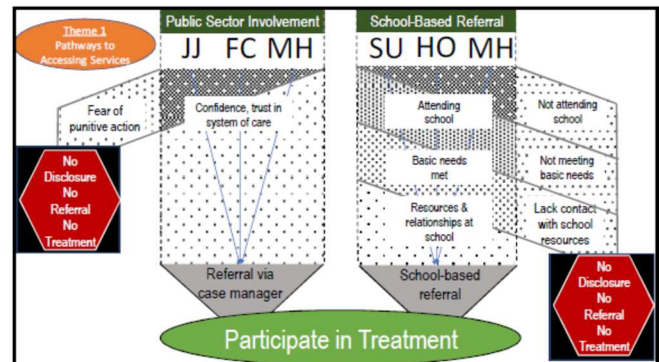
#### Reports

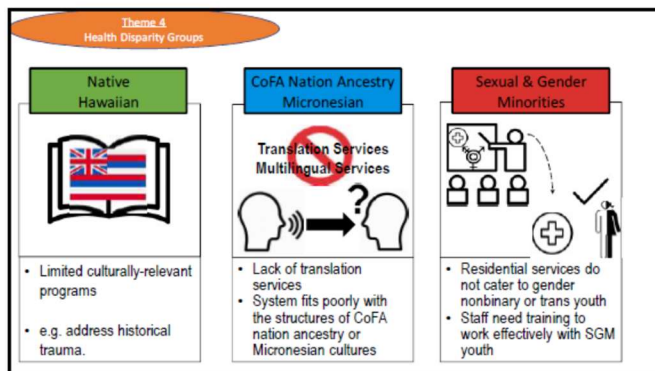
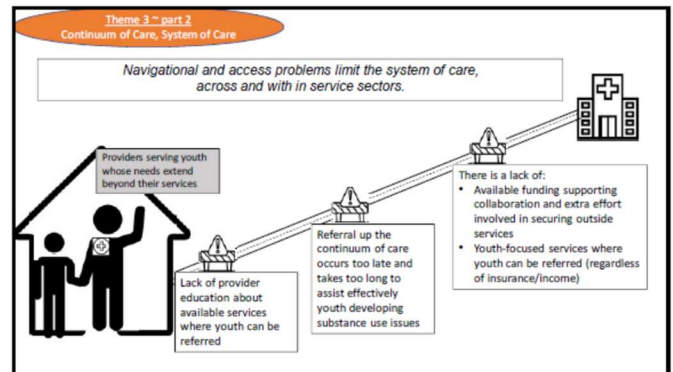
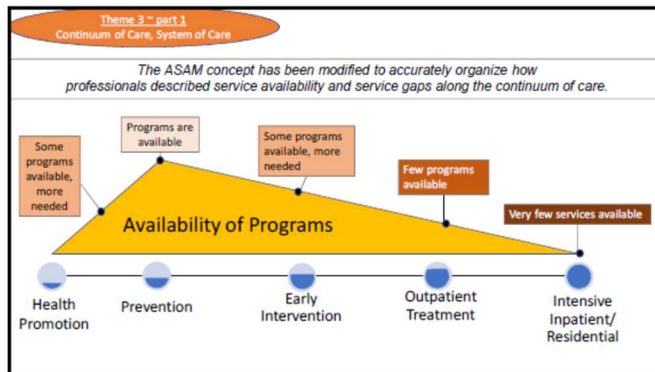
A report will be provided to ADAD. In the future, the Special Populations Team may share this information at conferences, workshops, community meetings, webinars, or journal articles.

### Interview Questions

*Theme 1: Pathways to Accessing Services.*  
*Theme 2: The School as a Partner.*  
*Theme 3: Continuum of Care, System of Care.*  
*Theme 4: HD Groups-NH, COFA/M, SGM.*  
*Theme 5: Rural Health Disparities.*

Ad:  
HD-Health Disparity  
NH-Native Hawaiian youth  
COFAM/Comp of Free Association/Micronesian youth  
SGM-Sex and Gender Minority youth





**Theme 5**  
Rural Health Disparity

Rural-Urban Service Strengths (★) and Weaknesses (✖)

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 -> social isolation for off island services ✖	Intensive treatment options unavailable or in very high demand ✖

What else would you like to add?

## NEXT STEPS



## Appendix C. Glossary of Terms and Abbreviations

### Abbreviations

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

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