

**REPORT TO THE TWENTY-THIRD LEGISLATURE
STATE OF HAWAII
2006**

**PURSUANT TO SECTION 3 OF ACT 213, SESSION LAWS OF
HAWAII 2005 (REGULAR SESSION), REQUIRING A REPORT BY THE
STUDENT SUBSTANCE ABUSE ASSESSMENT AND TREATMENT
ADVISORY TASK FORCE**

PREPARED BY:

**DEPARTMENT OF HEALTH
STATE OF HAWAII
DECEMBER 2005**

EXECUTIVE SUMMARY

This report is submitted pursuant to Section 3 of Act 213, Session Laws of Hawaii (SLH) 2005, which created the Student Substance Abuse Assessment and Treatment Advisory Task Force. The task force was charged with:

Reviewing the process by which a child who violates the zero tolerance policy for drugs and alcohol in public schools is referred for assessment and treatment of substance abuse and excluded from school; and

Submitting a report of its findings and recommendations, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2006.

BACKGROUND

Act 90, SLH 1996, established a “zero tolerance” policy “to allow principals, on a case-by-case basis, to exclude students found to be in possession of dangerous weapons, switchblade knives, intoxicating liquor, or illicit drugs while attending school.” Act 274, SLH 2000, amended the policy to allow a principal to suspend a student once it has been determined that the student consumed or used intoxicating liquor or illicit drugs prior to or while attending school or a department-supervised activity.

In January 2004, the Joint House-Senate Task Force on Ice and Drug Abatement issued its final report, which included a recommendation to amend Section 302A-1134.6, Hawaii Revised Statutes (HRS), to require that public school students be assessed and as appropriate, referred to treatment before student disciplinary action is taken. Part IV (Section 14) of Act 44, SLH 2004 amended Section 302A-1134.6, HRS, to require a student found to be in violation of the “zero tolerance” policy to be assessed by a certified substance abuse counselor to determine the need for substance abuse treatment. Subsequently, Section 2 of Act 213, SLH 2005, replaced Act 44, SLH 2004, amendments to Section 302A-1134.6, HRS.

The Student Substance Abuse Assessment and Treatment Advisory Task Force was formed pursuant to Section 3 of Act 213, SLH 2005, to review the implementation of Section 302A-1134.6, HRS, and the process by which a student who violates the zero tolerance policy for drugs and alcohol in public schools is referred for substance abuse screening, assessment and treatment.

FINDINGS AND RECOMMENDATIONS

The following are the findings and recommendations of the Student Substance Abuse Assessment and Treatment Advisory Task Force:

Policy on Suspensions for Alcohol and Other Drug Related Offenses

Findings for improving the policy on suspensions for alcohol and other drug related offenses.

The Task Force finds that:

- Schools are providing a range of alternative educational services to students suspended for alcohol and drug related offenses within the resources of the school.
- Crisis suspending a student for 10 days to complete referral for substance abuse assessments is not realistic as referral agencies are completing assessments within 30- to 45-day timeframe.
- Family support, involvement, participation and intervention should be sought.
- A range of educational services are provided for these students, but treatment options are limited within some communities.

Recommendation. The Task Force recommends that:

- If additional educational services are to be provided by schools, additional funding for qualified staff and personnel and space must be allocated with the amendment of Act 213, SLH 2005.
- DOE should maintain the discretion throughout the disciplinary process in decisions to impose suspension based on the severity, nature, age and history of the offending student so that a student may not be suspended for the entire 92 days. For example, to allow for completion of substance abuse assessment, a student may be suspended up to 45 days.
- When a student is determined to be in violation of Chapter 19, HAR, for an alcohol or drug related offense, DOE administer a screening tool to ascertain whether there is a need for substance abuse assessment.
- DOH should assist the DOE in providing the necessary training and staff development to support school staff in administering a screening tool for alcohol and drug related disorders.

Amending Act 213, SLH 2005

Findings for amending Act 213, SLH 2005. The Task Force finds that:

- A screening process needs to be established within the school's student support services process to determine the need for substance abuse assessment.
- As appropriate, families need to be integral components within the treatment and intervention processes.
- Early return to school from alcohol and drug related offenses may be permitted as the school administrator reviews progress and treatment outcomes and takes into consideration personal and school safety issues.
- Act 213, SLH 2005 amendments – to include changes recommended by the Task Force – should be made permanent.

Recommendation. The Task Force recommends that:

- A school screening process for determining the need for substance abuse assessment referral should be added to “zero tolerance” statutory provisions.
- Family involvement and participation follow-up counseling and/or other student support services should be included as one of the provisions for early return to school whenever appropriate.
- The ‘repeal and reenactment’ clause in Section 5 of Act 213, SLH 2005 should be deleted.

Financing of Substance Abuse Services

Findings for financing of substance abuse services. The Task Force finds that:

- Treatment providers’ eligibility for reimbursement by insurers (e.g., HMSA and Kaiser Permanente) for alcohol and drug assessments to accommodate gaps in the continuum of adolescent substance abuse treatment services need to be expanded to include reimbursement of Certified Substance Abuse Counselors (CSACs).
- Students who are not covered by health insurance or QUEST may be unable to access services without financial resources.
- All public high schools should have school-based substance abuse treatment services. Of the 53 intermediate/middle schools, 30 schools remain without school-based substance abuse treatment services. (There was a broad consensus that all high schools and intermediate/middle schools have school-based substance abuse treatment services available. However, a specific funding recommendation is not included as it was deemed to be beyond the scope of the Task Force.)
- Families need to be informed of how to approach insurance agencies to qualify for accessing assessment and treatment services.

Recommendation. The Task Force recommends that:

- Chapter 431M, HRS, should be amended to include certified substance abuse counselors as providers eligible to be reimbursed for student assessments for alcohol and other drug related “zero tolerance” offenders.
- DOH, DOE and insurers should work together to develop a broader range of treatment options for alcohol and drug related referred students. In addition, resources should be committed to provide for an “assessment bank” that would fund assessment services for uninsured students.
- DOH and DOE should develop informational packets for families and students to be disseminated to schools to ensure proper and adequate accessibility to appropriate substance abuse services.

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**REPORT TO THE LEGISLATURE
SUBMITTED BY
THE DEPARTMENT OF HEALTH
PURSUANT TO SECTION 3 OF ACT 213,
SESSION LAWS OF HAWAII 2005 (REGULAR SESSION)**

PURPOSE

This report is submitted pursuant to Section 3 of Act 213, Session Laws of Hawaii (SLH) 2005, which created the Student Substance Abuse Assessment and Treatment Advisory Task Force. The task force was charged with:

Reviewing the process by which a child who violates the zero tolerance policy for drugs and alcohol in public schools is referred for assessment and treatment of substance abuse and excluded from school; and

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TASK FORCE COMPOSITION

Members of the Student Substance Abuse Assessment and Treatment Advisory Task Force were appointed pursuant to Section 3 of Act 213, SLH 2005.¹ Members are as follows:

Senator Rosalyn H. Baker, Chairperson
Senate Committee on Health
(Task Force Chair)

Clayton J. Fujie
Deputy Superintendent
Department of Education (DOE)

Michelle R. Hill, Deputy Director for Behavioral
Health Administration
Department of Health (DOH)

Representative Blake K. Oshiro, Vice-Chair
House Committee on Judiciary

Keith Y. Yamamoto, Chief
Alcohol and Drug Abuse Division

Alvin Nagasako, Principal
Kapolei High School

Elaine Wilson, ACSW, LSW, MPH
Healthcare Professional

Alan Johnson, Managing Director
Hina Mauka

Anthony "Tony" Pftalzgraff
District Vice President
Young Men's Christian Association

Alternates. Alternates designated by members are as follows: Ember Shinn (for Representative Blake K. Oshiro), Margaret Tom (for Keith Y. Yamamoto), Darrel Galera and Darin Piliialoha (for Alvin Nagasako), and Colleen Fox (for Alan Johnson).

¹ Pursuant to Section 5 of Act 213, SLH 2005, the advisory task force shall cease to exist after June 30, 2006.

Other participants. The following representatives for insurers as well as staff from the Departments of Education and Health participated in Task Force deliberations:

Insurers. Jennifer Diesman, Hawaii Medical Service Association (HMSA); Kuhio Asam, M.D., HMSA; Mavis Alaimalo and Phyllis Dendle, Kaiser Permanente.

Department of Education - Student Support Branch. Steven Shiraki, Ph.D., Russell Yamauchi and Jean Nakasato.

Department of Education - Administrator Certification for Excellence (ACE) Program. Winona Enesa, Castle High School; Andrew Szkotak, Waianae High School; Anthony Jones, Hana High and Elementary; Robert Frey, Radford High School; Mark Nakamura, Waialua High and Intermediate; Joanne Higa, Maui Waena Intermediate; Paul Graham, Kailua Intermediate; Jennifer Luke Payne, Kailua Elementary School; Wayne Koki, Wheeler Middle School; and Ron Jarvis, Keaau High School.

Department of Health - Alcohol and Drug Abuse Division. Jared Yurow, Psy.D., Virginia Jackson, Chris Brown, Terri Nakano, and Chris Yamamoto.

Department of Health - Tobacco Settlement Project. Lola Irvin and Cathy Tanaka.

BACKGROUND

Act 90, SLH 1996, established a “zero tolerance” policy “to allow principals, on a case-by-case basis, to exclude students found to be in possession of dangerous weapons, switchblade knives, intoxicating liquor, or illicit drugs while attending school.” Act 274, SLH 2000, amended the policy to allow a principal to suspend a student once it has been determined that the student consumed or used intoxicating liquor or illicit drugs prior to or while attending school or a department-supervised activity.

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The Student Substance Abuse Assessment and Treatment Advisory Task Force was formed pursuant to Section 3 of Act 213, SLH 2005, to review the implementation of Section 302A-1134.6, HRS, and the process by which a student who violates the zero tolerance policy for drugs and alcohol in public schools is referred for substance abuse screening, assessment and treatment.

² Act 213, SLH 2005, amendments are repealed on June 30, 2006 and Section 302A-1134.6(f), HRS, reverts to the provisions of Act 44, SLH 2004.

DISCUSSION

For discussion purposes, the terms “screening,” “assessment,” and “treatment” are defined as follows:

Screening is the process of gathering and sorting of information used to determine if an individual has a problem with substance abuse and, if so, whether a detailed clinical assessment is appropriate.

Assessment is the process of evaluating or appraising a candidate’s suitability for substance abuse treatment and placement in a specific treatment modality or setting. This evaluation includes information on current and past use/abuse of drugs; justice system involvement; medical, familial, social, educational, military, employment, and treatment histories; and risk for infectious diseases (e.g., sexually transmitted diseases, tuberculosis, HIV/AIDS and hepatitis.)

Treatment refers to the broad range of services, including identification, intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services and follow-up for persons with substance abuse problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and/or drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems.

As stated in the Department of Education (DOE) memorandum addressed to departmental administrators, the Superintendent specifies the requirements for addressing students’ alcohol and other drug related offenses.³ The memorandum stipulates that:

A student, who possesses, sells, consumes, or uses intoxicating liquor or illegal drugs while attending school or while attending Department supervised activities held on or off school property shall be subject to the Department’s disciplinary rules.

A student who reasonably appears to have consumed or used intoxicating liquor or illegal drugs prior to attending school or attending Department supervised activities held on or off school property shall be subject to the Department’s disciplinary rules.

Any student found to be in violation of either of the above provisions shall be allowed to return to school earlier than the Department’s original disciplinary determination; provided that the student gives the school evidence of the following:

- A substance abuse assessment was completed and the student is progressing toward clinical discharge from any substance abuse treatment or substance abuse counseling recommended by the substance abuse assessment.
- If the substance abuse assessment finds the student does not need substance abuse treatment or substance abuse counseling, the school may

³ Superintendent’s memo dated August 15, 2005 on Act 213, Relating to Student Substance Abuse Referrals, Twenty-Third Legislature, 2005, State of Hawaii.

allow the student to return to school earlier than originally indicated; provided that the student provides a certified copy of the assessment, and the student’s parent or legal guardian consents to the student receiving follow-up counseling or other student support services to be provided by the Department.⁴

In determining whether to allow the student to return to school early, the school, at a minimum, must consider:

- The nature and severity of the offense;
- The age of the offender;
- The impact of the offense on others; and
- Whether the offender is a repeat offender.

Parents and/or guardians of the student are responsible to obtain an assessment and treatment services. For a student who is a first time offender, if the student provides evidence to the school of a clinical discharge from the substance abuse treatment program or substance abuse counseling, all records of disciplinary action relating to the original offense shall be expunged.

DOE alcohol and other drug related offenses. The table below presents data on the number of alcohol, drug paraphernalia, illicit substance, and marijuana or concentrate offenses by incident and individuals by school district for the 2004-05 school year. With the exception of 23 (2.5%) incidents involving 31 (2.8%) individual elementary students, the vast majority of incidents and individuals were in secondary grades (6-12).

| Alcohol and other drug related offenses: 2004-05 school year | | | | | | | | | | |
|---|------------------|--------------------|---------------------------|--------------------|--------------------------|--------------------|---------------------------------|--------------------|------------------|--------------------|
| DISTRICT | ALCOHOL | | DRUG PARAPHERNALIA | | ILLCIT SUBSTANCES | | MARIJUANA OR CONCENTRATE | | TOTALS | |
| | Incidents | Individuals | Incidents | Individuals | Incidents | Individuals | Incidents | Individuals | Incidents | Individuals |
| Honolulu | 28 | 43 | 26 | 24 | 5 | 4 | 45 | 60 | 104 | 127 |
| Central | 23 | 29 | 22 | 23 | 6 | 5 | 42 | 44 | 93 | 96 |
| Leeward | 45 | 50 | 13 | 14 | 14 | 19 | 84 | 99 | 156 | 178 |
| Windward | 19 | 29 | 22 | 25 | 3 | 5 | 42 | 54 | 86 | 111 |
| Hawaii | 90 | 107 | 29 | 33 | 8 | 12 | 129 | 153 | 256 | 293 |
| Maui | 32 | 40 | 20 | 23 | 8 | 8 | 86 | 100 | 146 | 167 |
| Kauai | 17 | 30 | 6 | 7 | 7 | 16 | 53 | 78 | 83 | 125 |
| Other* | 3 | 3 | -0- | -0- | -0- | -0- | 3 | 3 | 6 | 6 |
| TOTAL | 257 | | 138 | | 51 | | 484 | | 930 | 1103 |

*Charter and other schools.

Total individuals are an unduplicated total. Students are counted once, irrespective of the number of incidents in which a student may have been involved.

Of the 1,103 individual students suspended for alcohol and other drug related offenses during the 2004-05 school year, 38 (3.0%) were issued for the maximum allowable 92 days.

⁴ “Certified copy of the assessment” means that the person who administers the assessment attests to its completion by signing the assessment form.

In implementing the provisions of Act 213, SLH 2005, there are some underlying assumptions:

1. Throughout the administrative process, the DOE has discretion in decisions to impose suspension based on the severity of the offense and history of the offending student.
2. The DOE will administer a screening tool to ascertain whether there is a need for a substance abuse assessment.
3. The Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) will provide standardized screening and assessment instruments to be used by screeners and assessors.
4. Access to assessments will be ensured through third-party reimbursement (i.e., insurance, QUEST, etc.) or payment for services by parents.
5. Treatment could occur while students are attending school, depending on the level of care needed and the school administrator's decision.
6. Students would access treatment at the appropriate level of care according to their individualized need. The levels of care available are: residential, intensive outpatient, individual counseling and low intensity outpatient groups provided by a licensed clinician, and/or school-based outpatient services.

The flow chart in Appendix A depicts the proposed step-by-step process by which a student found in violation of an alcohol or other drug related offense is referred for appropriate services.

School-based substance abuse treatment. While all of the ADAD-funded school-based providers have low intensity outpatient programs designed primarily for voluntary, self-referred students, there are “mandated” (i.e., coerced) students who meet this level of care and currently access treatment subject to availability. Each of the school-based providers currently provide services to mandated students who comprise about 10% of the total students served in each of the school-based outpatient programs.

Many of the school-based programs operate at capacity with wait lists of self-referred students; however, mandatory students could access these programs if an opening occurs. Where there are school-based outpatient programs that are not full, and where the student is appropriate for that level of care, mandated students could be admitted to the school-based program or access services provided by a licensed clinician, as requested by parents and/or school administrators.

Currently, CARE Hawaii and Hawaii Counseling & Education Center (HCEC) on Oahu; BISAC on the Big Island; and Ke Ala Pono on Kauai are among providers who have developed non-school based, intensive outpatient programs that are funded by insurance providers for those students who are appropriate for that level of care. Also, Bobby Benson Center on Oahu, Maui Youth and Family on Maui and Marimed/BISAC have adolescent residential programs with multiple funding sources.

Services that address student alcohol and other drug abuse. The Departments of Education and Health provide or contract for services that address student alcohol and other drug abuse; however, programs are not available in all secondary schools. To ensure the implementation of a statewide system of services, the Task Force reviewed the availability and gaps in the DOH’s contracted school-based substance abuse outpatient treatment services and the DOE’s Comprehensive School Alienation Program.

DOH adolescent school-based substance abuse outpatient treatment services. Adolescent school-based substance abuse outpatient treatment programs provide non-residential comprehensive specialized services on a scheduled basis on school campuses for adolescents with substance abuse problems. Professionally directed evaluation, treatment, case management and recovery services are provided to clients with less problematic substance abuse related behavior than would be found in a residential or day treatment program. An outpatient program provides between one (1) and eight (8) hours per client per week of face-to-face treatment with a minimum of one (1) hour individual counseling per client per month. Services are available year-round, during the school year and through the summer months. School-based programs also provide outreach to students through classroom presentations, networking with teachers and other school personnel, and other appropriate methods.

DOH/ADAD contracts for school-based services further stipulate that school-based substance abuse treatment programs provide:

- Outpatient school-based treatment for a maximum of one hundred ninety-two (192) hours per client, per year consisting of face-to-face individual sessions including screening, assessment, treatment planning, and counseling; and
- Group sessions including process, education, skill building, and recreation groups; and family counseling.

The provider may only bill for assessments that result in a client's admittance into the outpatient program. The provider may bill by fifteen (15) minute increments after the client receives a minimum of thirty (30) minutes of outpatient substance abuse treatment.

Service providers. Adolescent substance abuse treatment providers contracted by the Department of Health, Alcohol and Drug Abuse Division and the type(s) of services provided for adolescents are as follows:

Adolescent residential services are provided by the Bobby Benson Center and Maui Youth and Family Services, Inc., which are located on Oahu and Maui, respectively.

Adolescent school-based services are provided by: Hina Mauka on Kauai and Oahu; the Young Men's Christian Association (YMCA) on Oahu; Aloha House, Inc. and Ohana Makamae, Inc. on Maui; Hale Ho`okupa`a on Molokai; and the Big Island Substance Abuse Council (BISAC) on the Big Island.

For services provided under contracts administered by the Department of Health, Alcohol and Drug Abuse Division, "treatment" means the broad range of emergency, outpatient, intermediate, domiciliary, and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation, career counseling, and other special services which may be extended to handicapped persons.⁵

Although the State of Hawaii has effective residential and school-based outpatient treatment programs for adolescents, less than 15% of the students diagnosed with a substance abuse problem have utilized a treatment facility.⁶ Students are much more likely to receive help for a substance abuse problem if they perceive they need help and if they have been told by others to get help.

The resources available to this population for treatment services include school-based services provided in all high schools, but not all of the middle schools. On Oahu, the Kalihi Branch of the YMCA and Hina Mauka (i.e., Alcohol Rehabilitation Services of Hawaii, Inc.) provide treatment services in 23 high schools and 3 middle schools; on the Big Island, the Big Island Substance Abuse Council (BISAC) provides services in 10 high schools and 9 middle schools; in Maui County, Aloha House, Inc. provides services to 5 (4 on Maui and 1 on Lanai) high schools and 4 middle schools, Ohana Makamae provides service to 1 (Hana) high school, and Hale Ho`okupa`a provides service to 1 high school on Molokai; on Kauai, Hina Mauka is providing services to 3 high schools and 3 middle schools.

Adolescent residential services are currently provided in only two facilities: the Bobby Benson Center on Oahu has 24 licensed beds and the Maui Youth and Family Service has 26 licensed beds. (For adolescents on the Big Island and Kauai, residential substance abuse treatment is only available "off-island.") The Family Court funds four YMCA counselors to provide outpatient treatment services for adolescents who are ordered by the court to receive treatment. The Hawaii Youth Correctional Facility provides limited substance abuse assessment and counseling services at the facility through funds provided by the Office of Youth Services.

⁵ Section 334-1, HRS

⁶ 2003 *Hawaii Student Alcohol, Tobacco, and Other Drug Use Study*.

Part of the core continuum of care needed for adolescents is early identification followed by early treatment. School-based treatment is an efficient and effective way to intervene in a timely manner and succeed in avoiding more costly treatment, avoiding school dropouts and producing functional adults.

Substance abuse treatment for adolescents is a multi-disciplinary effort. The focus is on developing attitudes, motivation, knowledge and skills to bring about harm reduction, abstinence and change – including physical, psychological, social, familial and spiritual aspects. Services also address relapse issues and help to develop coping skills to prevent or interrupt dependence and relapse.

Adolescent substance abuse treatment programs achieve significant outcomes. During State Fiscal Year 2005 (July 1, 2004 to June 30, 2005), six-month follow-ups were completed for a sample of 320 adolescents. Outcomes for the sample include: more than one-half (53.7%) of students are alcohol and drug-free 6 months after completion of the program; 74.7% require no new substance abuse treatment 6 months after discharge; 89.4% had no emergency room visits; and 80.3% reported no new arrests after discharge.

The use of legal and illegal substances by our youth can impede social and intellectual development and can lead individuals to engage in dangerous activities, such as reckless driving, premature and unprotected sex and/or violence. Substance abuse treatment for students helps stop their use and abuse of alcohol and other drugs, reduces criminal behavior, increases school attendance, allows them to remain in school until graduation, and increases the likelihood of becoming healthy productive, contributing adults.

Funding of adolescent school-based substance abuse treatment services. Current adolescent school-based services are funded through Year 2 of the 2005-07 biennium. Based on a range of between \$10,000 for schools with low enrollments and a maximum \$90,000 for schools with a 600+ enrollment, an estimated \$1,895,000 to \$2,700,000 would be needed to provide services in the remaining middle schools.⁷

All public high schools and 21 middle and intermediate schools are funded by ADAD for school-based treatment. The table on the following page identifies the middle and intermediate schools that remain without adolescent school-based substance abuse treatment services funded by ADAD.

⁷ The cost estimate for each school is based on assigning a maximum of \$90,000 to schools with an enrollment of 600 students or more. Schools with an enrollment of 300 to 599 students are costed at \$45,000, schools with 150 to 299 students are costed at \$22,500, and schools with less than 150 students are costed at \$10,000.

| MIDDLE SCHOOLS BY DISTRICT AND COMPLEX | | | | |
|---|--------------------------|----------------------------------|--------------------------|----------------------------------|
| COMPLEX (High School*) | MIDDLE SCHOOL | ADAD-funded Treatment | MIDDLE SCHOOL | ADAD-funded Treatment |
| HONOLULU DISTRICT (6 complexes) | | | | |
| Farrington | Dole | NO | Kalakaua | NO |
| Kaiser | Niu Valley | NO | | |
| Kaimuki | Jarrett | NO | Washington | NO |
| Kalani | Kaimuki | NO | | |
| McKinley | Central | NO | | |
| Roosevelt | Kawananakoa | NO | Stevenson | NO |
| CENTRAL DISTRICT (6 complexes) | | | | |
| Aiea | Aiea | NO | | |
| Moanalua | Moanalua | NO | | |
| Radford | Aliamanu | NO | | |
| Leilehua | Wahiawa | NO | Wheeler | N/A |
| Mililani | Mililani | NO | | |
| Waialua | Waialua | NO | | |
| LEEWARD DISTRICT (6 complexes) | | | | |
| Campbell | Ilima | pending | | |
| Kapolei | Kapolei | NO | | |
| Waianae | Waianae | NO | | |
| Nanakuli | Nanakuli | NO | | |
| Pearl City | Highlands | YES | | |
| Waipahu | Waipahu | NO | | |
| WINDWARD DISTRICT (4 complexes) | | | | |
| Castle | King | YES | | |
| Kahuku | Kahuku | YES | | |
| Kailua | Waimanalo | NO | Olomana | YES |
| Kalaheo | Kailua | NO | | |
| HAWAII DISTRICT (10 complexes) | | | | |
| Hilo | Hilo | YES | Kalaniana'ole | NO |
| Laupahoehoe | Laupahoehoe | NO | Paauiolo | NO |
| Waiakea | Waiakea | NO | Pahala | NO |
| Kau | Naalehu | YES | Honaunau | NO |
| Keaau | Keaau | YES | | |
| Pahoa | Pahoa | YES | | |
| Honokaa | Waimea | YES | Honokaa | YES |
| Kealakehe | Kealakehe | YES | | |
| Kohala | Kohala | YES | | |
| Konawaena | Konawaena | YES | | |
| MAUI DISTRICT (7 complexes) | | | | |
| Baldwin | Iao | YES | | |
| Kekaulike | Kalama | YES | | |
| Maui | Lokelani | NO | Maui Waena | YES |
| Hana | Hana | YES | | |
| Lahainaluna | Lahaina | YES | | |
| Lanai | Lanai | NO | | |
| Molokai | Molokai | NO | | |
| KAUAI DISTRICT (3 complexes) | | | | |
| Kapaa | Kapaa | YES | | |
| Kauai | Kamakahahei | YES | | |
| Waimea | Waimea Canyon | YES | | |

*All high schools have school-based substance abuse treatment services.

1/5/06

DOE alternative education services. The Task Force reviewed DOE-funded services for at-risk students. These programs are not an alternative for school-based substance abuse treatment services as admission of the alcohol/drug violator to these programs would change the composition of the target populations and activities that the programs are intended to serve.

DOE Comprehensive School Alienation Program (CSAP). The Comprehensive School Alienation Program which began in 1965 continues to be implemented as a prevention and an early intervention program to provide the appropriate services and supports to identified alienated/at-risk students in the secondary schools (middle, intermediate, and high schools). As an integral component of the Comprehensive Student Support System (CSSS), its goals are:

- To provide the appropriate instructional and counseling services and supports to ensure that the students meet the requirements of the Hawaii Content and Performance Standards (HCPS), and the high school graduation requirements.
- To develop the appropriate academic, socio-emotional, and behavioral competencies of the student; assist the student to develop a positive attitude toward school and a realistic self-concept through counseling services; and to provide career counseling and work-based learning experiences. Tutorial services also provided as part of the program.
- To encourage the potential dropout to remain in school, minimize the problem of school dropouts, and to provide viable options to the student who decides not to remain in school.
- To seek the appropriate services and supports from related community agencies and organizations to address the diverse needs of the students.

Criteria for Identifying Alienated/At-Risk Students (State criteria). Students who meet:

- Two or more of the criteria are identified as alienated/at-risk,
- Four or more following criteria to be identified as severely alienated/at-risk.
 - Ten or more unauthorized absences.
 - Two or more courses failed.
 - One or more grade levels behind, retained.
 - Three or more disciplinary referrals (Chapter 19 A,B,C, and D offenses).
 - Adjudicated (Involved with juvenile justice system).
 - Pregnant/Parenting Teen.

As an integral part of CSSS, the secondary schools implement the CSAP program using models such as the Special Motivation Program (SMP) and the Alternative Learning Centers (ALC). The SMC is the on-campus educational option for the alienated/at-risk, and is usually provided in a classroom setting on campus.

The ALC is the option for the severely alienated/at-risk students. It is provided through an on-campus or off-campus setting for those students whose behaviors may jeopardize the safety and well being of other students on campus.

The CSAP program provides counseling, tutorial services and work-based learning experience for eligible students to learn about work, careers, and related skills and knowledge while earning course credit.

The program supports “No Child Left Behind” by providing appropriate services and supports to the students to meet the performance goal of educating students in learning environments that are safe, drug-free, and conducive to learning, and to minimize the number of students who are potential dropouts or who dropped out of school before completing high school.

*Redesigned CSAP Model.*⁸ A redesigned CSAP model was introduced in 2004 as a viable model for schools to restructure the program to meet the needs of their at-risk target population.

The model encourages each school to create smaller learning environments with the “core team” concept as the foundational structure for developing academies, houses, and school-within-a-school structures. It was developed so that the program could service more students.

The model involves: implementing a standards-based education; providing differentiated approaches to teaching and learning; developing and enhancing relationship building, and creating a sense of belonging and community within the school environment. It takes into consideration the data and information on the number of at-risk students identified and serviced to determine the need to redesign or restructure the school’s CSAP program to meet the needs of the students.

The Talent Development High School (TDHS) model developed by John Hopkins University is a viable school dropout prevention and intervention model for the high schools. The model is currently being implemented by Campbell High School and Waianae High School as a viable dropout prevention model.

CSAP Personnel. The allocation of CSAP personnel is based on the number of students identified and serviced by each school program. CSAP positions are allocated as follows:

| | |
|--------|---|
| 108.50 | Secondary Teacher positions |
| 43.50 | Outreach Counselors; 0.50 High-risk Counselor |
| 17.00 | Educational Assistants |
| 1.00 | Alternative School Work Study Coordinator |
| 0.50 | Clerk Typist |

⁸The principles, themes and practices of the documents “*Breaking Ranks: Changing an American Institution,*” “*Turning Points*”, “*Making the Grade*” by Tony Wager, 2003, and research of “small school design” provides the conceptual framework for the redesigned CSAP model or core team model.

The schools need to address the program models (SMP and ALC), which are currently utilized to service the students. The SMP works well in some schools, and in others the ALC works best. However, there is need to explore other models to meet the needs of the student and the school.

Staffing is vital in the implementation of any at-risk program model. The current teacher staff of 108.5 teachers service about 5,250 students on average, resulting in a teacher to student ratio of 1:49. Research indicates that the ratio of teacher to student is 1:18-24 for at-risk, and 1:15 or less for severely at-risk students. The redesigned model to lower the teacher to student ratio while creating a smaller learning environment is based on three major guiding principles:

- Schools are required to provide educational activities for students who are suspended.
- Achieving a safe and drug-free campus requires a balance between punishment, alternative programs and treatment services.
- Flexibility in programming involves innovative approaches: on- and off-campus assistance, after school tutorials, after school or evening classes.

The average length of program participation is 18 to 24 months.

Estimated costs for additional DOE alternative education services for drug/alcohol suspended students

| Part-time Teacher Levels | Total Number of Middle Schools, High Schools Statewide* | Projected Costs for One Year for 1 Part-time Teacher | Projected Costs for One Year for 2 Part-time Teachers |
|---|---|--|---|
| Level A With Bachelor's Degree \$22.43 | 75 schools 17 hrs/week \$28,598.25 | 30 weeks of school \$857,947.50 | 30 weeks of school \$1,715,895.00 |
| Level B Without Bachelor's Degree \$20.67 | 75 schools 17 hrs/week \$26,354.25 | 30 weeks of school \$790,627.50 | 30 weeks of school \$1,581,255.00 |

* Grades 9-12 = 33
 Grades 6-8 = 24
 Grades 7-8 = 12
 Grades 7-12 = 6
 Total = 75

(See Appendix B for further information on the Comprehensive School Alienation Program (CSAP) and Appendix C for a table depicting a composite of intermediate/middle and high schools with DOE CSAP programs and ADAD-funded school-based substance abuse treatment services.)

Screening students.⁹ Screening determines the need for a comprehensive assessment; it does not establish definitive information about diagnosis and possible treatment needs. The process

⁹ *Screening and Assessing Adolescents for Substance Use Disorders*. Treatment Improvement Protocol (TIP) 31, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT); 1998.

should take no longer than 30 minutes and ideally will be shorter. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the hallmarks of a screening program are: (1) its ability to be administered in about 10 to 15 minutes, and (2) its broad applicability across diverse populations. A screen should be simple enough that a wide range of health professionals can administer it. It should focus on the adolescent's substance use severity (primarily consumption patterns) and a core group of associated factors such as legal problems, mental health status, educational functioning, and living situation. The client's awareness of the problem, his or her thoughts on it, and the motivation for changing behavior should also be solicited.

Components of the Screening Process. An appropriate screening procedure must consider several variables pertaining to the client, such as age, ethnicity, culture, gender, sexual orientation, socioeconomic status, and literacy level. There are three primary components to preliminary screening: (1) content domains, (2) screening methods, and (3) information sources.

Content. The screening procedure focuses on empirically verified "red flags," or indicators of serious substance-related problems among adolescents. The indicators tend to fall into two broad categories: those that indicate substance use problem severity and those that are psychosocial factors.

The Task Force reviewed the most current SAMHSA information on screening adolescents for substance abuse. Based on this review, the CRAFT screening tool is being recommended for use with students. The CRAFT is a series of six questions:¹⁰

1. Have you ever ridden in a **C**ar driven by someone (including yourself) who was "high" or who had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to **R**elax, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are **A**lone by yourself?
4. Do your family or **F**riends ever tell you that you should cut down on your drinking or drug use?
5. Have you ever gotten into **T**rouble while you were using alcohol or drugs?

A score of 2 or more has a sensitivity of 92% and a specificity of 82% for identifying adolescents who need intensive substance abuse treatment. (See Appendix D and Appendix E for additional information on screening.)

¹⁰ Bastiaens, L., Francis, G., & Lewis, K. (2000). The RAFT as a screening tool for adolescent substance abuse disorders. *American Journal of Addictions*, 9, 10-16.

Knight, J. R. (2001). The role of the primary care provider in preventing and treating alcohol problems in adolescents. *Ambulatory Pediatrics*, 1, 150-161.

There was consensus on the Task Force that:

- Schools use the 5-question CRAFT instrument as the screening tool.
- The Alcohol and Drug Abuse Division provide training to DOE staff on administering the CRAFT screening tool.
- Results from the screening administered by the DOE will determine the necessity for further assessment.
- The Alcohol and Drug Abuse Division make the *Adolescent Drug Abuse Diagnosis* (ADAD) instrument available and provide training to DOE staff on administering the assessment instrument, if requested.

Assessment.¹¹ The comprehensive assessment, which is based on initial screening results, has several purposes:

1. To accurately identify those youth who need treatment.
2. To further evaluate if a substance use disorder exists, and if so, to determine its severity including whether a substance use disorder exists based on formal criteria (e.g., *Diagnostic and Statistical Manual of Mental Disorders-IV*).
3. To permit the evaluator to learn more about the nature, correlates, and consequences of the youth's substance-using behavior.
4. To ensure that additional related problems not flagged in the screening process are identified (e.g., problems in medical status, psychological status, nutrition, social functioning, family relations, educational performance, delinquent behavior).
5. To examine the extent to which the youth's family (as defined in the introduction to this volume) can be involved not only in comprehensive assessment, but also in possible subsequent interventions.
6. To identify specific strengths of the adolescent (e.g., coping skills) that can be used in developing an appropriate treatment plan.
7. To develop a written report that:
 - Identifies the severity of the substance use disorder.
 - Identifies factors that contribute to or are related to the substance use disorder.
 - Identifies a corrective plan of action to address these problem areas.
 - Details an interim plan to ensure that the treatment plan is implemented and monitored to its conclusion.
 - Makes recommendations for referral to agencies or services.
 - Describes how resources and services of multiple agencies can best be coordinated and integrated.

In addition, the assessment begins a process of responding creatively to the youth's denial and resistance and can be seen as an initial phase of the youth's treatment experience.

¹¹ "Screening and Assessing Adolescents for Substance Use Disorders." Treatment Improvement Protocol (TIP) 31, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT); 1998.

The assessor should be a well-trained professional experienced with adolescent substance use issues, such as a psychologist or mental health professional, school counselor, social worker, or certified substance abuse counselor. One individual should take the lead in the assessment process, especially with respect to gathering, summarizing, and interpreting the assessment data. An assessor not licensed to make mental health diagnoses should refer an adolescent in apparent need of a formal mental health workup to an appropriate professional.

The assessment should be conducted in an office or other site where the adolescent can feel comfortable, private, and secure. To arrive at an accurate picture of the adolescent's problems, domains such as strengths or resiliency factors, medical health history, mental health history, school history, vocational history and peer relationships should be assessed. (See Appendix F for detailed list.)

Assessment instruments should be selected on the basis of their purpose, content, administration, time required for completion, training needed by the assessor, how the instrument can be obtained, its cost, and persons to contact for further guidance. The two most important criteria in the evaluation of any measurement instrument are reliability and validity. (Additional information on substance abuse assessments can be found at Appendix G.)

As a result of reviewing of assessment instruments, the Task Force is recommending continued use of the *Adolescent Drug Abuse Diagnosis* instrument since it meets the criteria described above. (See Appendix H.)

• • •

Third party insurance coverage for student assessments. Information received from the Hawaii Medical Service Association and Kaiser Permanente in response to the Task Force Chair's inquiry on substance abuse assessments for students as a covered benefit is as follows:

Hawaii Medical Service Association (HMSA). HMSA's Behavioral Care Connection program helps members find the behavioral health provider who's right for them. Behavioral Care Connection includes a case management benefit that works with the patient and provider to develop a wellness plan that takes the whole person into account by working with the patient, designated providers and other appropriate resources to deliver higher quality care and greater value.

All HMSA members are eligible for full program benefits for the Behavioral Care Connection program except: 65C+, 911-NET, QUEST Net, *Senior Connection*, Group Conversion and FEP.

Members no longer need a referral from their physician to access substance abuse services and are free to choose any provider participating with their HMSA plan. Assistance with selecting the most appropriate provider is available through the Behavioral Care Connection program office. Members who meet specific criteria may be eligible to receive Behavioral Care Connection's enhanced case management benefit. Interested members may respond to correspondence mailed to them, or call the program office for more information.

Act 44, SLH 2004, parity provisions removed limits on the extent of treatment covered by Chapter 431M, HRS. There is no charge to members, but services received from behavioral health providers or prescribed medicines are subject to co-payments and coinsurance described in health plans.

Alcohol and other drug data for 13-17 year olds for 2003 reveal that of the insurer's (500,000) members, there were only 23 claims for alcohol and 68 for other drugs. Utilization of the substance benefit is low; approximately 20% show up for the first appointment. QUEST clients, who have a higher utilization rate, make up approximately 15% of the HMSA covered population. For billing purposes, the "assessment" is charged as a "diagnostic interview."

There are approximately 600 mental health/substance abuse qualified providers statewide, however, capacity is limited to those willing or trained to treat adolescent substance abusers.^{12, 13} The estimated 1,000+ Chapter 19 alcohol/drug offenders would add 4 students (3 covered by HMSA) per day if they are HMSA members.

Kaiser Permanente Medical Care Program – Behavioral Health Services. Kaiser Permanente manages both benefits and care and operates as the health plan, insurer and treatment provider. Throughout 2005, Kaiser Permanente provided substance abuse treatment for 5 adolescents, 2 of whom were QUEST clients. From Kaiser's perspective, the process from assessment to referral and admission to treatment is as follows: (1) the student is using alcohol or other drugs (AOD's) on campus; (2) parents decide that the student needs chemical dependency (CD) "help;" (3) parent calls Behavioral Health Services Call Center to schedule an appointment for CD assessment; and (4) the student receives assessment and assessment/clinical interview indicates a need for further CD services.

If the student declines services, no further treatment action is taken despite recommendations by therapist. If the student is agreeable to treatment admission, a referral is made to either Hawaii Counseling and Education Center (HCEC) or other Kaiser Permanente chemical dependency services.

HCEC provides intensive outpatient services (6-9 hours per week, 3-5 times weekly). Less intense services are also provided. Adolescent residential services are provided through the Bobby Benson Center. Progress in treatment facilitates a return to school. Those (4 of 5)

¹² Professionals eligible to bill for services are defined in §431M-1, HRS, as follows:

"Advanced practice registered nurse" means a person recognized as such pursuant to chapter 457.

"Licensed clinical social worker" means a person who is a licensed clinical social worker pursuant to chapter 467E.

"Physician" means a person licensed in the practice of medicine or osteopathy pursuant to chapter 453 or 460, respectively.

"Psychologist" means a person licensed in the practice of psychology pursuant to chapter 465.

¹³ The term "qualified" is defined in §431M-1, HRS, as follows:

"Qualified" means:

(1) Having skill in the diagnosis or treatment of substance use disorders, based on a practitioner's credentials, including but not limited to professional education, clinical training, licensure, board or other certification, clinical experience, letters of reference, other professional qualifications, and disciplinary action; or

(2) Being a licensed physician, psychologist, licensed clinical social worker, or advanced practice registered nurse, and certified pursuant to chapter 321.

students who merely want documentation and not treatment so that they can return to school are not admitted to treatment.

The low rate for both HMSA and Kaiser of youth utilizing substance abuse treatment benefits indicates the need for a lot more education of consumers on the availability of substance abuse treatment for youth, the confidentiality of that treatment, and the need for improved outreach and engagement. Parents need guidance on insurance coverage for services and the process for accessing services.

Insurance reimbursement for assessment services. Amendment of Chapter 431M, HRS, relating to mental health and alcohol and drug abuse treatment insurance benefits, or other related statutes, would allow for Certified Substance Abuse Counselors (CSACs) to be reimbursed by insurers for screening and assessment services.

Cost estimate for assessment services. It is anticipated that approximately 20% of the 1,100 mandated students will not have health insurance. An estimated \$30,000 to \$50,000 would be required for 200 uninsured students needing assessments at \$150 per assessment. Options for implementation include, but are not limited to: (a) using the statewide substance abuse treatment provider list as a vehicle for accessing assessment services; or (b) procuring services through a Request for Proposals, with funding added to individual agreements.

FINDINGS AND RECOMMENDATIONS

The following are the findings and recommendations of the Student Substance Abuse Assessment and Treatment Advisory Task Force:

Policy on Suspensions for Alcohol and Other Drug Related Offenses

Findings for improving the policy on suspensions for alcohol and other drug related offenses.
The Task Force finds that:

- Schools are providing a range of alternative educational services to students suspended for alcohol and drug related offenses within the resources of the school.
- Crisis suspending a student for 10 days to complete referral for substance abuse assessments is not realistic as referral agencies are completing assessments within 30- to 45-day timeframe.
- Family support, involvement, participation and intervention should be sought.
- A range of educational services are provided for these students, but treatment options are limited within some communities.

Recommendation. The Task Force recommends that:

- If additional educational services are to be provided by schools, additional funding for qualified staff and personnel and space must be allocated with the amendment of Act 213, SLH 2005.

- DOE should maintain the discretion throughout the disciplinary process in decisions to impose suspension based on the severity, nature, age and history of the offending student so that a student may not be suspended for the entire 92 days. For example, to allow for completion of substance abuse assessment, a student may be suspended up to 45 days.
- When a student is determined to be in violation of Chapter 19, HAR, for an alcohol or drug related offense, DOE administer a screening tool to ascertain whether there is a need for substance abuse assessment.
- DOH should assist the DOE in providing the necessary training and staff development to support school staff in administering a screening tool for alcohol and drug related disorders.

Amending Act 213, SLH 2005

Findings for amending Act 213, SLH 2005. The Task Force finds that:

- A screening process needs to be established within the school’s student support services process to determine the need for substance abuse assessment.
- As appropriate, families need to be integral components within the treatment and intervention processes.
- Early return to school from alcohol and drug related offenses may be permitted as the school administrator reviews progress and treatment outcomes and takes into consideration personal and school safety issues.
- Act 213, SLH 2005 amendments – to include changes recommended by the Task Force – should be made permanent.

Recommendation. The Task Force recommends that:

- A school screening process for determining the need for substance abuse assessment referral should be added to “zero tolerance” statutory provisions.
- Family involvement and participation follow-up counseling and/or other student support services should be included as one of the provisions for early return to school whenever appropriate.
- The ‘repeal and reenactment’ clause in Section 5 of Act 213, SLH 2005 should be deleted.

Financing of Substance Abuse Services

Findings for financing of substance abuse services. The Task Force finds that:

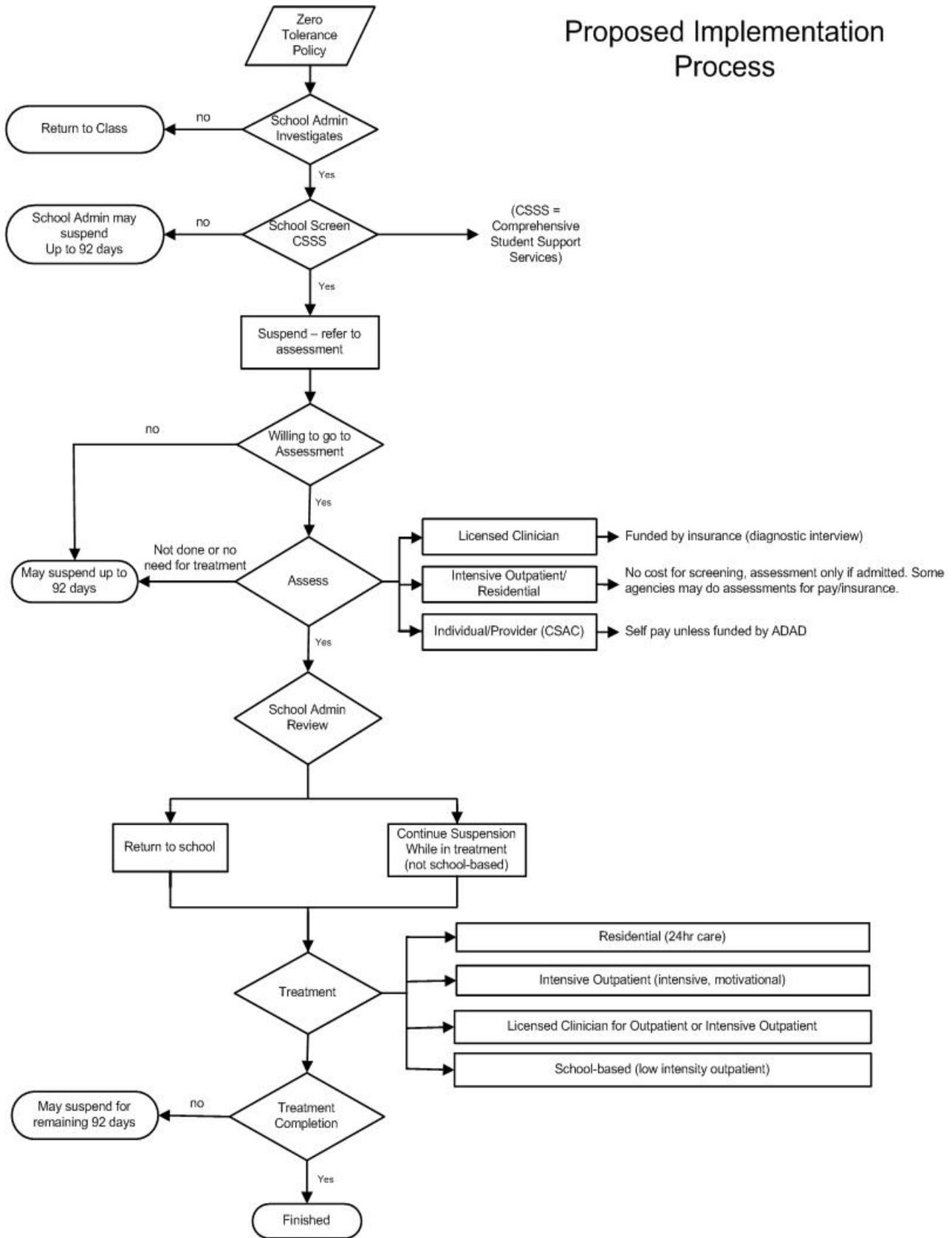
- Treatment providers' eligibility for reimbursement by insurers (e.g., HMSA and Kaiser Permanente) for alcohol and drug assessments to accommodate gaps in the continuum of adolescent substance abuse treatment services need to be expanded to include reimbursement of Certified Substance Abuse Counselors (CSACs).
- Students who are not covered by health insurance or QUEST may be unable to access services without financial resources.
- All public high schools should have school-based substance abuse treatment services. Of the 53 intermediate/middle schools, 30 schools remain without school-based substance abuse treatment services. (There was a broad consensus that all high schools and intermediate/middle schools have school-based substance abuse treatment services available. However, a specific funding recommendation is not included as it was deemed to be beyond the scope of the Task Force.)
- Families need to be informed of how to approach insurance agencies to qualify for accessing assessment and treatment services.

Recommendation. The Task Force recommends that:

- Chapter 431M, HRS, should be amended to include certified substance abuse counselors as providers eligible to be reimbursed for student assessments for alcohol and other drug related "zero tolerance" offenders.
- DOH, DOE and insurers should work together to develop a broader range of treatment options for alcohol and drug related referred students. In addition, resources should be committed to provide for an "assessment bank" that would fund assessment services for uninsured students.
- DOH and DOE should develop informational packets for families and students to be disseminated to schools to ensure proper and adequate accessibility to appropriate substance abuse services.

APPENDIX A

Proposed Implementation Process



APPENDIX B

Additional information on the DOE Comprehensive School Alienation Program (CSAP)

Program Data and Indicators of Effectiveness. Annually, the following data is collected and entered in the CSAP section of the CSSS database through the Request for Assistance (RFA), and CSAP database. All school programs are required to provide the data and information. Schools without CSAP allocated personnel and no “formal” program must adhere to the request since the data reflects statewide trends. The following data is collected.

1. The number of students identified as alienated and severely alienated (by state criteria):
 - Attendance (10 or more unauthorized days absences)
 - Courses failed (two or more)
 - Grade levels retained (one or more)
 - Number of disciplinary referrals (three or more Chapter 19 offenses)
 - Adjudicated (involved with the juvenile justice system)
 - Pregnant/Parenting Teen (documentation)
2. The number of students serviced and includes:
 - Number of student who passed all courses while in the program
 - Student attendance rate while in the program
 - Number of seniors who graduate while enrolled in the program (percentage)
 - Number of students mainstreamed or returned back to the regular education program
 - Drop out rate of students (official 4140 or unofficial)
3. Indicators of Program Effectiveness:
 - The number of students who passed all their courses while in the program.
 - The graduation rate of the program seniors (percentage of senior who graduate)
 - Attendance rate of the student while enrolled in the program
 - The number of students who are mainstreamed back into the regular education program
 - The dropout rate of the program students

The following table presents the data for the number of students who were identified and serviced over an eight year period. During 2004-2005 approximately 14,924*** students were identified as alienated, and 3,108*** students were directly serviced by CSAP. (The 31% of “Students Identified and Serviced” are those who met the *Criteria for Identifying Alienated/At-Risk Students* that is required for admission to the program. Less severe cases (69%) of students who do not meet program admission criteria are diverted to appropriate services – tutoring, counseling, monitored coursework, etc.).

Number of Students Identified and Serviced by CSAP (2004-2005)

| School Years | Total Secondary Student Enrollment 7-12 Grade (*included Grade 6) | Number of Students Identified as At-Risk (by criteria) (**counts impacted by data entered) | Percentage of the Total Number of Students Enrolled | Total Number of Students Serviced (as part of identified) | % of CSAP Students Identified and Serviced |
|---------------------|--|---|--|--|---|
| 1997-1998 | 72,970 | 13,815 | 19% | 4,612 | 34% |
| 1998-1999 | 81,864 | 17,258 | 21% | 5,683 | 33% |
| 1999-2000 | 80,919 | 17,797 | 22% | 5,561 | 31% |
| 2000-2001 | 81,129 | 17,482 | 21% | 5,708 | 33% |
| 2001-2002 | 80,413 | 18,024 | 22.4% | 4,576 | 26% |
| 2002-2003 | 84,465* | 16,893 | 20% | 6,403 | 38% |
| 2003-2004 | 83,295* | 16,566 | 19.9% | 6,350 | 38% |
| 2004-2005 | 83,354 | 14,924*** | 18%*** | 3,108** | 21%*** |
| Average | 81,051 | 16,596 | 20% | 5,250 | 31% |

Although the data presented for the 2004-2005 school year reveals a decrease in the number of students identified, the 18%*** is near the overall average when compared with the “Average” percentages over the 8 years presented. Therefore, the number of at-risk students meeting the criteria continues to remain at a constant percentage for the target population.

For the 2004-2005 school year it cannot be assumed that the data trend for the number of students identified holds “constant” since the data collected for that past year indicated that there were discrepancies (i.e. loss of data and information during the transfer of data; incorrect and incomplete data entered; and replication of student data and information) which impacted the data summary.

This is also indicative of number of students serviced during the same school year. The “percentage” for the number serviced during the 2004-2005 school year was significantly lower as compared with overall average for the 8 years presented due to “discrepancies which occurred with the data****” collection.

The CSSS/CSAP database system had undergone modifications in April of 2005. Therefore, the decrease in the numbers of students identified and serviced by CSAP may have been impacted by the discrepancies in the data entered including:

1. Data and information “loss” during the transfer to current CSSS system;
2. Incomplete entries of data and information in the CSSS and CSAP databases;
3. Deletion of replications; and data items which were incorrectly entered.

Indicators of Program Effectiveness. The indicators of program effectiveness are based on the program’s student outcomes and related to the objectives of the program.

Indicators of Program Effectiveness (Based on the number of students serviced)

| Program Objectives | 1997-1998 | 1998-1999 | 1999-2000 | 2000-2001 | 2001-2002 | 2002-2003 | 2003-2004 | 2004-2005 | Ave. Over Years |
|---|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------------|
| Number Served | 4,612 | 5,683 | 5,561 | 5,708 | 4,576 | 6,403 | 6,350 | 3,108 | 5,250 |
| % Students Who Passed All CSAP Courses (50%+) | 73% | 71% | 73% | 77% | 70% | 51% | 62% | 67% | 68% |
| Graduation Rate (75%+ of program seniors) | 82% | 82% | 88% | 88% | 91% | 81% | 83% | 84% | 85% |
| Improved Attendance Rates of Students (70%+ or better) | 79% | 75% | 78% | 78% | 83% | 72% | 71% | 79% | 77% |
| Students Mainstreamed (Returned to regular ed. program 10%+) | 31% | 40% | 32% | 38% | 44% | 39% | 39% | 44% | 38% |
| Dropped Out Rate (Less than 10%) | 6% | 6% | 5% | 4% | 3% | 5% | 5% | 8% | 5% |

2004-2005 Data: Indicators of Program Effectiveness, Analysis, and Trends

Passed All CSAP Course. For 2004-2005 the table indicates that of the 3,108 students who were serviced, 67% of the students passed all of their CSAP courses even though the number of students serviced was lower than the previous year's data trend.

Graduation Rate of the Program Seniors. For 2004-05, 85% of the program seniors graduated high school. The program supports and assists the program seniors to graduate from high school.

Improved Attendance Rates. The program assists students to improve their school attendance rate (79%) as indicated by the 2004-2005 data.

Students Mainstreamed or Returned to the Regular Education Program. Overall, 44% of the students were mainstreamed for the 2004-05 school year. The goal of CSAP is to intervene and assist students to remain in school and to return to the regular education program.

Dropout Rate. CSAP continues to decrease the dropout rate of the students it services. It helps students to remain in school, and minimizes the dropout rate as students remain and complete high school. The goal is to keep the dropout rate less than 10% for the students served by CSAP. The data presented (with the exception of the 2004-2005 school year's data) indicates that the Comprehensive School Alienation Program purports what it supposed to do, that is to provide a dropout prevention and early intervention program to the alienated/at-risk student population as an integral program component of the Comprehensive Student Support System.

APPENDIX C

The following tables are a composite of schools (presented by district and complex) with DOE CSAP programs ADAD-funded school-based substance abuse treatment services. The table depicts the locations by DOE district and school for the 69 Special Motivation Classes (SMC's) and 37 Alternative Learning Centers (28 on-campus and 12 off-campus sites), as well as schools in which DOH contracted substance abuse school-based treatment services are established.

Abbreviations used in column headings are as follows:

SMC – Special Motivation Class

ALC – Alternative Learning Center

ON-campus

OFF-campus

DOH – Adolescent School-based Substance Abuse Treatment Program.

DOE AND DOH/ADAD SERVICES BY SCHOOL (AS OF 6/30/05)

| Complex | High School | Middle School | SMC | ALC | | DOH | Enrollment (2004-05) |
|--|---|--------------------------------|-----|-----|-----|---------|---------------------------------|
| | | | | ON | OFF | | |
| HONOLULU DISTRICT (6 Complexes) | | | | | | | |
| Kaimuki | Kaimuki | Jarrett | X | X | | X | 1093 |
| | | Washington | X | | | | 266 |
| | | | X | | | | 947 |
| Kalani | Kalani | Kaimuki | X | X | | X | 1000 |
| | | | X | | | | 668 |
| Farrington | Farrington | Dole | X | X | | X | 2198 |
| | | Kalakaua | X | | | | 678 |
| | | | X | | | | 947 |
| Kaiser | Kaiser* | Niu Valley | X | X | | X | 929 |
| | | | X | | | | 393 |
| McKinley | McKinley* | Central | X | X | | X | 1694 |
| | | | X | | | | 461 |
| Roosevelt | Roosevelt | Kawananakoa | X | X | | X | 1445 |
| | | Stevenson | X | | | | 749 |
| | | | X | | | | 541 |
| CENTRAL DISTRICT (6 Complexes) | | | | | | | |
| Leilehua | Leilehua | Wahiawa | X | | | X | 1510 |
| | | Wheeler* | X | | | | 825 |
| | | | X | | | | 497 |
| Mililani | Mililani | Mililani | X | | | X | 2121 |
| | | | X | | | X | 1594 |
| Waialua | Waialua High & Intermediate ADAD contract is only for H.S. | | X | | | X | (9-12) 369 (7-8) 180 |
| Aiea | Aiea | Aiea | X | | | X | 1136 |
| | | | X | | | | 568 |
| Moanalua | Moanalua | Moanalua | X | | | X | 1816 |
| | | | X | | | | 737 |
| Radford | Radford* | Aliamanu | X | | | X | 1215 |
| | | | X | | | | 795 |
| LEEWARD DISTRICT (6 Complexes) | | | | | | | |
| Campbell | Campbell | Ilima* | X | X | | X | 1702 |
| | | | X | X | | pending | 1088 |
| Kapolei | Kapolei* | Kapolei | X | | | X | 1913 |
| | | | X | | | | 1508 |
| Waianae | Waianae | Waianae | X | X | X | X | 1546 |
| | | | X | X | | | 940 |
| Nanakuli | Nanakuli High & Intermediate ADAD contract is only for H.S. | | X | X | | X | (9-12) 663 (7-8) 419 |
| Pearl City | Pearl City | Highlands* | X | X | | X | 1718 |
| | | | | X | | X | 880 |
| Waipahu | Waipahu | Waipahu | X | X | | X | 2149 |
| | | | X | X | | | 1228 |
| WINDWARD DISTRICT (4 Complexes) | | | | | | | |
| Kailua | Kailua Olomana (7 th -12 th) | Waimanalo El & Intermediate | X | | X | X | 784 |
| | | | | | X | | 71 |
| | | | | | | | 311 |
| Kalaheo | Kalaheo | Kailua | X | | X | X | 998 |
| | | | | | | | 746 |
| Castle | Castle | King | X | | X | X | 1476 |
| | | | X | | | X | 674 |
| Kahuku | Kahuku High & Intermediate ADAD contract is only for H.S. | | X | | X | X | (9-12) 1067 (7-8) 549 |

| Complex | High School | Middle School | SMC | ALC | | DOH | Enrollment (2004-05) |
|---------------------------------------|---|--|--------|-----|-----|--------|--|
| | | | | ON | OFF | | |
| HAWAII DISTRICT (10 Complexes) | | | | | | | |
| Hilo | Hilo* | Hilo* Kalaniana'ole Elem. & Inter. | X | X | X | X | 1269 542 (7-8) 71 (K-6) 264 |
| Laupahoehoe | Laupahoehoe High & Elem. Contract is only for high school* | | | | | X | 61 (7-8) 35 (K-6) 101 |
| Waiakea | Waiakea | Waiakea | X X | X | | X | 1132 786 |
| Honokaa | | Honokaa High* & Intermediate* Waimea Inter Paauilo Elem.& Inter | X X | X | | X X | 555 104 (K-5) 523 (K-9) 222 |
| Kealakehe | Kealakehe* | Kealakehe* | X | X | | X | 1257 913 |
| Kohala | Kohala* | Kohala* | X | X | | X | 219 191 |
| Konawaena | Konawaena | Konawaena* | X X | X | | X X | 789 457 |
| Kau | Kau High & Pahala Elementary | | | X | | X | (9-12) 207 (7-8) 40 (K-6) 121 |
| | Naalehu Elem. & Intermediate* | | X | | | X | (7-8) 79 (K-6) 253 |
| Keaau | Keaau* | Keaau* | X X | | | X X | 663 487 |
| Pahoa | | Pahoa High & Intermediate* | X | X | | X X | 410 230 |
| MAUI DISTRICT (7 Complexes) | | | | | | | |
| Baldwin | Baldwin | Iao* | X | | X | X | 1467 741 |
| | | | | X | | X | |
| Kekaulike | Kekaulike | Kalama* | X | | | X | 1098 867 |
| | | | | | | X | |
| Maui | Maui | Lokelani | X | | X | X | 1390 712 |
| | | Maui Waena* | X | | | X | 894 |
| Hana | Hana High* & Elementary contract is for 7th - 12th grades | | | | | X | (7-12) 155 (K-6) 151 |
| Lahainaluna | Lahainaluna | Lahaina | X X | X | | X | 867 552 |
| | | | | | | X | |
| Lanai | Lanai High & Elementary Contract is only for high school | | | | | X | (9-12) 140 (7-8) 88 (K-6) 278 |
| Molokai | Molokai* | Molokai* | X | X | | X | 324 180 |
| | | | | | | X | |
| KAUAI DISTRICT (3 Complexes) | | | | | | | |
| Kapaa | Kapaa | Kapaa | X X | | X | X | 919 641 |
| | | | | | | X | |
| Kauai | Kauai* | Kamakahahelei* | X X | | | X | 1122 925 |
| | | | | | | X | |
| Waimea | Waimea | Waimea Canyon Elem. & Inter.* | X X | X | X | X | 744 309 (K-6) 168 |

Enrollment information based on DOE Official Enrollment Count 2004-05, dated 9/9/04.

*Funded by Act 40, SLH 2004. **BOLD** – services contracted for specified grades only.

APPENDIX D

Additional Information on Substance Abuse Screening

Indicators or markers for substance use problem severity and psychosocial factors are as follows:

Substance use disorder related –

- Use of substances during childhood or early teenage years.
- Substance use before or during school.
- Peer involvement in substance use.
- Daily use of one or more substances.

Psychosocial –

- Physical or sexual abuse.
- Parental substance abuse (including driving under the influence / driving while intoxicated).
- Sudden downturns in school performance or attendance.
- Peer involvement in serious crime.
- Marked change in physical health.
- Involvement in serious delinquency or crimes.
- HIV high-risk activities (e.g., intravenous drug use, sex with intravenous drug user).
- Indicators of serious psychological problems (e.g., suicidal ideation, severe depression).

There is no definitive rule as to how many uncovered red flags dictate a referral for a comprehensive assessment. Many screening questionnaires provide empirically validated cut scores to assist with this decision. Nevertheless, any time there are several red flags or a few that appear to be meaningful, it is advisable to refer the adolescent for a comprehensive assessment.

Interviews and questionnaires. A model screening instrument is short, simple, and appropriate to the youth's age. The instrument should give the "big picture" of the youth's situation, not a lot of specific, detailed information. However, the instrument should be of sufficient scope to cover the "red flag" areas of substance use disorders and psychosocial functioning noted above. The tool should not require sophisticated knowledge in test administration or interpretation; it must have high utility for a broad range of professionals and paraprofessionals.

The most commonly used screening method is the interview. Not only is a screening interview an efficient means to gathering information on the essential red flags, it also offers an opportunity to observe the client's nonverbal behaviors and to gauge his verbal skills.

When structured screening interviews are used, it is important that the interviewer follow the administration structure provided in the interview booklet. Unstructured interviews pose special administration problems that contribute to measurement error. Interviews should not be performed with parents present.

When using paper-and-pencil questionnaires, administration procedures should have the client read aloud the instructions that accompany the test to ensure that the client understands what is expected of him and to judge whether the client's reading ability is appropriate for the testing situation.

Other sources of information. Although it is a luxury in most screening situations, supplemental and corroborative information is useful during a screening evaluation. In most instances, obtaining information will involve interviewing a knowledgeable parent or guardian. Other logical sources at this level may be other family members, or the youth's caseworker, probation officer, or teacher. Getting information from other sources helps the screener guard against developing an incorrect picture based solely on the young person's self-report. There is evidence that knowledgeable parents generally provide valid information about their child's "externalizing" problems, such as conduct problems, delinquency, and attention deficits, while they provide less valid and corroborating information with respect to the child's "internalizing" concerns, such as mood distress and self-view. Parents also can report on signs of use such as paper bags with inhalable substances in them, beer cans in a car, or drug-seeking behaviors such as stealing money from family members. Clinical wisdom suggests that parents' knowledge of their child's substance use is probably based on observation of its consequences (e.g., physical effects of intoxication).

After getting the teenager's consent, the screener should also collect information about family life, including substance use behaviors and attitudes in the home, and whether physical, sexual, or emotional abuse is present. It is wise to collect the information when the youth is not present in the interview room and to tell the parents that what they say may be shared with the adolescent in the summary of the screening.

Other concerns. At-risk behavior among youth is often viewed solely as a disciplinary problem rather than a signal that intervention is needed. Training in the screening process can go a long way toward enhancing effective responses to substance-using adolescents. Administrative considerations regarding preliminary screening include cost, ease of use, flexibility of use in different settings among different populations, analyses of screening data, and preparation of relevant reports. To address these considerations, agencies must coordinate their screening policies.

Protocols developed by agencies to govern screening must be clear about consent and patient notice, confidentiality and privacy, State and Federal regulations (including those regarding child abuse reporting), and duty-to-warn requirements. Programs must establish and follow guidelines on confidentiality and privacy, including policies for administrative procedures and training. In other words, confidentiality and privacy must be highlighted as priorities in every aspect of the program. Training must be provided so that protocols and instruments are clearly understood. Interviewers must remind clients in a clear, realistic, and understandable manner about their rights concerning informed consent and privacy.

APPENDIX E

SAMHSA/CSAT Treatment Improvement Protocols—TIP 11¹⁴
Simple Screening Instrument for Alcohol and Other Drug Abuse

Self-Administered Form

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

During the last 6 months...

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)

Yes

No

2. Have you felt that you use too much alcohol or other drugs?

Yes

No

3. Have you tried to cut down or quit drinking or using alcohol or other drugs?

Yes

No

4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)

Yes

No

5. Have you had any health problems? For example, have you:

Had blackouts or other periods of memory loss?

Injured your head after drinking or using drugs?

Had convulsions, delirium tremens ("DTs")?

Had hepatitis or other liver problems?

Felt sick, shaky, or depressed when you stopped?

Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?

Been injured after drinking or using?

Used needles to shoot drugs?

¹⁴ "Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse Infectious Diseases." Treatment Improvement Protocol (TIP) 11, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT); 1994.

6. Has drinking or other drug use caused problems between you and your family or friends?

Yes No

7. Has your drinking or other drug use caused problems at school or at work?

Yes No

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)

Yes No

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?

Yes No

10. Are you needing to drink or use drugs more and more to get the effect you want?

Yes No

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?

Yes No

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?

Yes No

13. Do you feel bad or guilty about your drinking or drug use?

Yes No

The next questions are about your lifetime experiences.

1. Have you ever had a drinking or other drug problem?

Yes No

2. Have any of your family members ever had a drinking or drug problem?

Yes No

3. Do you feel that you have a drinking or drug problem now?

___ Yes

___ No

Thanks for filling out this questionnaire.

Simple Screening Instrument for AOD Abuse
Interview Form

Note: **Boldfaced questions** constitute a short version of the screening instrument that can be administered in situations that are not conducive to administering the entire test. Such situations may occur because of time limitations or other conditions.

Introductory statement:

"I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. Your answers will be kept private. Based on your answers to these questions, we may advise you to get a more complete assessment. This would be voluntary - it would be your choice whether to have an additional assessment or not."

During the past 6 months...

1. **Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants.)** (yes/no)
2. **Have you felt that you use too much alcohol or other drugs?** (yes/no)
3. **Have you tried to cut down or quit drinking or using drugs?** (yes/no)
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) (yes/no)
5. Have you had any of the following?
 - o Blackouts or other periods of memory loss
 - o Injury to your head after drinking or using drugs
 - o Convulsions, or delirium tremens ("DTs")
 - o Hepatitis or other liver problems
 - o Feeling sick, shaky, or depressed when you stopped drinking or using drugs
 - o Feeling "coke bugs," or a crawling feeling under the skin, after you stopped using drugs
 - o Injury after drinking or using drugs
 - o Using needles to shoot drugs.

6. Has drinking or other drug use caused problems between you and your family or friends? (yes/no)
7. Has your drinking or other drug use caused problems at school or at work? (yes/no)
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) (yes/no)
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes/no)
10. Are you needing to drink or use drugs more and more to get the effect you want? (yes/no)
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)
13. Do you feel bad or guilty about your drinking or drug use? (yes/no)

Now I have some questions that are not limited to the past 6 months.

1. Have you ever had a drinking or other drug problem? (yes/no)
 2. Have any of your family members ever had a drinking or drug problem? (yes/no)
 3. **Do you feel that you have a drinking or drug problem now?** (yes/no)
- Thanks for answering these questions.
 - Do you have any questions for me?
 - Is there something I can do to help you?

Notes:

Observation Checklist

The following signs and symptoms may indicate an AOD abuse problem in the individual being screened:

- Needle track marks
- Skin abscesses, cigarette burns, or nicotine stains
- Tremors (shaking and twitching of hands and eyelids)
- Unclear speech: slurred, incoherent, or too rapid
- Unsteady gait: staggering, off balance
- Dilated (enlarged) or constricted (pinpoint) pupils
- Scratching
- Swollen hands or feet
- Smell of alcohol or marijuana on breath
- Drug paraphernalia such as pipes, paper, needles, or roach clips
- "Nodding out" (dozing or falling asleep)
- Agitation
- Inability to focus
- Burns on the inside of the lips (from freebasing cocaine)

Scoring for the AOD Abuse Screening Instrument

Date:

Name/ID No.:

Place/Location:

Items 1 and 15 are not scored. The following items are scored as 1 (yes) or 0 (no):

| | | |
|---|-----------------------------|-----------------------------|
| <input type="checkbox"/> 2 | <input type="checkbox"/> 7 | <input type="checkbox"/> 12 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 8 | <input type="checkbox"/> 13 |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 9 | <input type="checkbox"/> 14 |
| <input type="checkbox"/> 5 (any items listed) | <input type="checkbox"/> 10 | <input type="checkbox"/> 16 |
| <input type="checkbox"/> 6 | <input type="checkbox"/> 11 | |

Total score: ____

Score range: 0--14

Preliminary interpretation of responses:

Score

Degree of Risk for AOD
Abuse

0—1

None to low

2—3

Minimal

>4

Moderate to high: possible
need for further assessment

Glossary for AOD Abuse Screening

Agitation: A restless inability to keep still. Agitation is most often psychomotor agitation, that is, having emotional and physical components. Agitation can be caused by anxiety, overstimulation, or withdrawal from depressants and stimulants.

Blackouts: A type of memory impairment that occurs when a person is conscious but cannot remember the blackout period. In general, blackouts consist of periods of amnesia or memory loss, typically caused by chronic, high-dose AOD abuse. Blackouts are most often caused by sedative-hypnotics, such as alcohol and the benzodiazepines.

CAGE questionnaire: A brief alcoholism screening tool asking subjects about attempts to Cut down on drinking, Annoyance over others' criticism of the subject's drinking, Guilt related to drinking, and use of an alcoholic drink as an Eye opener.

Coke bugs: Tactile hallucinations (also called formications) that feel like bugs crawling on or under the skin. Chronic and high-dose stimulant abuse can cause various types of hallucinations.

Constricted pupils (pinpoint pupils): Pupils that are temporarily narrowed or closed. This is usually a sign of opiate abuse.

Convulsions: A seizure is a sudden episode of uncontrolled electrical activity in the brain. If the abnormal electrical activity spreads throughout the brain, the result may be a loss of consciousness and a grand mal seizure. One symptom of a seizure is convulsions or twitching and jerking of the limbs. Seizures may occur as the result of head injury, infection, cerebrovascular accidents, withdrawal from sedative-hypnotic drugs, or high doses of stimulants.

Crack: Cocaine (cocaine hydrochloride) that has been chemically modified so that it will become a gas vapor when heated at relatively low temperatures; also called "rock" cocaine.

Dilated pupils: Pupils that have become temporarily enlarged.

Downers: Slang term for drugs that exert a depressant effect on the central nervous system. In general, downers are sedative-hypnotic drugs, such as benzodiazepines and barbiturates.

DTs: Delirium tremens; a state of confusion accompanied by trembling and vivid hallucinations. Symptoms may include restlessness, agitation, trembling, sleeplessness, rapid heartbeat, and possibly convulsions. Delirium tremens often occurs in chronic alcoholics after withdrawal or abstinence from alcohol.

Ecstasy: Slang term for methylenedioxymethamphetamine (MDMA), a member of the amphetamine family (for example, speed). At lower doses, MDMA causes distortions of emotional perceptions. At higher doses, it causes potent stimulation typical of the amphetamines.

Hallucinogens: A broad group of drugs that cause distortions of sensory perception. The prototype hallucinogen is lysergic acid diethylamide (LSD). LSD can cause potent sensory perceptions, such as visual, auditory, and tactile hallucinations. Related hallucinogens include peyote and mescaline.

Hepatitis: An inflammation of the liver, with accompanying liver cell damage and risk of death. Hepatitis may be of limited duration or a chronic condition. It may be caused by viral infection, as well as chronic exposure to poisons, chemicals, or drugs of abuse, such as alcohol.

Ice: Slang term for smokeable methamphetamine. Much as cocaine can be modified into a smokeable state (crack cocaine), methamphetamine can be prepared so that it will produce a gas vapor when heated at relatively low temperatures. When smoked, ice methamphetamine produces an extremely potent and long-lasting euphoria, an extended period of high energy and possible agitation, followed by an extended period of deep depression.

Legal problems: AOD abusers are at a higher risk for engaging in behaviors that are high risk and illegal. These behaviors may result in arrest and other problems with the criminal justice system. Examples of legal problems include driving while intoxicated, writing bad checks to obtain money for drugs, failure to pay bills and credit card debts, being arrested for possession or sale of drugs, evictions, and arrest for drug-related violence.

Marijuana: The dried leaves and flowering tops of the Indian hemp plant *cannabis sativa*; also called "pot" and "weed." It can be smoked or prepared in a tea or food. Marijuana has two significant effects. In the nontolerant user, marijuana can produce distortions of sensory perception, sometimes including hallucinations. Marijuana also has depressant effects and is partially cross-tolerant with sedative-hypnotic drugs such as alcohol. Hashish (or hash) is a combination of the dried resins and compressed flowers from the female plant.

Needle tracks: Bruising, collapsed veins, or a series of small holes on the surface of the skin caused by chronic injection of drugs into the veins (intravenous injection) or muscle (intramuscular injection) or under the skin (subcutaneous injection).

Nodding out: Slang term for the early stages of depressant-induced sleep. Opioids and sedative-hypnotics induce depression of the central nervous system, causing mental and behavioral activity to become sluggish. As the nervous system becomes profoundly depressed, symptoms may range from sleepiness to coma and death. Typically, "nodding out" refers to fading in and out of a sleepy state.

Opiates: A type of depressant drug that diminishes pain and central nervous system activity. Prescription opiates include morphine, meperidine (Demerol), methadone, codeine, and various opioid drugs for coughing and pain. Illicit opioids include heroin, also called "smack," "horse," and "boy."

Paranoia: A type of delusion, or a false idea, that is unchanged by reasoned argument or proof to the contrary. Clinical paranoia involves the delusion that people or events are in some way specially related to oneself. People who are paranoid may believe that others are talking about them, plotting devious plans about them, or planning to hurt them. Paranoia often occurs during episodes of high-dose chronic stimulant use and may occur during withdrawal from sedative-hypnotics such as alcohol.

Paraphernalia: A broad term that describes objects used during the chemical preparation or use of drugs. These include syringes, syringe needles, roach clips, and marijuana or crack pipes.

Self-help groups: Self-help groups differ from therapy groups in that self-help groups are not led by professional therapists. Some self-help groups, such as Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous, are called 12-step programs because they are based on the 12 steps or recommendations for living of Alcoholics Anonymous.

Skin abscesses: A collection of pus formed as a result of bacterial infection. Abscesses close to the skin usually cause inflammation, with redness, increased skin temperature, and tenderness. Abscesses may be caused by injecting drugs and impurities into the body.

Slurred speech: A sign of depressant intoxication. When people consume significant amounts of sedative-hypnotics and opioids, their speech may become garbled, mumbled, and slow.

Tremors: An involuntary and rhythmic movement in the muscles of parts of the body, most often the hands, feet, jaw, tongue, or head. Tremors may be caused by stimulants such as amphetamines and caffeine, as well as by withdrawal from depressants.

Unsteady gait: Unsteady, crooked, meandering, and uncoordinated walk, typical of alcohol-impaired individuals.

Uppers: Slang term used to describe drugs that have a stimulating effect on the central nervous system. Examples include cocaine, caffeine, and amphetamines.

Sources for the AOD Screening Questions

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DAST: Skinner, H.A. Drug Abuse Screening Test. *Addictive Behavior* 7:363-371, 1982.

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MAST: Selzer, M.L. The Michigan Alcohol Screening test: the quest for a new diagnostic instrument. *American Journal of Psychiatry* 127:1653-1658, 1971.

POSIT: Rahdert, E.R. The Adolescent Assessment and Referral System Manual. DHHS pub. no. (ADM) 91-1735. Rockville, Md.: National Institute on Drug Abuse, 1991.

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APPENDIX F

Assessment Domains¹⁵

- Strengths or resiliency factors, including self-esteem, family, religiosity, other community supports, coping skills, and motivation for treatment.
- History of use of substances, including over-the-counter and prescription drugs (including Ritalin), tobacco, caffeine, and alcohol. The history notes age of first use, frequency, length, pattern of use, and mode of ingestion, as well as treatment history.
- Medical health history and physical examination (noting, for example, previous illnesses, infectious diseases, medical trauma, pregnancies, and sexually transmitted diseases). An adolescent's HIV risk behavior status (e.g., does he inject drugs or practice unsafe sex?) should be assessed as well. A full sexual history, including sexual abuse and sexual orientation, should be taken.
- Developmental issues, including influences of traumatic events, such as physical or sexual abuse and other threats to safety (e.g., pressure from gang members to participate in drug trafficking).
- Mental health history, with a focus on depression, suicidal ideation or attempts, attention deficit disorders, oppositional defiance and conduct disorders, and anxiety disorders, as well as details about prior evaluation and treatment for mental health problems. Also assess the disability status of the individual young person.
- Family history, including the parents' and/or guardians' history of substance use, mental and physical health problems, chronic illnesses, incarceration or illegal activity, child management concerns, and the family's cultural, racial, and socioeconomic background and degree of acculturation. The description of the home environment should note substandard housing, homelessness, proportion of time the young person spends in shelters or on the streets, and any pattern of running away from home. Issues regarding the youth's history of child abuse or neglect, involvement with the child welfare agency, and foster care placements are also key considerations. The family's strengths should also be noted as they will be important in intervention efforts.
- School history, including academic performance and behavior, learning-related problems, extracurricular activities, and attendance problems. Has the child been assessed with a learning disability, or perhaps received special education services at some time in his educational career?
- Vocational history, including paid and volunteer work.
- Peer relationships, interpersonal skills, gang involvement, and neighborhood environment.
- Juvenile justice involvement and delinquency, including types and incidence of behavior and attitudes toward that behavior.
- Social service agency program involvement, child welfare involvement (number and duration of foster home placements), and residential treatment.
- Leisure activities, including recreational activities, hobbies, interests, and any aspirations associated with them.

¹⁵ “*Screening and Assessing Adolescents for Substance Use Disorders.*” Treatment Improvement Protocol (TIP) 31, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT); 1998.

APPENDIX G

Additional Information on Assessment

It is critical to form a therapeutic alliance with the family to the fullest extent possible and to involve the family in the assessment process. If there is evidence that the adolescent is being abused at home, the family should still be questioned about the adolescent's substance use. Providers must, however, report child abuse.

The use of well-designed questionnaires and interviews can yield an accurate, realistic understanding of the teenager and the problems she is experiencing. Assessment instruments must have both validity and reliability.

Of great importance to the user is the author's description of how the instrument is to be administered, scored, and interpreted. Specific statements should include:

- The purpose or aim of the test.
- For whom the test is and is not appropriate.
- Whether the test can be administered in a group or only on an individual basis.
- Whether it can be self-administered or if it must be given by an examiner.
- Whether training is required for the assessor and, if so, what kind, how much, and how and where it can be obtained.
- Where the test can be obtained and what it costs.

Once selected, the tests should be administered and scored in the manner recommended by the authors; no substitutions should be made for any test items and no items should be eliminated or modified. For structured interviews, the interview format and item wording should be strictly followed.

After the information from the different sources (interview, observation, specialized testing) has been assembled, the assessor writes a report of what he has learned about the adolescent in terms that can be understood by all concerned, including the adolescent. The report should deal with such issues as: (1) the way the adolescent processes information most effectively and how this will affect treatment, (2) how the adolescent's past experiences will affect her reaction to certain treatment interventions, (3) specific treatment placement recommendations and justifications, and (4) counselor recommendations.

APPENDIX H Adolescent Drug Abuse Diagnosis (ADAD)¹⁶

The *Adolescent Drug Abuse Diagnosis* instrument is a 150-item instrument for structured interviewer administration that produces a comprehensive evaluation of the client and provides a 10-point severity rating for each of nine life problem areas. Composite scores to measure client behavioral change in each problem area during and after treatment can be calculated.

Only 83 items of the 150 items are used for measuring change: posttest, follow-up tracking in an evaluation of clients after treatment, and evaluation of treatment outcome. These 83 items are circled on the instrument.

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Purpose. To assess substance use and other life problems, to assist with treatment planning, and to assess changes in life problem areas and severity over time.

Type of Assessment: Structured interview.

Life Areas/Problems Assessed:

- Medical
- School
- Employment
- Social relations
- Family and background relationships
- Psychological
- Legal
- Alcohol use
- Drug use

Checklists. A special feature of the *Adolescent Drug Abuse Diagnosis* is three problem checklists in the medical, school, and family sections. These lists, which require only a yes or no response from the adolescent, enable the interviewer to gather a considerable amount of information from the youth in an easy and efficient manner. The items on the problem checklists were selected from longer lists of items of an open-ended instrument that had been administered to several different populations of adolescent substance users. The items that were found to

¹⁶ “*Screening and Assessing Adolescents for Substance Use Disorders.*” Treatment Improvement Protocol (TIP) 31, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT); 1998.

predict treatment outcome to the most significant degree were selected for inclusion in the instrument.

Reading Level. Not applicable; a staff person interviews the client.

Completion Time. 45-55 minutes.

Credentials/Training. A 1-day training session is recommended. As an alternate minimal training method, a training videotape is available at a cost of \$25.00. Technical assistance for this training procedure is available at no cost by telephone.

The videotape shows an actual *Adolescent Drug Abuse Diagnosis* interview which can be used as (1) a simple model for the administration of the instrument, and (2) a means of developing proficiency with assigning severity ratings (by comparing the trainee's severity ratings with those of the trainer).

Scoring Procedures. Each life problem area is scored for problem severity on a 10-point scale. Collectively, these scores are referred to as the Interviewer Severity Ratings and comprise a comprehensive adolescent life problem profile.

The interviewer's ratings usually reflect the judgment of the severity of the problems based on the historical perspective of the client's behavior and life conditions over a period of time that is longer than the most recent 30-day period covered by the items that are included in the formulas for deriving the composite scores.

Mathematically derived composite scores (based on a formula for weighting selected item scores) can be used to assess changes in problem severity over time. These scores are independent of both the interviewer's clinical judgment of the "severity" of each life problem area, as well as the adolescent client's problem severity and treatment need self-ratings.

Scoring Time. Less than 10 minutes.

General Commentary. Although ADAD was originally developed for use with adolescents in substance use disorder treatment settings, it has proved useful as a general assessment tool for adolescents in school settings, youth social service agencies, mental health facilities, and facilities and programs within the criminal justice system. Formal ADAD training sessions have been provided to intake workers, drug counselors, and therapists in 12 States. It has also been translated into French, Swedish, and Greek.

A computerized version for administration of ADAD, which has been developed by the Target Cities Research Project at the University of Akron in Akron, Ohio, is now available on disk. This software version of ADAD provides a narrative summary of the data collected from each individual client that is intended to facilitate report writing and treatment planning.

Normative Information. The standardization sample consists of 1,042 clients admitted to six outpatient programs ($n=683$), three residential, nonhospital programs ($n=157$), and three hospital programs ($n=202$). Some of the demographics of this standardization sample are:

- Mean age: 15.6 years
- Sex distribution: 73 percent male, 27 percent female
- Race distribution: 53 percent white, 25 percent African-American, 20 percent Hispanic, and 2 percent other
- Mean school grade completed: 8.1
- There were an insignificant number of Native Americans in the standardization sample; therefore, the *Adolescent Drug Abuse Diagnosis* may not be appropriate for use with Native Americans.

Psychometrics. Good two-year rater interrater reliability ($r=0.85-0.97$) was demonstrated for the interviewers' severity ratings of the nine life problem areas. Good test-retest reliability was shown for interviewer severity ratings (r between .83 and .96) and for the composite scores (r between .91 and .99), except for the employment of life problems area ($r=.71$). Adequate concurrent (external) validity (r between .43 and .67) was established for all but two life problem areas (by correlating with scores obtained on other previously validated instruments that purported to measure the same life problem area). The exceptions were the medical and social relations life problem areas; obtained correlations were lower.

Pricing Information:

\$15.00 per instruction manual

\$25.00 per training videotape

\$40.00 per computerized version of the *Adolescent Drug Abuse Diagnosis* with a manual for installing and using software.

The *Adolescent Drug Abuse Diagnosis* is in the public domain. In response to inquiries about the instrument, the following items are sent free of charge: a copy of the instrument; a copy of the original journal paper about the instrument, which describes its development, its psychometric properties, and its normative sample; a letter that provides additional information about the instrument and a price list.

Reviewed in: Leccese and Waldron, 1994.