California's
Safe and Drug-Free
Schools and Communities
Governor's Program

Technical Assistance
& Training Project

SDFSC Grantee

Learning Community Conference 2008

CARS
CENTER FOR APPLIED RESEARCH SOLUTIONS

Managed by The Center for Applied Research Solutions
Funded by The California Department of Alcohol and Drug Programs

SDFSC Grantee Learning Community

December 10th and 11th, 2008
Doubletree Hotel Sacramento, CA

Day One: Wednesday, December 10th, 2008

8:00 to 8:30	Registration, Networking and Continental Breakfast
8:30 to 9:00	Welcome, Meeting Overview, and Group Check-In *Kerrilyn Scott-Nakai, CARS with Sharon Dais and Jane Williams, ADP*
9:00 to 10:15	Partnerships: The Road to a Sustainable Continuum of Services Presentation, facilitated discussion and exercise *Dustianne North and Jerry Sherk*
10:15 to 10:30	BREAK
10:30 to 11:30	AOD Screening and Referral: Tools and Strategies Presentation and facilitated discussion *Jan Ryan and Kerrilyn Scott-Nakai*
11:30 to 12:00	Understanding Youth Culture Exercise Facilitated Discussion *Maggie Escobedo-Steele*
12:00 to 1:00	LUNCH AND NETWORKING
1:00 to 2:45	Indicated Prevention: Considerations for Confidentiality and Consent Presentation, Q & A and group discussion *Chuck Ries and Kerrilyn Scott-Nakai*
2:45 to 3:00	BREAK
3:00 to 4:30	Introduction to Motivational Interviewing and Brief Intervention Techniques Presentation, discussion and hands-on exercise *Jan Ryan and Chuck Ries*
4:30 to 5:00	Closing Remarks *Kerrilyn Scott-Nakai and Maggie Escobedo-Steele*

Day Two: Thursday, December 11th, 2008

General Session with Local Evaluators Included

8:00 to 8:30 — Registration, Networking and Continental Breakfast

8:30 to 9:00 — Welcome and Exercise
Kerrilyn Scott-Nakai and Maggie Escobedo-Steele

9:00 to 10:00 — Overview and Status of Proposed Statewide Evaluation
Presentation and group discussion
Christina Borbely, Ph.D. and Kerrilyn Scott-Nakai

10:00 to 10:15 — BREAK

Concurrent Breakouts

10:15 to 12:00 — Program Track
Strategies for Implementation and Adaptation: Successes, Challenges, and Lessons Learned
Concurrent facilitated discussion groups and large group report out:

- Project Success: *Jan Ryan and Chuck Ries*
- Strengthening Families: *Rocco Cheng, Angela Da Re, and Judy Strother-Taylor*
- Foster Youth: *Dustianne North and Jerry Sherk*

10:15 to 12:00 — Evaluator Track
Overview of Local Evaluation Components and Peer Learning Forum
Facilitated group discussion, *Christina Borbely, Ph.D.*

12:00 to 1:00 — LUNCH AND NETWORKING

1:00 to 2:30 — Program Track
Recruiting, Engaging, and Retaining Youth and Families
Presentation and facilitated discussion, *Rocco Cheng, Ph.D.*

1:00 to 2:30 — Evaluator Track
Review of Proposed Statewide Evaluation Components and Action Planning
Workgroup planning around recommended next steps and cross-coordination (if applicable), *Christina Borbely, Ph.D.*

2:30 to 2:45 — BREAK

General Session with Local Evaluators Included

2:45 to 3:30 — Evaluator Report Out and Group Discussion Regarding Next Steps
Report out and group discussion

3:30 to 4:00 — Closing and Wrap-Up, *Kerrilyn Scott-Nakai and Maggie Escobedo-Steele*

Welcome & Overview

Facilitators: Sharon Dais, Jane Williams, and Kerrilyn Scott-Nakai

Welcome and Overview

SDFSC Grantee Learning Community ~ December 10-11, 2008

Sharon Dais and Jane Williams, ADP
Kerrilyn Scott-Nakai, CARS

Doubletree Hotel Sacramento, CA

Session Overview

- Brief Overview and Background
  - Focus of the Initiative
  - Priority populations
  - Services proposed
- Learning Community Overview
  - Define objectives
  - Review agenda

I. Introduction and Background

- Focus of the Initiative
- Cohort III Focus Areas
- Grantees by Population and Service Design

SDFSC Governor's Funding Priority

- Children and youth who are not typically served by State or Local Education Agencies

AND/OR

- Populations that need special services or additional resources such as youth in juvenile detention facilities, foster youth, runaway or homeless youth, pregnant and parenting teenagers, and school dropouts

Funding Overview

- Funding Process
  - Competitive grant process—3 rounds of RFA's
    - Cohort I: 33; Cohort II: 10; Cohort III: 18
- ADP's Partnership with Counties
  - County AOD administrator eligible applicant for grants
  - Majority of programs sub-contracted with CBO's and/or LEA's for direct service p
- Program Support Structure
  - State staff are assigned to each county
  - A dedicated TA contract is in place.

Technical Assistance Approach

- **Customized and On-Going Approach**
  - Limited number of grantees (n=33, 10, 18)
  - Set number of TA days
  - Working with same programs over a 3 to 5 year period
  - Utilizing an intensive team approach to service delivery
  - Three point coordination with ADP, CARS, and Grantee
- **A Balance of a Developmental and Prescriptive Approach**
  - TA should be properly aligned with stages of programming: planning, implementation, improvement/refinement, documenting results, dissemination/sustainability

SDFSC TA Project Objectives

- To provide technical assistance, training, and support to assist grantees in achieving:
  - Compliance with the federal and state funding requirements (i.e. NCLB and POEs)

    AND
  - More effective ATOD and violence prevention services for at-risk and underserved youth and their families

Round III Grantees

- Alameda
- Butte
- Del Norte
- El Dorado
- Kern
- Marin
- Mendocino
- Napa
- Placer
- Riverside
- San Bernardino
- San Luis Obispo
- San Mateo
- Santa Cruz
- Shasta
- Sonoma
- Sutter-Yuba
- Tulare

Cohort III: Priority Populations

- Youth who engage in High Rate/Binge Drinking
  - 12 grantees (2-5 grantees "at-risk of")
    - Primarily chose Project Success (at least 8)
- Children of Substance Abusing Parents
  - 4 grantees
    - Primarily chose Strengthening Families
- Foster Youth
  - 2 grantees

Curricula/Strategies Selected

- Project Success
  - 8 grantees
- Family Strengthening
  - 4 grantees
- Aggression Replacement Therapy (ART)
- Basics
- CASASTART
- CMCA/CT
- Friday Night Live
- Project Alert
- Reconnecting Youth
- Sembrando Salud
- Seven Challenges

Age Range

- Age ranges from elementary to high school
  - From 6 years of age to 18 years of age
  - At least 11 grantees are serving H.S. students
  - At least 9 grantees are serving M.S. students
  - At least 4 grantees are serving Elementary students
- A considerable portion of grantees (n=7) are serving a broad age range
  - Developmental adaptations of services will need to be considered

Recruitment

- Ranges from 30 to 150 a year for more intensive services.
  - A considerable portion of grantees identified serving at least 100 youth and/or families in the first year.
  - These are ambitious numbers for the first year of a project.
- Broader services are proposed to larger target groups including school and district-wide services.
- Target retention and program completion rates are less clearly noted in the original grant applications

Program Setting

- School-Based
  - The majority of grantees are providing at least a portion of the services at school sites.
    - At least 8 grantees are proposed to provide services at alternative and continuation schools
- Community-Based
  - A considerable number of grantees proposed integrating community-based services.
- Home Visits
  - At least 2 grantees are conducting home visits

III. Learning Community Overview

Conference Objectives

- To provide information and build capacity in core requested topic areas:
  - Brief Intervention and motivational interviewing
  - Partnership building
  - AOD screening
  - Recruitment and engagement
- To provide an opportunity for directed discussion and move towards clarification regarding:
  - Considerations for confidentiality and consent
  - The potential role of a statewide evaluation process
- To provide a learning community forum for grantees to begin to share and document successful strategies for:
  - Implementation and adaptation of models
  - Building partnerships
  - Recruiting, retaining, and engaging youth and families

Future Opportunities for Technology Transfer

- Opportunities for expanding the learning community
  - COSSR—Continuum of Services Statewide Reengineering Task Force
  - CADPAAC-County Alcohol and Drug Program Administrators' Association of California
  - SIT—State Interagency Team
  - MHSA—PEI -Mental Health Service Act—Prevention and Early Intervention
  - GPAC—HRUU—Governor's Prevention Advisory Council, High Rate Underage Users' Workgroup. Partnership with California Department of Education and includes a focus on Student Assistance Programs (SAPs)
- Critical Topics for further exploration and documentation of best practices
  - Effectively serving selected and indicated populations—particularly priority populations
  - The role of AOD screening and brief intervention in bridging the gap between prevention and treatment services
  - The role of confidentiality and consent when providing indicated services

Review Agenda

- Review agenda
  - Day One
  - Day Two
- Review organization and contents of binder
  - Program
  - Evaluation
  - Resources
  - Contact Directory
  - Other Binder Goodies
- Housekeeping items

Partnerships: The Road to a Sustainable Continuum of Services

Facilitators: Dustianne North and Jerry Sherk

Partnerships: The Road to a Sustainable Continuum of Services

Developed by
Dustianne North, MSW
and Jerry Sherk, MA

Learning Objectives

- Understand the need for a continuum of services when serving youth with multiple needs
- Consider the role of your partnerships in your overall sustainability
- Evaluate strengths & needs of existing partnerships
- Examine best practices for partnership and sustainability
- Identify specific tasks for strengthening your partnerships & therefore sustaining your programs

Multiple Needs: Barriers to Assistance

Youth who face multiple risk factors often require multiple forms of support or assistance. This alone can create barriers: if stressed individuals must travel to several locations and interact separately with multiple providers, this can be overwhelming and untenable.

Barriers to serving SDFSCal target populations:

- Identifying and accessing youth is often difficult
- Retaining and tracking youth pose challenges
- Youth have multiple needs during and after the program
- Youth are connected to multiple systems which dictate their experiences in and out of the program

Collaboration: A Strategy to Overcome Barriers

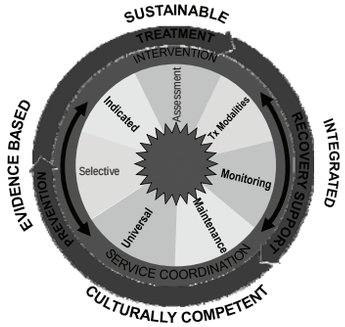
- Programs, systems, agencies and individuals come together to achieve a mission that could otherwise be difficult or unattainable
- Resource leverage and development
- Sustainable infrastructure, continuum of care, and referral networks

A Continuum of Services

The idea of a continuum of services is that…

- Individuals are connected to *all* of the services they need, no matter where they first request assistance
- Services are provided in a coordinated and "seamless" fashion
- Duplication of services is avoided

Continuum of Services



Continuum of Service Goals

- **A comprehensive and integrated continuum of alcohol and other drug services.**
- **Services are effective, high quality, client and community centered, sustainable and culturally competent.**
- **They have the capacity and resources to facilitate holistic health and promote wellness.**

Common Obstacles*

1. ***Access*** —including a refusal from principals to let prevention programs in their schools.
2. ***Attitude*** —teachers saw programs as another added duty rather than an asset.
3. ***Funding Cuts*** —including the impact of funding cuts at the school level.
4. ***Turnover*** —staff turnover at the schools created breaks in services.
5. ***Recruitment*** —specifically, recruiting school personnel.
6. ***Follow Through*** — poor follow through of school personnel was a problem, at both the administrative and school staff level.

** These 6 obstacles were identified by 2004 ADP Grantees*

From Managing to Sustaining

"Managing" your program will help maintain it, but it takes effort & creativity to…

Sustain & Grow a Program

Two Way Street

A Strategy to Enhance Sustainability is to "Build Better Partnerships."

A Strategy to Strengthen Partnerships is to Focus on "Sustainability."

The Continuum Begins at Home…

Youth in your program will be living in one of three situations:

- With their biological or adopted families
- With systems-involvement
- Are homeless, have run away, or are severely neglected

What composes an effective continuum of services for an individual youth or family will depend upon their needs and the major societal systems and institutions which govern them.

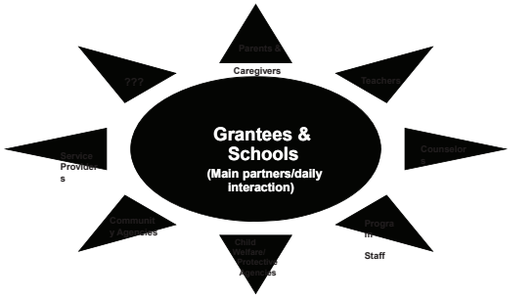
Youth Service Systems

Youth in your program may be served via several infrastructures:

- Family or non-family caregivers
- Educational systems
- Child welfare and juvenile justice systems
- Substance abuse mandates and programs for youth and parents
- Runaway and homeless youth outreach services
- Other community services and resources
- Positive and negative informal networks

Your program will need to interact with these systems if you are to effectively access, serve, and retain youth.

Collaboration: Potential Partners



ACTIVITY

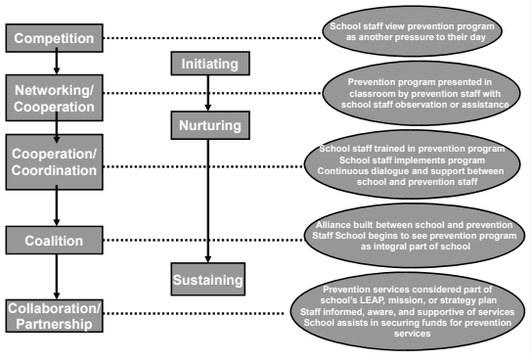
Mapping your Partnership

Who are Your Partners???

Using a blank sheet of paper, please draw a diagram of your partnership.

- Begin with your agency near the center of the drawing
- Now draw in the school you serve and any other central and formal partners
- With whom else do you collaborate in some formal or informal capacity? Draw these out toward the periphery of the drawing.
- What about youth and their families or caregivers?

Stages of Collaboration

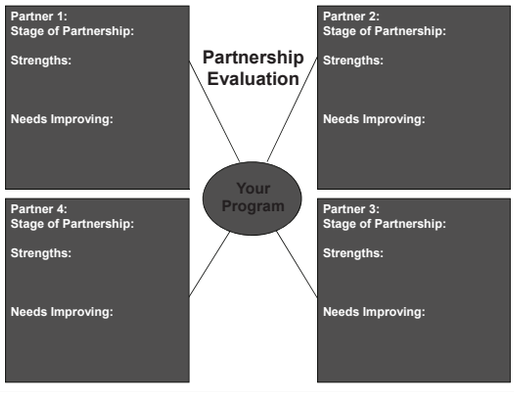


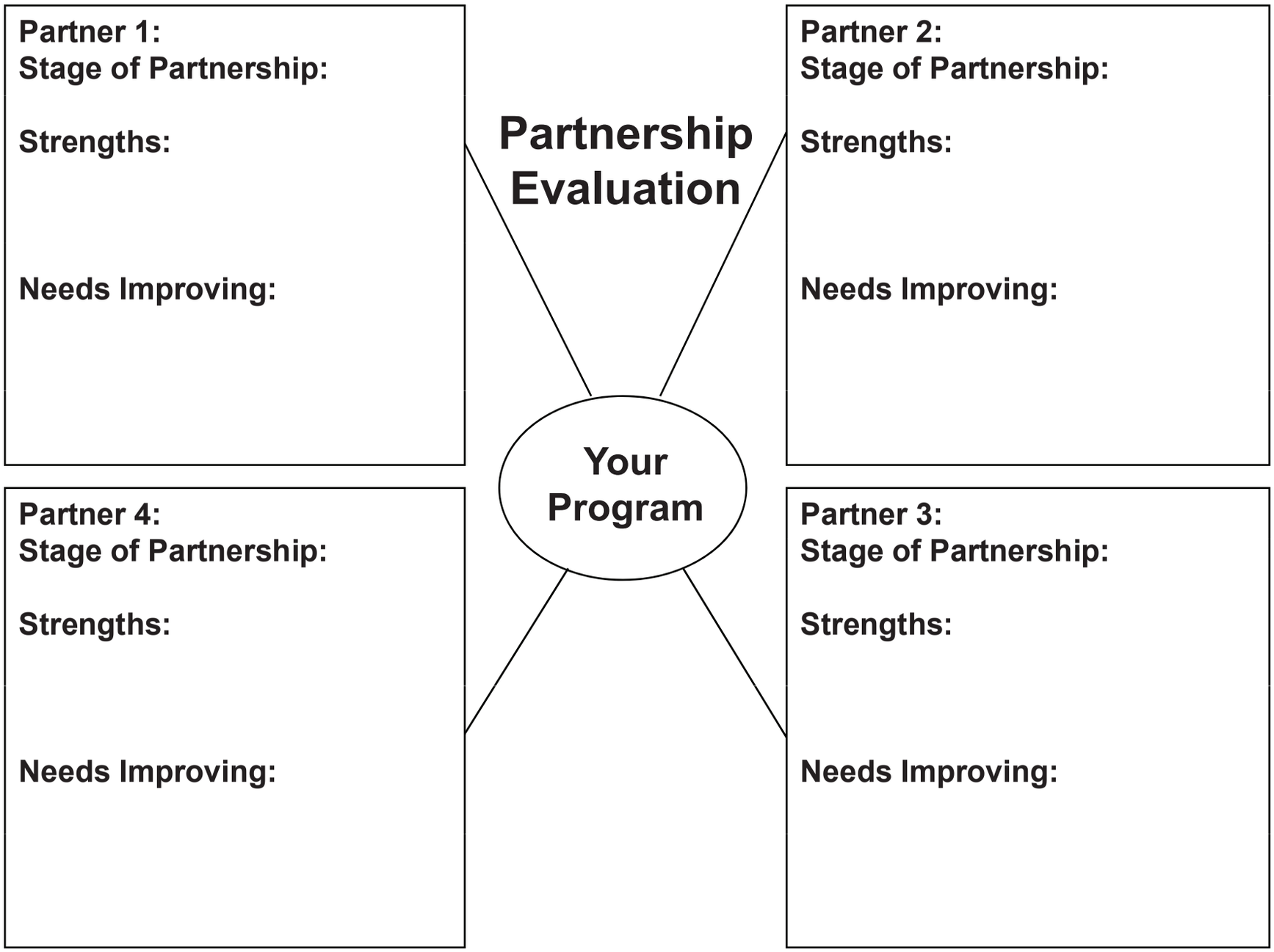
Some Predictors of Successful Partnerships

- The Program's Mission Aligns with its Partners' Missions
- The Program Can Be Modified to Meet New Conditions and Funding Availability
- The Program has an Active Champion
- Benefits to Clients and Staff are Readily Perceived
- Stakeholders in Other Organizations Provide Support

Status of Your Partnerships

Evaluate the stage of evolution, as well as strengths and areas for growth, of EACH of your current partnerships.




Partnership Evaluation
Partner 1:
Stage of Partnership:
Strengths:
Needs Improving:
Partner 2:
Stage of Partnership:
Strengths:
Needs Improving:
Your Program
Partner 4:
Stage of Partnership:
Strengths:
Needs Improving:
Partner 3:
Stage of Partnership:
Strengths:
Needs Improving:

Collaboration Strategy : Make a Balanced Exchange

In order for your collaboration to be effective, it must involve a healthy & mutual exchange among agencies, & among the individuals who represent them in the collaboration.

Consider:

- What are your program needs?
- How do both partners benefit?
- How might partners leverage resources?
- How might partners create joint resources?
- What is the most effective way to work with this partner?
- What are some advantages/disadvantages to working with this partner?
- How might the disadvantages be overcome?

The Importance of Relationships

"Service is important because it is the right thing to do. This is the message the prevention field brings into every setting. But if you still need convincing, remember that *relationships last longer than the money*. This will help all of us to remember that we are in a people business."

-- Jan Ryan

Strategies for Solidifying Institutional Relationships

- **Put Everything in Writing**--Outline Specific Deliverables of All Parties
- **Share Data** -- The Sharing of Data Shows How Your Program Impacts Youth
- **Show Linkages Between Prevention & Academic Outcomes** -- Provide Your Partners with Research Outlining Benefits of Prevention Efforts on Academics
- **Become a Valuable Commodity Rather than a Burden** --E.g., Become Part of the Local Educational Agency Plan, & Also, Always Strive to be Part of the Solution
- **Manage Staff Turnover**--Have a Plan for Solidifying Relationships when Either Partner Loses Key Personnel
- **Treat Everyone with Respect**--**This** Year's Assistant May be Next Year's Lead Person

Improving Your Partnership

- On Your Handout, Write One to Two Things You Will Do to Improve the Value of and Relationship with EACH PARTNER.
- Also Identify Two GENERAL Things You Will Do to Improve Your Overall Program & Partnerships.
- Share Your Findings with Your Group

Case Study of A Successful Partnership:
Sonoma County Parenting Project

Their Findings:

- Plan & Prepare -- All Staff Members & Board
- Value What Your Program Has to Offer
- Tie Into Passions & Values of Funder
- Identify Problems & Needs, Offer Solutions
- Collaborate With Other Known Service Providers
- Develop a Slogan & a Focus
- Set Milestones
- Celebrate & Share Successes

What about you???

Are there a couple of programs out there who can share what they have learned about your program, and how you will work to improve your collaborative???

Thinking Out of the Box

- Can You Share Examples of Unusual Partnerships?
- What Brought Partners Together?
- How Did the Partnership Work?

Questions & Comments

- Your Questions?
- Your Comments?
- What is the One Thing You Will Take Away from This Workshop?

MAKING REFERRALS AND MANAGING REFERRAL NETWORKS

Creating referral networks:

• Actively seek out and research agencies in your area that serve the same population you do

• Join community coalitions and other organizations which are designed to promote collaboration among agencies

• Invite potential and existing partners to fundraising and other events programs

• Continually create new alliances of agencies serving the same or related populations

• Always look for potential new referral sources and agencies with whom to collaborate

Selecting referral partners:

- Visit the agencies with whom you consider working. Collect their literature and get to know their staff.
- Look for ways to *coordinate* services (avoid duplication, make smooth referrals, share information as appropriate, make multiple services seamless)

Establishing roles and referral processes:

- Establish an open line of communication with other agencies-share with them about the needs of your participants as well as the philosophy of your agency, and ask about theirs
- When entering into a partnership and/or referral relationship, create written agreements (Memorandums Of Understandings or similar documents) to ensure that each agency understands what is expected of them
- Invite representatives from agencies to offer training to your staff or participants regarding the services they provide, and conversely offer to train their personnel about your program

Once referral relationship is established:

- Ask agencies to keep you informed about the services they offer, including changes over time.
- Visit agencies periodically.
- Always follow up when you make or receive a referral.
- Be prepared to re-refer if an attempt is unsuccessful.
- Keep an open line of communication with referral sources and partnering agencies.

AOD Screening and Referral: Tools and Strategies

Facilitators: Jan Ryan and
Kerrilyn Scott-Nakai

Moving Towards a Continuum of Services: The Role of Screening and Referral

Presented by:
Jan Ryan and
Kerrilyn Scott-Nakai

Session Overview

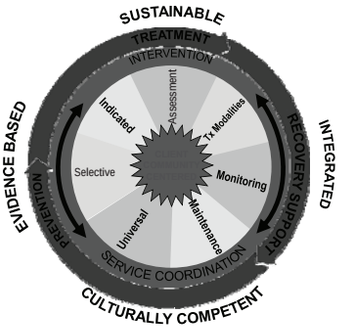
- I. Towards a Continuum of Services
  - Bridging the gap between prevention and treatment
- II. Participant Identification
  - The role of inclusion and exclusion criteria
- III. AOD Screening: Tools and Strategies
- IV. Screening and Referral in Action
  - BRIMM Case Study
- V. Learning Community Forum
  - Sharing Strategies

I. Towards a Continuum of Services:
Making the Connection

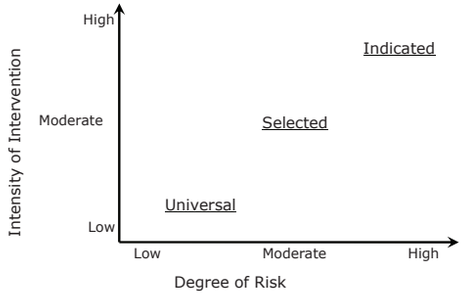
Towards a Continuum of Services

- An individual centered continuum of services approach facilitates entry through multiple service doors and is able to effectively meet the diverse needs of individuals.
- Prevention services which are focused on indicated populations are well positioned to foster entry to both prevention as well as treatment services (as needed).

Continuum of Services



Intensity Versus Degree of Risk



Target Population: Indicated Prevention

- To identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse, but without a clinical diagnosis and to target them with special programs.
- To prevent the onset of substance abuse in individuals of all ages who do not meet Diagnostic and Statistical Manual (DSM-IV) criteria for addiction, but who are demonstrating early signs that we know ultimately can lead to addiction.
- To address risk factors associated with the individual. Less emphasis is placed on assessing or addressing environmental influences, such as community values.
- To reduce first-time substance abuse, and to reduce the length of time the signs and symptoms of use continue, to delay of onset of substance abuse, and/or to reduce the severity of substance abuse.
  - **Source: Institute of Medicine Research cited on CalOMS Prevention**

Bridging the Gap Between Prevention and Treatment

- AOD screening plays a critical role in identifying individuals who need to be referred on for further assessment and thus fostering linkages to treatment services

II. Participant Identification: Inclusion and Exclusion Criteria

Participant Identification

- One size does not fit all
  - Is the program appropriate for participants?
- Be clear and realistic about the fit between program and participants
  - It is important to have a good understanding about the participant
    - Program screening vs. diagnostic assessment

Referral, Intake and Screening

- Referral form from other agency
  - Strengths
  - Challenges
- Program intake form
  - Demographic information
  - Family structure, school & community
  - Past experience
- AOD screening tools

Participant Identification

- It is important to use intake and screening tools to find appropriate participants
- Screening can be used to identify needs as well as assets so appropriate intervention can be provided
- It is important to screen in (inclusion) as well as screen out (exclusion) candidates to make sure program is within the scope of practice and funding guidelines

Participant Identification

Examples

- School-based mentoring program geared towards:
  - Improving academic performance
  - Reducing absences
- Selected prevention program geared towards children of known substance abusers
- Indicated prevention program geared towards high rate underage users

III. AOD Screening: Tools and Strategies

State Interagency Team (SIT)

- Comprised of Deputy Directors from 10 state agencies
- Charged with strengthening services for children, youth, and families where there is a nexus between AOD use and safety, education, workforce readiness, maternal/child health, and mental health
- First goal in 2006-2007 was to improve screening, identification, and intervention regarding AOD risk in families and children.

SIT Survey Findings

- Lack of uniform standards for screening of AOD use, including benchmarks and outcomes
- Variations in
  - Definitions of screening and assessment
  - Screening tools
  - Definitions of youth (e.g. 12-21 versus 10-21)
  - (these variations seen within and across counties)
- Inconsistent presence of written policies for screening referral and tracking of referral

Definition of AOD Screening

- **Alcohol and Other Drug (AOD) screening** is a formal process to determine whether an individual warrants further attention at the current time for alcohol or other drug use. Note, that the screening process does not necessarily identify what kind of AOD problem the person might have or how serious it might be but determines whether further assessment is warranted.
- Age-appropriate screening is used to identify the AOD level of risk present for an individual to determine: 1) if the individual is appropriate for AOD prevention services, or 2) if the risk level is too high for prevention services to provide optimum benefit, in which case the person needs referral for AOD assessment and potentially treatment or other services (as identified).

AOD Screening

Gathering information to make informed decisions in regard to individual appropriateness of:

- *prevention services,*
- *referral to other services and/or*
- *referral for assessment of AOD abuse, co-occurring disorders, etc.*
- *AOD screening does not provide a diagnosis and does not determine the need for treatment.*

Sample Screening Tools

- See reference document
- This represents a list of tools--not formally endorsed or recommended by ADP or CARS

Characteristics of AOD Screening Tools

- Ten-twenty minutes to complete
- Five-ten minutes to score
- Training varies, with minimal levels for some
- Valid and reliable for target population
- Yes/no answers, ratings, frequency of use
- Free or inexpensive

Sample questions

(DAP Quick Screen, 1990)

Have you ever had an in-school or out-of-school suspension for any reason?

Did you receive (even if it was unfair) more than two D or F grades on your last report card in the current (or just finished) school year?

In the past 6 months did your parents hassle you (at least a few times) because they accused you of drinking alcohol or smoking some pot?

Has anyone (friend, parent, teacher or counselor) ever told you that they believe that you may have a drinking or drug problem?

MAYSI-2 Study (2006)

- A total of 2,989 youth at 56 sites across nine California
  - Juvenile Justice Halls or Ranch Programs ("JJ" youth) – N = 1,151 youth (38.5%)
  - • High Risk Youth ("HR" youth - e.g., continuation schools, group homes, etc.) – N = 776 (26%)
  - • Mainstream High Schools in the community ("MS" youth) – N = 1,062 (35.5%)

http://www.alcoholdrugpolicy.com/documents/MAYSI-2REPORT-final.pdf

Referral for Assessment

- Intake & screening indicate a combination of factors:
  - High rates of AOD use/abuse
  - School failure
  - Behavioral problems (at home and/or in school)
  - Violence
  - Juvenile crime
  - Mental health indicators (depression, suicidality)

Making Effective Referrals

- Avoid motion without action
- Good customer service
  - Thorough list of referral agencies
  - Case management model
    - gathering information
    - assist to access needed resources and/or services
  - Personal linkage to service providers
  - Follow-up
    - monitoring their progress

IV. Screening and Referral in Action:
BRIMM Case Study

Three Questions

- **Why does screening make sense?**
- **How do the tools of prevention work together?**
- **How can screening fit into your Continuum of Service?**
  - ***School/District*** Student Assistance Programs
  - ***County or contractor*** services within the Countywide Strategic Prevention Plan

Connecting the Tools

- Dart board: Continuum of Services and SPF:
- Circles: IOM prevention populations: universal, selected and indicated
- Darts: Six Prevention Strategies: Alternatives, Environmental, Information Dissemination, Education, Community-based Processes, Problem Identification and Referral
- Score: Cal OMS Prevention, Evaluation of SPF

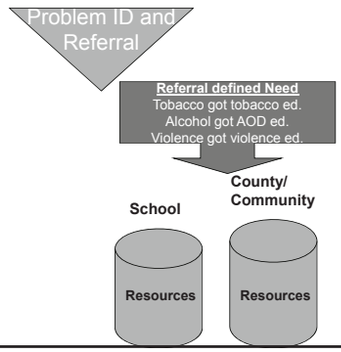
Strategy: Problem Identification and Referral

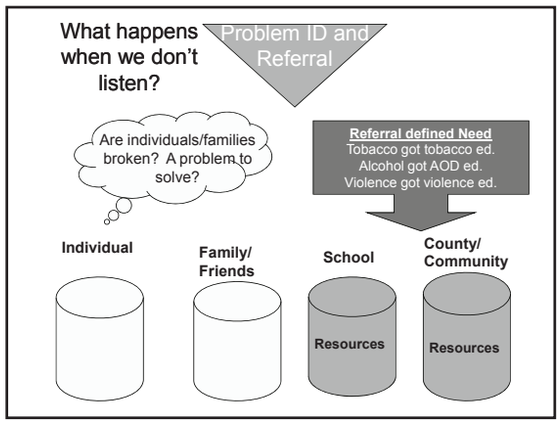
- WHO: This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs
- WHY: in order to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- EXAMPLES: Employee Assistance Programs, Student Assistance Programs; and Driving Under the Influence/Driving While Intoxicated education programs.

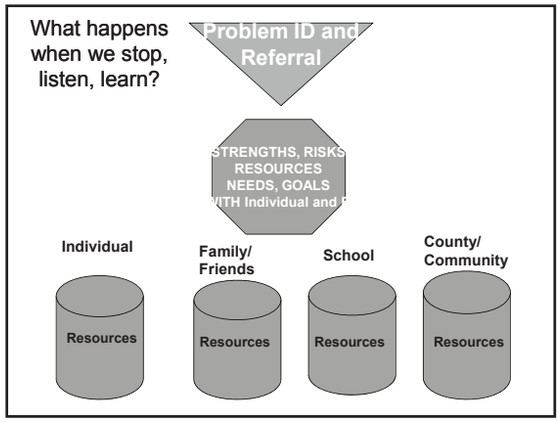
Source: **Net Negotiated Agreement (NNA) Contract**

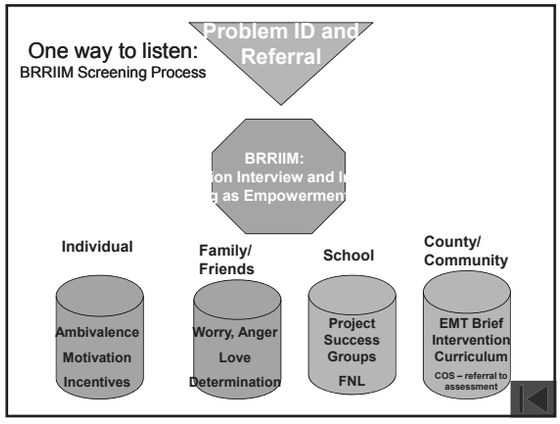
What happens when there are no support services?

What happens when we think in funding streams?




What happens when we don't listen?
Problem ID and Referral
Are individuals/families broken? A problem to solve?
Referral defined Need
Tobacco got tobacco ed.
Alcohol got AOD ed.
Violence got violence ed.
Individual
Family/ Friends
School
County/ Community
Resources
Resources


What happens when we stop, listen, learn?
Problem ID and Referral
STRENGTHS, RISKS
RESOURCES
NEEDS, GOALS
Individual
Family/ Friends
School
County/ Community
Resources
Resources
Resources
Resources


One way to listen:
BRRIIM Screening Process
Problem ID and Referral
BRRIIM:
Individual
Family/ Friends
School
County/ Community
Ambivalence
Motivation
Incentives
Worry, Anger
Love
Determination
Project Success Groups
FNL
EMT Brief Intervention Curriculum
COS – referral to assessment

Brief Risk Reduction Interview and Intervention Model (BRRIIM)

Structured, Scripted Three Stage Screening Process

1. **Engage**
2. **Explore and Energize**
   - Can be supplemented with screening tools/questionnaires
3. **Enlist and Extend**

Customized to the setting: school or county
Data collection/analysis: CalOMS Prevention

How the Friends/Family/Allies participate

- Referrals:
  - Concerned family, friends, peers can refer
- Interview and Agreement:
  - Participate in process, be willing to support agreement and evaluate the progress
- Education and Intervention:
  - Support education for the Participant and themselves, return for services as needed

BRRIIM Service Objectives:

based on the IOM definition of Indicated Prevention and using strategies of Problem ID and Referral and Education

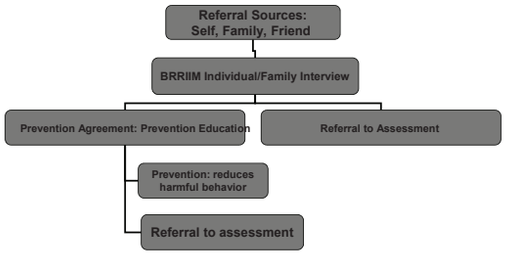
- To provide concerned family members, physicians, nurses, employers, friends, or the courts who want prevention available to people of all ages who do not meet the criteria for a diagnosis for treatment.
- To engage the individual's personal motivation to make positive health choices when they experience something negative associated with their AOD use.
- To provide evidence-based prevention practices that target multiple behaviors simultaneously, reduce the risk factors and problem behaviors and stems the progression of substance abuse and related disorders.

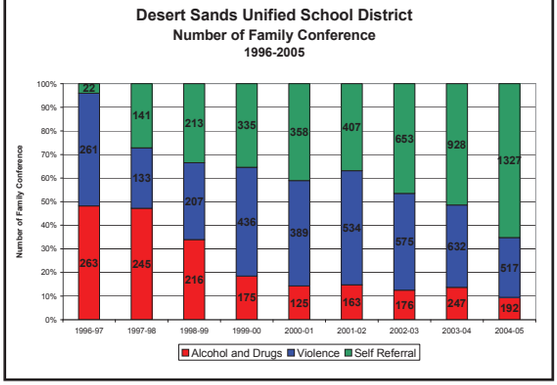
Additional Aims of BRRIIM

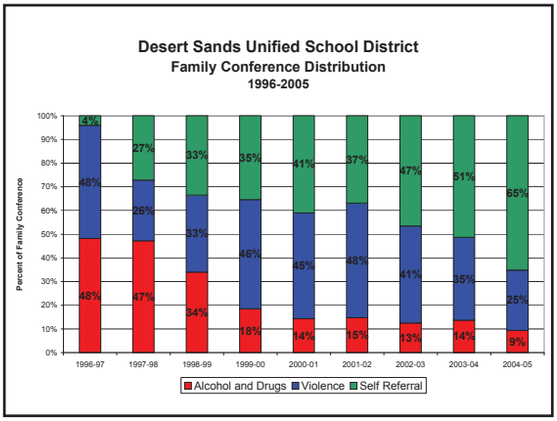
1. To re-engineer prevention programs into a Continuum of Services (COS) focused on the individual participant.
2. To increase the implementation of effective, research based prevention strategies.
3. To increase the number of people who seek prevention support and reduce the number of people who require substance abuse treatment.
4. To reduce the wait time for services.
5. To implement comprehensive prevention systems and partnerships that sustain.

How does BRRIIM work?

Flow of Process





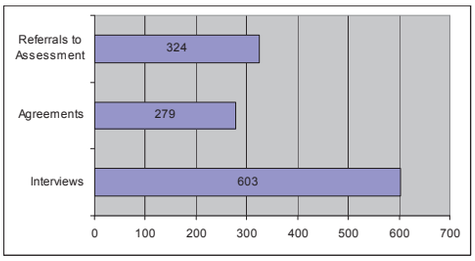


July 07 thru March 08 Progress

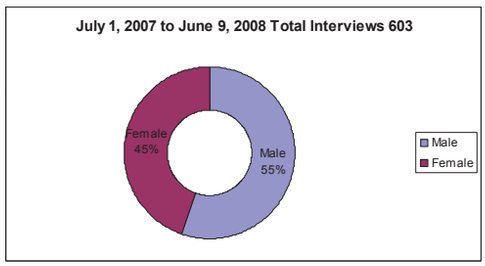
- √ Six clinics with co-located prevention services provided by trained Prevention Specialists.
- √ One full time lead Prevention Specialist, with back up staff in each clinic location.
- √ Total interviews: 603
- √ Prevention Agreements: 279 (46%)
  - √ Total Contacts: 642
  - √ Hours of Service: 843
  - √ Average duration of each service: 1.9 hours
- √ Referrals to assessment: 324 (54%)

7/1/07 to6/9/08 Data

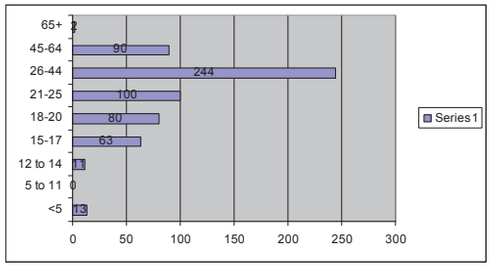
46% of Interviews enter a Prevention Agreement



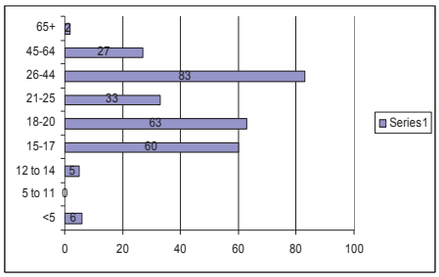
603 Total Interview: Gender



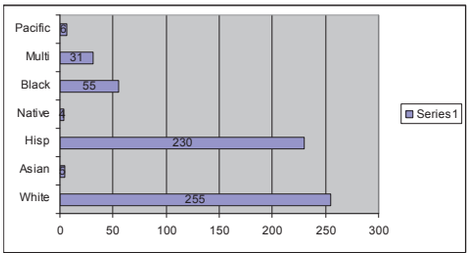
Interviews: Age



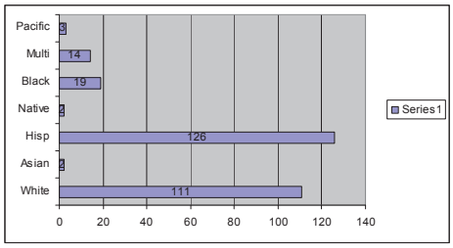
Agreements: Age



Interviews: Ethnicity



Agreements: Ethnicity



Prop. 63 MHSA Challenge to Prevention/Early Intervention Practioners

Expand and transform mental health services system

- **Reduce disparities in access to prevention services**
- **Increase prevention response to early signs and symptoms of mental health problems, emotional and behavioral health problems**
- **Reduce stigma and discrimination**
- **Increase capacity of system for prevention and early intervention**
- **Collaborate, leverage, target priority populations, use evidence from past practice and current successes**

A Life in the Community for Everyone!

V. Learning Community: Sharing Strategies

SAMPLE AOD SCREENING TOOLS
(This does not represent a comprehensive list)

AOD Screening Tools	Priority populations	Time to complete	Setting	Areas Screened	Cost	Reliability/ Validity
Treatment Improvement Protocol (TIP) Series – Best Practice Guidelines (suggested protocols for screening and assessment) http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.part.22441	High rate users	10 minutes	Appropriate for Schools	AOD use, frequency, recent use; identify abuse, need for treatment/assessment	Free	n/a
GAIN Short Screener (Chestnut Health Systems, 2005) http://www.chestnut.org/LI/gain/GAIN_SS/index.html	High rate users, COSAPs and foster youth; available in Spanish	5 minutes	Appropriate for Schools; juvenile justice settings	AOD use, frequency, recent use, mental health, behavior; identify need for further assessment	Yes	Highly reliable/ valid/ specific
Personal Experience Screening Questionnaire (PESQ) (Center for Adolescent Substance Abuse, 1991) *http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/50_PESQ.pdf*	High rate users	10 minutes	Appropriate for schools	Identifies need for further assessment, AOD use & frequency	Yes	Highly reliable/valid
Rutgers Alcohol Problem Index (RAPI) *http://eib.emcdda.europa.eu/html.cfm/index4200EN.html*	Binge drinkers	10 minutes	Appropriate for schools	Identifies alcohol use, frequency, potential abuse	Free	Highly reliable
DAP Quick Screen (Vienna Pediatrics Associates, 1990) *http://eib.emcdda.europa.eu/html.cfm/index4381EN.html*	High rate users, COSAPS, foster youth	10 minutes	Appropriate for schools; traditionally used by physicians	Identify risk for substance abuse	Free	Not research based
Problem Oriented Screening Instrument for Teenagers (POSIT) (National Institute for Drug Abuse –NIDA, 1991) *http://eib.emcdda.europa.eu/html.cfm/index3654EN.html*	High rate users, ideal for COSAPS, foster youth; available in Spanish	20 minutes	Appropriate for schools	Designed to identify potential problem substance abuse and mental health areas that require further in-depth assessment	Free	Highly reliable/ valid

SAMPLE AOD SCREENING TOOLS
(This does not represent a comprehensive list)

AOD Screening Tools	Priority populations	Time to complete	Setting	Areas Screened	Cost	Reliability/ Validity
AlcoholScreening.Org *http://www.alcoholscreening.org/*	Binge drinkers	10 minutes; self-administered online survey	Appropriate for schools, online access needed	Identifies hazardous, binge-drinking and at-risk for binge-drinking behavior	Free	n/a
MAYSI-II *http://www.maysiware.com/MAYSI2.htm*	High rate users, ideal for COSAPS, foter youth	10 minutes	Primarily used in juvenile justice settings but can be used in schools	AOD risk and abuse, frequency, recency; ID for potential treatment or assessment; mental health component identifies need for treatment	Yes	Validated on adjudicated, high risk & mainstream youth population
SASSI (Substance Abuse Subtle Screening Inventory) *http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/66_SASSI.pdf*	High rate users	10 minutes	Primarily used in mental health settings	Psychological screening, identify need for assessment for substance abuse disorder	Yes	Extremely reliable and valid
CRAFFT *http://www.projectcork.org/clinical_tools/pdf/CRAFFT.pdf*	High rate users	5 minutes	Appropriate for school settings	Identify need for assessment for substance abuse	Free	Internally consistent, high sensitivity and specificity rates among adolescents who use AOD.

Understanding Youth Culture Exercise

Facilitator: Maggie Escobedo-Steele

CULTURAL PURSUIT

Instructions:

1. **Read this page and note mentally which ones you can answer.**
2. **Find different people who know the answer to each of the questions.**
3. **Fill in their name and the answer.**
4. **Be prepared to sign your name and share what you know with others.**
5. **CHALLENGE YOURSELF TO CIRCULATE & HAVE FUN!!!!!!**

FIND SOMEONE WHO:

1. Knows who Nelson Mandela is_____

   Name_____
2. Knows who Willma Mankiller is_____

   Name_____
3. Can make lumpia_____

   Name_____
4. Knows the date of Boys day_____

   Name_____
5. Knows when the year of the Monkey is. When_____

   Name_____
6. Knows a song buy Bob Marley. Which one_____

   Name_____
7. Can speak more than one language. Which one_____

   Name_____
8. Knows what the Hula dance is_____

   Name_____
9. Is someone you have never met before.

   Name_____

Session 1: Culture and Values

What is culture?

Ranking Values

Values are what we are taught to hold in importance.
They are the guides to the choices we make in life.

Below are **some** general values that run throughout the world's cultures.
Rank them from 1 to 14, with 1 being the most important and 14 the least important to **you**.
What would be other values that you might add?

Acceptance of Authority: _____
Obedient; respectful, deferent to authority figures, abiding by rules, polices voluntarily, will follow orders dutifully.

Adventure: _____
Actively seeking creative imaginative activities and endeavors.

Affluence: _____
Wealth and status. Being able to buy and have what you want, whenever you want.

Ambition: _____
Having goals and desires and actually working and taking action to work towards them.

Spirituality: _____
Believing in higher power, participating in organized religion, living ones spiritual beliefs day to day.

Equality: _____
Fairness, belief in equal opportunity, acceptance of others regardless of culture, color, or creed.

Honesty: _____
Truthfulness, representing self truthfully and sincerely. Not cheating or breaking laws, (laws of man and God/nature).

Independence: _____
Self reliant, free thinking. Living life without control of others, when given a choice.

Intellectualism: _____
Interest in knowledge, education, current affairs. Wisdom and intelligence.

Kindness: _____
Caring for others, loving, forgiving.

Loyalty: _____
Staying committed to person, family, tribe, ethnic identity, or organization.

Family: _____
Having and maintaining close family ties. Having a family identity. Relations.

Pleasure: _____
Enjoyment, doing what you want to do in choice situations.

Respect: _____
Admired, feared, or looked up to buy family, peers, or community.

Culture Colony

Pretend you and other people are part of a new forming culture. Your group will range in age from very young to elderly. Consider the physical environment, how would that affect your culture, the ways of survival, and the values people would hold?

1. How would people best live: separately, communally, by status...?

2. Will there be a ruler, queen, spiritual leader or leaders, face to face government, or a democracy?

3. Will there be organized religion, spiritual practices?

4. What ritual or celebrations would you have?

5. What would people do for survival?

6. How would people dress?

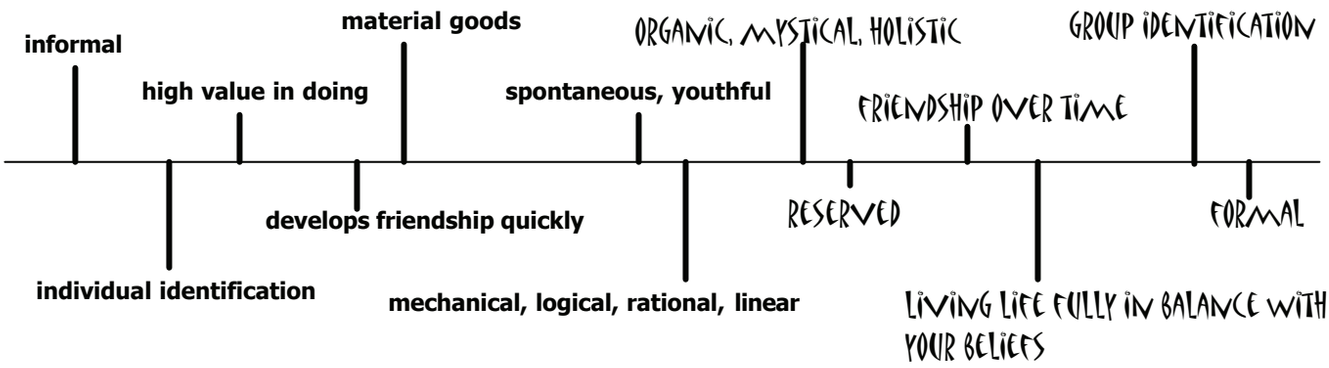
7. What would people do for entertainment?

8. What foods would you eat (five foods)?

9. How would your culture endure?

Generalized Cultural Differences

Culture- that complex whole that includes, knowledge, beliefs, morals, law, customs, opinions, religion, superstition, and art.
-Perserved Smith



Culture: a complex of typical behavior or standard social characteristic peculiar to a specific group, occupation, profession, age or social class.

Cultural change: modification of society through innovation, discovery, or through contact with other societies.
-Webster's

The Seasons of Youth Development

To Native peoples the seasons showed life's constant cycle of growth and change.
Spring is the time when the sprouting seed grows incredibly fast.
In the heat of the summer sun the plant matures.
Fall; the time for harvest, the physically mature plant bears its fruit.
Finally winter, and plant the rest, gaining strength for the next cycle of growth.

Journey of adulthood: Winter
Preparing to be an elder. Turning 18 is just a cultural marker of adulthood. We still continue to grow, change, mature, and hopefully continue to remain teachable.

Age 19-up

Rising of self: Spring seed growing
Even experiences in the womb
Affect fetal development

Age 0-3 years

The bonds of physical touch, feeding and responding to an infants cries, creates attachments and intellectual development.

Sometimes as children and youth we develop ways of survival that retard our growth and potential to live life fully. The lessons of youth are to learn, live, feel, grow, and heal.

Knowing yourself and living with purpose.

Learns to walk, play, bladder control
Learns language frame work, can express feelings, can soon consider needs and feelings of others.

Foundations of self

Powerful Youth preparing for adulthood: Fall
The sapling is strong but still flexible. A growing body developing adult characteristics and emotions. Identity part child, part adult.

Fullness of childhood: Summer
The young plant taken root nourished by family and environment. Physical motor skills and sense of independence well developed. Highly verbal, can joke, do projects, and label feelings.

Impressive cognitive development, capable of introspection, growth in ability to think abstractly and use imagination to problem solve. Consider a career.

Still needs and likes affection from adults, but also asserting identity through independence.

Identifies with significant others outside of home, develops personal morality code. Defining, sexuality, experimenting.

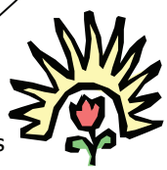
Defining self

Builds group identity, participates through play, work, achievement.

Growing self

Age 12-18 years

Age 4 -11 years



We are all under "Development"

Adapted from Calgary and Area Child Family Services Authority

Developmental Stages for Children and Youth

Contributed by Calgary and Area Child and Family Services Authority:
www.calgaryandareacfsa.gov.ab.ca/crv.nsf/serviceshome

Developmental Stages for Children/Youth

Age	Physical Development	Intellectual Development	Emotional Development	Social Development	Moral Development
0 - 6 months	· needs to be touched and held physically · caregiver feeds child · feeding pattern is established · has sucking and grasping reflexes · reaches toward objects and grasps them · makes large muscle movements (arms and legs) · is able to follow objects and focus · rolls over · supports head · sleeps a lot · no bladder or bowel control · rapid physical growth and change	· vocalizes (makes cooing sounds and chuckles) · vocalizes spontaneously · discovers s/he has impact on environment (e.g., if s/he cries, caregiver will come)	· establishes attachment/bonding with caregivers (caregiver and child get to know each other – learn to read each other's cues and become emotionally attached to one another) · crying and smiling · comforts self with thumb or pacifier · learns to trust that basic needs will be met · concerned with satisfaction of needs · distinguishes between physical self and physical other	· recognizes caregivers · very dependent upon caregivers for fulfillment of needs · initiates social contact (e.g., smiles when caregiver appears)	· sees him/herself as the centre of the world · has no sense of right or wrong

Developmental Stages for Children/Youth

Age	Physical Development	Intellectual Development	Emotional Development	Social Development	Moral Development
6 months to 1½ years	· feeds self with a spoon · stands and walks · "dances" to music · sits by him/herself · has precise thumb and finger grasp · can stack 2 or more blocks	· uses one or two words to name things or actions · says words like "Mama" and "Dada" · points to familiar things · points to at least one body part · curious about everything (explores his/her world) · realizes an object can exist when out of sight and will look for it (e.g., drops things from high chair and looks for it)	· hugs caregiver · does not like separation from caregiver · expresses several emotions clearly but is unable to identify them · trusts caregivers · sees him/herself as permanent with enduring qualities (e.g., male versus female)	· plays simple games (e.g., peek-a-boo, pat-a-cake) · extends attachment to people other than caregivers · developing some independence from caregivers (can meet some of his/her own needs e.g., can feed him/herself and reach for objects)	· sees him/herself as the centre of the world · has no sense of right or wrong

Developmental Stages for Children/Youth

Age	Physical Development	Intellectual Development	Emotional Development	Social Development	Moral Development
1½ years to 3 years	· walks up and down stairs (one step at a time) · rides a tricycle · throws and kicks a ball · can put on a simple garment · can hold a crayon with fingers · increased eye-hand coordination (e.g., simple puzzles) · can draw a complete circle · handles small toys skillfully · bladder and bowel control	· child has knowledge of the following: - - - - · can draw a partial person (e.g., head and body) · talks in sentences · speech is understandable half of the time · uses pronouns for self and other (e.g., I, you)	· can express feelings verbally · shows sympathy · refers to self as "I" or "me" · can be separate from caregivers · recognizes people outside of immediate environment · role of caregivers is crucial to the development of self (e.g., will imitate adults' behaviour)	· plays with children (e.g., plays cooperatively sometimes) · washes and dries own hands · toilet trained · tests boundaries and limitations (e.g., learns to say "no") · learns to consider needs and feelings of others · world expands beyond home to the "outside world"	· beginning to learn about right and wrong

Developmental Stages for Children/Youth

Age	Physical Development	Intellectual Development	Emotional Development	Social Development	Moral Development
3 years to 6 years	· hops on one foot repeatedly · skips and dances well · good balance and coordination · has refined motor skills (e.g., can draw a square with good corners) · prints a few letters	· child knows the following: - - - - · can draw a complete person · can complete a puzzle · talks in sentences · is completely understandable · defines familiar words · has developed certain likes and dislikes · understands cause and effect relationships only in relation to his/her own needs, wants or experiences (e.g., hot stove hurts me) · expresses ideas, asks questions, and engages in discussions	· can identify pictures of happy and sad people appropriately · identifies with caregivers and likes to imitate them · forms images of self · can be further away (physically) from caregivers · frequently overwhelmed by feelings (s/he can experience feelings of doubt and shame)	· dresses and undresses without help except for tying shoes · plays role in "make-believe" play · follows simple game rules · needs choices as s/he wants more independence · can share and take turns · often has "best friends" · likes to show off skills to adults · will test authority · can identify differences in self and others (e.g., gender, colour of eyes and hair)	· protects self and stands up for his/her rights · is concerned with what behaviour works to bring about reward or punishment · still needs outside controls as his/her conscience relatively unformed.

Developmental Stages for Children/Youth

Age	Physical Development	Intellectual Development	Emotional Development	Social Development	Moral Development
6 years to 12 years	· can play sports and develop new skills · energetic · has a large appetite · height and weight increasing at a steady rate · increased coordination and strength · body proportions becoming similar to an adult's · fine motor coordination well-developed (e.g., writing and drawing skills)	· highly verbal (e.g., tells jokes, makes puns) · asks fact-oriented questions (e.g., wants to know "how," "why" and "when") · can deal with abstract ideas · judges success based on ability to read, write and do arithmetic · wants to develop skills and become competent · enjoys projects that are task-oriented (e.g., sewing, woodwork) · learns to think systematically and generally about concrete objects · learns the concept of "past," "present" and "future"	· acts very independent and self-assured but can be childish and silly at times · self is partly defined by school environment (personality is more defined) · likes affection from adults · more independent but wants caregivers to be present to help · can identify and label what s/he is feeling · can distinguish between wishes, motives and actions	· participates in community activities · enjoys working and playing with others · has friends · plays mostly with same-sex peers · can be alone · strong group identity (e.g., Brownies) · learns to achieve and compete · imitates and identifies with same-sex adult	· begins to experience conflict between parents' values and those of peers · has strong sense of fairness · rules are important and must be followed (i.e., breaking rules is bad)

Developmental Stages for Children/Youth

Age	Physical Development	Intellectual Development	Emotional Development	Social Development	Moral Development
12 years to 18 years	· growth spurts · develops sexual characteristics and has sexual drives · new needs in personal hygiene (e.g., menstrual pads, razors)	· achieves impressive changes in cognitive development (i.e., able to think and reason) · able to reason, generate general principles and test them out against evidence · capable of introspection and of perceiving differences between how things are and how they may be · begins to consider and sometimes make career choices · growth in ability to think abstractly and utilize imagination in solving problems	· identifies with significant others outside of home · develops sexual identity · part child, part adult (e.g., "Go away, come closer" messages) · develops independence (e.g., "I dare you to tell me what to do!") · likely to show extreme mood swings · less dependent on family for affection and emotional support · strives to define self as separate individual · often feels misunderstood	· many engage in part-time work · enjoys many social activities (e.g., at school) · relies heavily on peers (e.g., tries to conform to peer group norms) · has close friendships and emotional involvements · experiences conflict with parents (e.g., expectations) · experiments with sex-role expectations and standards	· challenges values of home · develops personal morality code · what becomes important is whether the behaviour conforms to the behaviour of others, not its inherent rightness or wrongness · belief that good behaviour is maintained by some presence of authority

Milestones in Development and Learning

Contributed by the American Academy of Pediatrics: www.aap.org

Milestones in Development and Learning								
	Developmental Domains					Developmental Domains		
Age/Years	**Physical**	**Cognitive**	**Social**	**Emotional**	**Language**	**Piaget**	**Erikson**	**Kohlberg**
Infancy (0-2)	1. Can hear and see at birth 2. Rapid growth in height and weight 3. Rapid neurological 4. Motor development proceeds steadily (crawling, standing, walking)	1. Seek stimulation 2. An egocentric view of the world begins to decrease 3. Demonstrates considerable memory ability 4. Begins to process information	1. Need for interaction 2. Smiling appears 3. Reciprocal interactions begin immediately 4. Attachment develops	1. Beginnings of emotions discernible in first months 2. Infant passes through emotional milestones	1. Proceed from cooling and babbling to words and sentences 2. Word order and inflection appear 3. Vocabulary begins to increase rapidly	Sensorimotor 1. Use of reflexes 2. Primary circular reactions 3. Secondary circular reactions 4. Coordination of secondary schemata 5. Tertiary circular reactions 6. Representation	1. Development of trust	1. Begins to learn wrong from right
Preschool (2-6)	1. Extremely active 2. Mastery of gross motor behaviour 3. Refinement of fine motor behaviour	1. Perceptual discrimination becomes sharper 2. Attention more focused 3. Noticeable improvement in memory 4. Easily motivated	1. Attachment 2. Beginning of interpersonal relationships a. Parents b. Siblings c. Peers d. Teachers 3. Play highly significant	1. Still becomes angry at frustration 2. Prone to emotional outbursts 3. Emotional control slowly appearing 4. Aware of gender 5. Fantasies conform more to reality 6. May begin to suppress emotionally unpleasant memories	1. From first speech (cooing, babbling) to use of sentences with conjunctions and prepositions 2. Acquires basic framework of native language	Properational 1. Deferred imitation 2. Symbolic play 3. Mental imagery 4. Drawing 5. Language	1. Growing competence and autonomy 2. Initiative and purpose	1. Beginning of preconventional moral reasoning
Middle Childhood (7-11)	1. Mastery of motor skills 2. Considerable physical and motor skills	1. Attention becomes selective 2. Begins to devise memory strategies 3. Begins to evaluate behaviour 4. Problem-solving behaviour shows marked improvement	1. Organized activities more frequent 2. Member of same sex group 3. Peer influence 4. Usually have “best” friend	1. Pride in competence 2. Confident 3. Growing sensitivity 4. Volatile 5. Striving, competitive 6. Growing sexual awareness	1. Rapid growth of vocabulary 2. Uses and understands complex sentences 3. Can use sentence content to determine work meaning 4. Good sense of grammar 5. Can write fairly lengthy essays	Concrete Operational 1. Conservation 2. Seriation 3. Classification 4. Number 5. Reversibility	Industry and competence	1. Continued development of preconventional moral reasoning 2. Conventional moral reasoning

In the story, this eagle is raised by chickens, and thinks he is a chicken even in the end and he dies never knowing he was an eagle.
* Chicken Eagle story by Michael Winn

But one time, a youth realized the story had to be changed. It's a hard life sometimes and it's easy to let things get you down and get off track.

"True Heart Warriors are waking up and breaking up wit dem things that keep them off track, they are staying on a good life path, finding a way to survive, succeed and be happy in life – that's *Eagle Medicine.."*

So this story is going to end with the eagle finding out it's a mighty eagle and it flies to the heavens to its dreams. *(E + R =O)*.

Follow your dreams young people, know yourself, learn every thing you can and never let life's sufferings get you down for too long, keep the beat of the drum in your heart and soar like the eagles.

There is no perfect in this world
Their is no perfect life,
We are given only once this precious gift
And must learn to do it right,
Right is knowing what's good is good, but how so much can change in just one day,
Right is knowing the love you have for yourself and others will surely lead the way
Right is living with conviction and presence and healing from the past
For in the end it's only love which truly lasts.

I WISH YOU, ALL THE BEST
AND I HOPE OUR PATHS WILL CROSS
AGAIN SOMETIME IN THIS LIFE,
PEACE AND BLESSINGS TO YOU ALL
WITH RESPECT,
Maggie Escobedo-Steele

The Peace Warrior drawing represents much. To understand, you must first learn its secrets. The Eagle is at the top, near the heavens. Look closely, there are three hearts. The first heart is a human heart (in the tree) and represents your own heart - take care of it, know it, heal it. The next heart is in the roots of the tree, for when you nourish your heart you nourish the heart of your family and community (cradling hands), which in turn takes care of the big heart of Mother Earth. The woman embodies motherhood; without mothers we would not exist. The Bear is the protector of children. Never has a bear attacked a child, but instead is known to adopt the children it finds. The Flicker with its bright throat patch and orange shafted feathers has a call similar to an Hawk's. Its call can bring its children and its children's children to its side. Lastly, the eyes of the warrior are really the eyes of a mountain lion… M.E.S.

Indicated Prevention: Considerations for Confidentiality and Consent

Facilitators: Chuck Ries and
Kerrilyn Scott-Nakai

Indicated Prevention: Considerations for Confidentialityand Consent

A Facilitated Discussion

Chuck Ries and Kerrilyn Scott

1

Session Overview

- I. Indicated Prevention
  - Role of AOD screening, brief intervention, and/or referral
- II. Guidelines
  - Federal and state
- III. Considerations and Group Discussion
- IV. Summary and Next Steps

2

I. Indicated Prevention

3

Indicated Prevention

- Focuses on individuals who are exhibiting early signs or consequences of AOD use.
- Implies that information is collected at the individual level regarding use.

4

Types of Services

- By nature, requires additional confidentiality and consent considerations when,
  - Collecting information regarding individual use (e.g. AOD screening)
  - Having frank discussions regarding individual use (e.g. brief intervention/motivational interviewing)
  - Referring for further assessment/potential AOD treatment services
  - Referring for mental health and/or other health care services or assessment

5

Setting

- Different considerations may need to be taken into account based on service setting.
- For example, when
  - Indicated prevention services are provided within a clinical, treatment, or healthcare setting
  - Indicated prevention services are provided in a school setting

6

Provider

- Sometimes it's not the "how" but the "who"
  - Different considerations may need to be taken into account based on "who" is providing the services
  - For example
    - Licensed school counselors have their own set of confidentiality and reporting requirements
    - AOD treatment providers have their own requirements

7

Funding

- Sometimes it's not the "how" but the "how funded"
  - Certain federally funded services follow federal guidelines
  - Certain state funded services follow state guidelines
  - Under some circumstances federal guidelines trump state and vice versa.

8

It Gets Complicated

- Determining guideline applicability is complex, multi-layered, and ultimately contextual and locally defined.
- SDFSC grantees have been struggling with determining under what circumstances parents must receive notification of student participation and when a parent may have access to counseling records (particularly Project Success Grantees).
- Project Success developer guidelines require strict adherence to student confidentiality, which may be difficult to apply for California SDFSC grantees.

9

II. Confidentiality and Consent Guidelines

10

Guidelines to be Reviewed

- 42 CFR Part 2—federal, DHHS
- California Family Code (Section 6920-6929)
- Family Education Rights and Privacy Act (FERPA)
- California Education Code (Chapter 10. Educational Counseling, 49602. Confidentiality of Pupil Information)
- Cal Law-CHSC (123115(a)(2))
- California Parental Opt Out Statutes

11

Main Topics to be Explored

- Parental Notification
- Parental Consent
- Access to records

12

42 CFR Part 2
Federal

- 42 CFR Part 2 –Confidentiality of Alcohol and Drug Abuse Patient Records, Department of Health and Human Services.
- Intent: Insure that an alcohol or drug abuse patient is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment.

13

42 CFR Part 2
(continued)

- 42 CFR P2: Patient defined as "any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program...."
  - Concern that this definition of patient is not in keeping with definition of student.
- 42 CFR P2 defines program as "any individual or entity who holds itself out as providing, and provides , alcohol or drug abuse diagnosis, treatment or referral for treatment."
  - Under this code treatment and rehabilitation settings include, notably, school-based programs.

14

California Family Code
Section 6920-6929

- "A minor who is 12 years old or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem. The treatment plan of a minor authorized by this section shall include the involvement of the minor's parent or guardian, if appropriate, as determined by the professional person or treatment facility treating the minor."
- Must be stated in record if parent contacted and if not then why.

15

FERPA, Family Education Rights and Privacy Act

Covers information sharing between school and other entities, including parents.

- Under FERPA, parents are entitled to inspect and review their children's education records, which are defined as records that are directly related to a student and maintained by an educational agency or institution, or by a party acting for the agency or institution. Personally identifiable documents produced during the counseling sessions and maintained by the school district will be considered a student record and may be released to a parent/guardian upon their request.

16

California Education Code

Chapter 10. Educational Counseling
49602. Confidentiality of Pupil Information

- Any information of a personal nature disclosed by a pupil 12 years of age or older in the process of receiving counseling from a school counselor as specified in Section 49600 is confidential. Any information of a personal nature disclosed to a school counselor by a parent or guardian of a pupil who is 12 years of age or older and who is in the process of receiving counseling from a school counselor as specified in Section 49600 is confidential. The information shall not become part of the pupil record, as defined in subdivision (b) of Section 49061, without the written consent of the person who disclosed the confidential information.

17

California Education Code – Exceptions to Confidentiality

- The information shall not be revealed, released, discussed, or referred to, except as follows:
- (a) Discussion with psychotherapists as defined by Section 1010 of the Evidence Code, other health care providers, or the school nurse, for the sole purpose of referring the pupil for treatment.
- (b) Reporting of child abuse or neglect as required by Article 2.5 (commencing with Section 11165) of Chapter 2 of Title 1 of Part 4 of the Penal Code.
- (c) Reporting information to the principal or parents of the pupil when the school counselor has reasonable cause to believe that disclosure is necessary to avert a clear and present danger to the health, safety, or welfare of the pupil or the following other persons living in the school community: administrators, teachers, school staff, parents, pupils, and other school community members.
- (d) Reporting information to the principal, other persons inside the school, as necessary, the parents of the pupil, and other persons outside the school when the pupil indicates that a crime, involving the likelihood of personal injury or significant or substantial property losses, will be or has been committed.
- (e) Reporting information to one or more persons specified in a written waiver after this written waiver of confidence is read and signed by the pupil and preserved in the pupil's file.

18

California Education Code – Exceptions to Confidentiality *cont.*

- Notwithstanding the provisions of this section, a school counselor shall not disclose information deemed to be confidential pursuant to this section to the parents of the pupil when the school counselor has reasonable cause to believe that the disclosure would result in a clear and present danger to the health, safety, or welfare of the pupil.
- Notwithstanding the provisions of this section, a school counselor shall disclose information deemed to be confidential pursuant to this section to law enforcement agencies when ordered to do so by order of a court of law, to aid in the investigation of a crime, or when ordered to testify in any administrative or judicial proceeding.
- Nothing in this section shall be deemed to limit access to pupil records as provided in Section 49076.
- Nothing in this section shall be deemed to limit the counselor from conferring with other school staff, as appropriate, regarding modification of the pupil's academic program.
- It is the intent of the Legislature that counselors use the privilege of confidentiality under this section to assist the pupil whenever possible to communicate more effectively with parents, school staff, and others.
- No person required by this section to keep information discussed during counseling confidential shall incur any civil or criminal liability as a result of keeping that information confidential.
- As used in this section, "information of a personal nature" does not include routine objective information related to academic and career counseling.

19

California Education Code

- Parents have the right to review all records related to their child…
  - Cal Ed Code sec 49063

20

Cal Law – Records

- Cal law gives health care providers the right to refuse access to records ANYTIME the …provider determines that access …would have a detrimental effect on the providers relationship … or the minors physical safety or psychological well being. The decision…shall not attach any liability to the provider…unless the decision is found to be in bad faith.

Cal Law-CHSC 123115(a)(2)

21

California Parental Opt Out Statutes

What types of information do parents legally have the right to choose to excuse their child from

Question, "Do parents have the right to prevent their children form receiving education in public schools on subjects they disapprove?"

Answer, "Almost Never….Parents do not have veto power over the content…"

"…Parental rights are generally outweighed by the state's interests in educating students and avoiding disruption…"

Parents have the right to opt their children out of content that involves sexual education and HIV education.

22

III. Considerations and Group Discussion

23

Considerations and Discussion

- The basic premise behind many of the programs being implemented, such as Project Success, is that a young person is more likely to disclose sensitive information and receive services if the youth is provided confidential services.
- Confidentiality of services is put forth as a recommended practice by the Society for Adolescent Medicine

24

Considerations and Discussion

- Research also supports the inclusion of family whenever possible and safe for the youth.
- Ideally, parents/caregivers would be informed participants, engaged in services, and supporting the youth's involvement and desire for change.

25

Considerations and Discussion

- Balancing a youth's need (at times) for confidentiality with the benefits of family engagement is a delicate and contextual decision based on professional judgment and individual circumstances.
- Providing on-going support for direct service providers is critical.

26

Considerations and Discussion

- Multiple codes from Federal Government, State and CA Department of Education appear to have potential application depending on circumstances.
- The CA Department of Alcohol and Drug Programs is in the process of exploring the application of the federal codes, given the various settings and types of services delivered under the prevention realm.
- The relevance and applicability of California Education Codes are clearer in regards to confidentiality.
- Strict adherence to confidentiality by programs such as Project Success, (which was implemented in another state in a variety of school and non school-based settings) may not apply to all local SDFSC grantee settings.

27

IV. Summary and Next Steps

28

Summary and Next Steps

- What additional TA and training support is recommended?
- What additional support or guidance from the Department is recommended?

29

FAMILY.CODE
SECTION 6920-6929

6920. Subject to the limitations provided in this chapter, notwithstanding any other provision of law, a minor may consent to the matters provided in this chapter, and the consent of the minor's parent or guardian is not necessary.

6921. A consent given by a minor under this chapter is not subject to disaffirmance because of minority.

6922. (a) A minor may consent to the minor's medical care or dental care if all of the following conditions are satisfied:
(1) The minor is 15 years of age or older.
(2) The minor is living separate and apart from the minor's parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence.

(3) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income.
(b) The parents or guardian are not liable for medical care or dental care provided pursuant to this section.
(c) A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian.

6924. (a) As used in this section:
(1) "Mental health treatment or counseling services" means the provision of mental health treatment or counseling on an outpatient basis by any of the following:
(A) A governmental agency.
(B) A person or agency having a contract with a governmental agency to provide the services.
(C) An agency that receives funding from community united funds.
(D) A runaway house or crisis resolution center.
(E) A professional person, as defined in paragraph (2).
(2) "Professional person" means any of the following:
(A) A person designated as a mental health professional in Sections 622 to 626, inclusive, of Article 8 of Subchapter 3 of Chapter 1 of Title 9 of the California Code of Regulations.
(B) A marriage and family therapist as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.
(C) A licensed educational psychologist as defined in Article 5 (commencing with Section 4986) of Chapter 13 of Division 2 of the Business and Professions Code.
(D) A credentialed school psychologist as described in Section

49424 of the Education Code.
(E) A clinical psychologist as defined in Section 1316.5 of the Health and Safety Code.
(F) The chief administrator of an agency referred to in paragraph (1) or (3).
(G) A marriage and family therapist registered intern, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in subdivision (f) of Section 4980.40 of the Business and Professions Code.
(3) "Residential shelter services" means any of the following:
(A) The provision of residential and other support services to minors on a temporary or emergency basis in a facility that services only minors by a governmental agency, a person or agency having a contract with a governmental agency to provide these services, an agency that receives funding from community funds, or a licensed community care facility or crisis resolution center.
(B) The provision of other support services on a temporary or emergency basis by any professional person as defined in paragraph (2).
(b) A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if both of the following requirements are satisfied:
(1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services.
(2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse.
(c) A professional person offering residential shelter services, whether as an individual or as a representative of an entity specified in paragraph (3) of subdivision (a), shall make his or her best efforts to notify the parent or guardian of the provision of services.
(d) The mental health treatment or counseling of a minor authorized by this section shall include involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person who is treating or counseling the minor shall state in the client record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.
(e) The minor's parents or guardian are not liable for payment for mental health treatment or counseling services provided pursuant to this section unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian. The minor's parents or guardian are not liable for payment for any residential shelter services provided pursuant to this section unless the parent or guardian consented to the provision of those services.
(f) This section does not authorize a minor to receive convulsive therapy or psychosurgery as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic

drugs without the consent of the minor's parent or guardian.

6925. (a) A minor may consent to medical care related to the prevention or treatment of pregnancy.
(b) This section does not authorize a minor:
(1) To be sterilized without the consent of the minor's parent or guardian.
(2) To receive an abortion without the consent of a parent or guardian other than as provided in Section 123450 of the Health and Safety Code.

6926. (a) A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer, or is a related sexually transmitted disease, as may be determined by the State Director of Health Services.
(b) The minor's parents or guardian are not liable for payment for medical care provided pursuant to this section.

6927. A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape.

6928. (a) "Sexually assaulted" as used in this section includes, but is not limited to, conduct coming within Section 261, 286, or 288a of the Penal Code.
(b) A minor who is alleged to have been sexually assaulted may consent to medical care related to the diagnosis and treatment of the condition, and the collection of medical evidence with regard to the alleged sexual assault.
(c) The professional person providing medical treatment shall attempt to contact the minor's parent or guardian and shall note in the minor's treatment record the date and time the professional person attempted to contact the parent or guardian and whether the attempt was successful or unsuccessful. This subdivision does not apply if the professional person reasonably believes that the minor's parent or guardian committed the sexual assault on the minor.

6929. (a) As used in this section:
(1) "Counseling" means the provision of counseling services by a provider under a contract with the state or a county to provide alcohol or drug abuse counseling services pursuant to Part 2 (commencing with Section 5600) of Division 5 of the Welfare and Institutions Code or pursuant to Division 10.5 (commencing with

Section 11750) of the Health and Safety Code.
(2) "Drug or alcohol" includes, but is not limited to, any substance listed in any of the following:
(A) Section 380 or 381 of the Penal Code.
(B) Division 10 (commencing with Section 11000) of the Health and Safety Code.
(C) Subdivision (f) of Section 647 of the Penal Code.
(3) "LAAM" means levoalphacetylmethadol as specified in paragraph (10) of subdivision (c) of Section 11055 of the Health and Safety Code.
(4) "Professional person" means a physician and surgeon, registered nurse, psychologist, clinical social worker, marriage and family therapist, marriage and family therapist registered intern when appropriately employed and supervised pursuant to subdivision (f) of Section 4980.40 of the Business and Professions Code, psychological assistant when appropriately employed and supervised pursuant to Section 2913 of the Business and Professions Code, or associate clinical social worker when appropriately employed and supervised pursuant to Section 4996.18 of the Business and Professions Code.
(b) A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem.
(c) The treatment plan of a minor authorized by this section shall include the involvement of the minor's parent or guardian, if appropriate, as determined by the professional person or treatment facility treating the minor. The professional person providing medical care or counseling to a minor shall state in the minor's treatment record whether and when the professional person attempted to contact the minor's parent or guardian, and whether the attempt to contact the parent or guardian was successful or unsuccessful, or the reason why, in the opinion of the professional person, it would not be appropriate to contact the minor's parent or guardian.
(d) The minor's parent or guardian is not liable for payment for any care provided to a minor pursuant to this section, except that if the minor's parent or guardian participates in a counseling program pursuant to this section, the parent or guardian is liable for the cost of the services provided to the minor and the parent or guardian.
(e) This section does not authorize a minor to receive replacement narcotic abuse treatment, in a program licensed pursuant to Article 3 (commencing with Section 11875) of Chapter 1 of Part 3 of Division 10.5 of the Health and Safety Code, without the consent of the minor's parent or guardian.
(f) It is the intent of the Legislature that the state shall respect the right of a parent or legal guardian to seek medical care and counseling for a drug- or alcohol-related problem of a minor child when the child does not consent to the medical care and counseling, and nothing in this section shall be construed to restrict or eliminate this right.
(g) Notwithstanding any other provision of law, in cases where a parent or legal guardian has sought the medical care and counseling for a drug- or alcohol-related problem of a minor child, the physician shall disclose medical information concerning the care to the minor's parent or legal guardian upon his or her request, even if the minor child does not consent to disclosure, without liability for the disclosure.

Family Educational Rights and Privacy Act (FERPA)

Family Policy Compliance Office (FPCO) Home

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students."

Parents or eligible students have the right to inspect and review the student's education records maintained by the school. Schools are not required to provide copies of records unless, for reasons such as great distance, it is impossible for parents or eligible students to review the records. Schools may charge a fee for copies.

Parents or eligible students have the right to request that a school correct records which they believe to be inaccurate or misleading. If the school decides not to amend the record, the parent or eligible student then has the right to a formal hearing. After the hearing, if the school still decides not to amend the record, the parent or eligible student has the right to place a statement with the record setting forth his or her view about the contested information.

Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):

- School officials with legitimate educational interest;
- Other schools to which a student is transferring;
- Specified officials for audit or evaluation purposes;
- Appropriate parties in connection with financial aid to a student;
- Organizations conducting certain studies for or on behalf of the school;
- Accrediting organizations;
- To comply with a judicial order or lawfully issued subpoena;
- Appropriate officials in cases of health and safety emergencies; and
- State and local authorities, within a juvenile justice system, pursuant to specific State law.

Schools may disclose, without consent, "directory" information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance. However, schools must tell parents and eligible students about directory information and allow parents and eligible students a reasonable amount of time to request that the school not disclose directory information about them.

Schools must notify parents and eligible students annually of their rights under FERPA. The actual means of notification (special letter, inclusion in a PTA bulletin, student handbook, or newspaper article) is left to the discretion of each school.

For additional information or technical assistance, you may call (202) 260-3887 (voice). Individuals who use TDD may call the Federal Information Relay Service at 1-800-877-8339.

Or you may contact us at the following address:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202-5920

California Education Code
Chapter 10. Educational Counseling

49602. Confidentiality of Pupil Information

Any information of a personal nature disclosed by a pupil 12 years of age or older in the process of receiving counseling from a school counselor as specified in Section 49600 is confidential. Any information of a personal nature disclosed to a school counselor by a parent or guardian of a pupil who is 12 years of age or older and who is in the process of receiving counseling from a school counselor as specified in Section 49600 is confidential. The information shall not become part of the pupil record, as defined in subdivision (b) of Section 49061, without the written consent of the person who disclosed the confidential information. The information shall not be revealed, released, discussed, or referred to, except as follows:

(a) Discussion with psychotherapists as defined by Section 1010 of the Evidence Code, other health care providers, or the school nurse, for the sole purpose of referring the pupil for treatment.

(b) Reporting of child abuse or neglect as required by Article 2.5 (commencing with Section 11165) of Chapter 2 of Title 1 of Part 4 of the Penal Code.

(c) Reporting information to the principal or parents of the pupil when the school counselor has reasonable cause to believe that disclosure is necessary to avert a clear and present danger to the health, safety, or welfare of the pupil or the following other persons living in the school community: administrators, teachers, school staff, parents, pupils, and other school community members.

(d) Reporting information to the principal, other persons inside the school, as necessary, the parents of the pupil, and other persons outside the school when the pupil indicates that a crime, involving the likelihood of personal injury or significant or substantial property losses, will be or has been committed.

(e) Reporting information to one or more persons specified in a written waiver after this written waiver of confidence is read and signed by the pupil and preserved in the pupil's file.

Notwithstanding the provisions of this section, a school counselor shall not disclose information deemed to be confidential pursuant to this section to the parents of the pupil when the school counselor has reasonable cause to believe that the disclosure would result in a clear and present danger to the health, safety, or welfare of the pupil.

Notwithstanding the provisions of this section, a school counselor shall disclose information deemed to be confidential pursuant to this section to law enforcement agencies when ordered to do so by order of a court of law, to aid in the investigation of a crime, or when ordered to testify in any administrative or judicial proceeding.

Nothing in this section shall be deemed to limit access to pupil records as provided in Section 49076.

Nothing in this section shall be deemed to limit the counselor from conferring with other school staff, as appropriate, regarding modification of the pupil's academic program.

It is the intent of the Legislature that counselors use the privilege of confidentiality under this section to assist the pupil whenever possible to communicate more effectively with parents, school staff, and others.

No person required by this section to keep information discussed during counseling confidential shall incur any civil or criminal liability as a result of keeping that information confidential.

As used in this section, "information of a personal nature" does not include routine objective information related to academic and career counseling.

THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS REGULATION AND THE HIPAA PRIVACY RULE: IMPLICATIONS FOR ALCOHOL AND SUBSTANCE ABUSE PROGRAMS

JUNE 2004

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov


DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

TABLE OF CONTENTS

This is an educational document from the Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services. It was prepared by SAMHSA staff and contractors in consultation with the Office of the General Counsel, the Office for Civil Rights and other offices and agencies within the U.S. Department of Health and Human Services, Washington, D.C.

The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs

Introduction

In the early 1970's, Congress recognized that the stigma associated with substance abuse and fear of prosecution deterred people from entering treatment and enacted legislation that gave patients a right to confidentiality. For the almost three decades since the Federal confidentiality regulations (42 CFR Part 2 or Part 2) were issued, confidentiality has been a cornerstone practice for substance abuse treatment programs across the country.

In December, 2000, the Department of Health and Human Services (HHS) issued the "Standards for Privacy of Individually Identifiable Health Information" final rule (Privacy Rule), pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, Subparts A and E.[1] Substance abuse treatment programs that are subject to HIPAA must comply with the Privacy Rule.[2] [3] Substance abuse treatment programs that already are complying with Part 2 should not have a difficult time complying with the Privacy Rule, as it parallels the requirements of Part 2 in many areas. Programs subject to both sets of rules must comply with both, unless there is a conflict between them. Generally, this will mean that substance abuse treatment programs should continue to follow the Part 2 regulations. In some instances, programs will have to establish new policies and procedures or alter existing policies and practices. In the event a program identifies a conflict between the rules, it should notify the Substance Abuse and Mental Health Services Administration of HHS immediately for assistance in resolving the conflict.

This guidance is for substance abuse treatment programs that are subject to and already complying with the confidentiality requirements of Part 2.[4] It explains which programs must also comply with the Privacy Rule and outlines what compliance will require. The guidance is not a legal opinion. To comply with the Privacy Rule, programs should apply this guidance to their individual situations; programs may also want to call upon State agencies, provider organizations and legal counsel for assistance in establishing and implementing the practices and policy changes required by the Privacy Rule.

---

[1] In August 2002, HHS adopted modifications to the Privacy Rule.

[2] The compliance date for the Privacy Rule was April 14, 2003. However, small health plans, as defined by the Privacy Rule, are not required to be in compliance until April 14, 2004.

[3] This guidance applies to substance abuse treatment programs that are also covered entities as defined by the Privacy Rule. Programs should seek legal counsel for assistance in determining whether they are covered entities.

[4] The Part 2 regulations apply to substance abuse treatment "programs" as defined by 42 CFR §2.11 that are "federally assisted" as defined by 42 CFR §2.12(b).

I. Applicability

A. Programs to which the Privacy Rule applies

The Privacy Rule applies to "covered entities" which are health plans, health care clearinghouses and health care providers[5] who transmit health information in electronic form (*i.e.*, via computer-based technology) in connection with transactions for which HHS has adopted a HIPAA standard in 45 CFR Part 162. See 45 CFR §160.103. HIPAA transactions that a substance abuse treatment program[6] might engage in include:

- Submission of claims to health plans
- Coordination of benefits with health plans
- Inquiries to health plans regarding eligibility, coverage or benefits or status of health care claims
- Transmission of enrollment and other information related to payment to health plans
- Referral certification and authorization (*i.e.,* requests for review of health care to obtain an authorization for providing health care or requests to obtain authorization for referring an individual to another health care provider)

If a substance abuse treatment program transmits health information electronically in connection with one or more of these Part 162 transactions, then it must comply with the Privacy Rule. Part 162 may be amended in the future to cover additional transactions.[7]

B. Information that is protected under Part 2 and the Privacy Rule

Part 2 protects any and all information that could reasonably be used to identify an individual and requires that disclosures be limited to the information necessary to carry out the purpose of the disclosure. See 42 CFR §§2.11 and 2.13(a). Under the Privacy Rule, a program may not use or disclose "protected health information" (PHI) except as permitted or required by the Rule.[8] See 45 CFR §164.502(a). Neither rule applies to information that has been de-identified.[9] See 45 CFR §164.514(a) (de-identification of

---

[5] The Privacy Rule generally defines a health care provider to include a person or organization who furnishes, bills or is paid for health care in the normal course of business, which would include substance abuse treatment programs.

[6] A substance abuse treatment program is defined as an individual or entity that provides alcohol or drug abuse diagnosis, treatment or referral. For the purposes of this document, the term "program" includes both individual substance abuse providers and substance abuse provider organizations.

[7] Neither Part 2 nor the Privacy Rule protects employment records held by a program in its role as employer. Note that while 42 CFR Part 2 arguably applies to substance abuse patient records covered by the Family Educational Rights and Privacy Act (FERPA) (20 USC §1232g; 34 CFR Part 99), the Privacy Rule does not.

[8] PHI is defined as individually identifiable health information held or transmitted by a covered entity or its "business associate," with limited exceptions. See 45 CFR §160.103.

[9] The Privacy Rule includes numerous elements that make information identifiable, such as, but not limited to, information regarding employers, relatives and household members that are not necessarily

PHI) and 42 CFR §2.11 (definition of "patient identifying information"). The Privacy Rule permits programs to assign a code or other means of record identification to allow information that has been de-identified to be re-identified, as provided in 45 CFR §164.514(c).

The two regulations have some differences in the definition of what information is protected. For instance, the Privacy Rule treats medical record numbers as PHI, subject to all the same requirements as other PHI. Part 2 would permit a program to disclose a medical record number because the regulation does not apply to "a number assigned to a patient by a program, if that number does not consist of, or contain numbers . . . which could be used to identify a patient with reasonable accuracy and speed from sources external to the program." See 42 CFR §2.11. Programs subject to both rules must follow the Privacy Rule's protection of a medical record number.

C. When protections begin for someone seeking substance abuse treatment

Part 2 protects all information about any person who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program. See 42 CFR §2.11 (definition of a "patient"). Information is subject to the Privacy Rule if it is individually identifiable information created, received, or maintained by the covered entity. Former patients and deceased patients are protected under both Part 2 and the Privacy Rule. See 42 CFR §§2.11 and 2.15 and 45 CFR §§164.501 and 164.502(f). Programs should generally continue to follow Part 2, but note that if PHI is received prior to a patient applying to a program, under the Privacy Rule, such information is protected.

II. How the Privacy Rule affects disclosures of information

A. The General Rule

The "general rules" established by Part 2 and the Privacy Rule regarding uses and disclosures of patient health information are very different.[10]

Substance abuse treatment programs must comply with both rules. Generally, this will mean that they will continue to follow Part 2's general rule and not disclose information unless they can obtain consent or point to an exception to that rule that specifically permits the disclosure. Programs must then make sure that the disclosure is also permissible under the Privacy Rule.

B. When disclosures are permitted

---

identifiable information under Part 2. Such information should be protected consistent with the Privacy Rule requirements.

[10] Part 2 uses the term "disclosure" to cover what the Privacy Rule refers to as "uses" and "disclosures." See the definition of these terms in 45 CFR §160.103. Some Privacy Rule provisions differ for "uses" and "disclosures." For convenience, we generally use the Part 2 term "disclosure" throughout to encompass both uses and disclosures under the Privacy Rule. In some instances, however, specific uses or disclosures are discussed.

1. Part 2 Consent[11] and Privacy Rule Authorization

42 CFR Part 2	The Privacy Rule
Programs may not use or disclose any information about any patient unless the patient has consented in writing (on a form that meets the requirements established by the regulations) or unless another very limited exception specified in the regulations applies. Any disclosure must be limited to the information necessary to carry out the purpose of the disclosure.	The Privacy Rule permits uses and disclosures for "treatment, payment and health care operations" as well as certain other disclosures without the individual's prior written authorization. Disclosures not otherwise specifically permitted or required by the Privacy Rule must have an authorization that meets certain requirements. With certain exceptions, the Privacy Rule generally requires that uses and disclosures of PHI be the minimum necessary for the intended purpose of the use or disclosure.

Substance abuse treatment programs most often make disclosures after a patient has signed a consent form that meets the requirements of 42 CFR §2.31. Note that a disclosure under Part 2 includes the acknowledgment that someone has applied to or is enrolled in the program, and thus is only permitted if the patient has signed a consent form (or another of the regulations' narrow exceptions applies). See 42 CFR §§2.11 and 2.13. A Part 2 consent form must include the following elements:

- Name or general designation of the program or person permitted to make the disclosure;
- Name or title of the individual or name of the organization to which disclosure is to be made;
- Name of the patient;
- Purpose of the disclosure;
- How much and what kind of information is to be disclosed;
- Signature of patient (and, in some States, a parent or guardian);
- Date on which consent is signed;
- Statement that the consent is subject to revocation at any time except to the extent that the program has already acted on it; and
- Date, event, or condition upon which consent will expire if not previously revoked.

[11] This document uses the term "consent" when referring to any written permission provided by a patient for the use or disclosure of identifiable health information. The Privacy Rule uses the term "authorization" for certain permissions, and also permits, but does not require, programs to obtain "consent" for the use and disclosure of PHI for purposes of treatment, payment, or health care operations.

When programs operating under Part 2 disclose information pursuant to a consent form, they must include a written statement that the information cannot be redisclosed. See 42 CFR §2.32.

The core required elements for the Privacy Rule written authorization are similar to those of Part 2. However, to comply with the Privacy Rule authorization requirements, the Part 2 consent must also contain a statement reflecting the ability or inability of the substance abuse treatment program to condition treatment on whether the patient signs the form as described in 45 CFR §164.508(c)(2)(ii). In addition, the consent may be signed by a personal representative, and if so, must include a description of such representative's authority to act for the patient. See 45 CFR §164.508(c)(1)(vi). Finally, the consent must be written in plain language. See 45 CFR §164.508(c)(3).

The requirements above must be met with respect to the Part 2 consent form when the purpose of the disclosure is *not* for "treatment, payment or health care operations" or for any other permitted or required disclosure under the Privacy Rule. See 45 CFR §164.502(a).[12] The statements would have to be added when the consent form authorizes a program to make a disclosure for which an authorization is required under the Privacy Rule, e.g., those disclosures addressed by 45 CFR §164.508.

The Privacy Rule imposes three additional steps programs must take when disclosing information pursuant to a patient's written consent:

- Programs must ensure that the consent complies with the applicable requirements of 45 CFR §164.508.
- Programs must give patients a copy of the signed form (45 CFR §164.508(c)(4)).
- Programs must keep a copy of each signed form for six (6) years from its expiration date (45 CFR §164.508(b)(6)).

Therefore, substance abuse treatment programs should generally continue to use the consent form for disclosures subject to Part 2. If the Privacy Rule requires authorization for the disclosures, the substance abuse treatment program may use the Part 2 consent form with additional elements required by the Privacy Rule as listed above.

Minors

[12] See the Privacy Rule's definitions of "treatment," "payment," and "health care operations" at 45 CFR §164.501. When a substance abuse treatment program obtains information about a patient from a school, relatives, health care providers and health plans for treatment or payment activities, when it refers a patient to other providers and services and when it coordinates care with other health care providers, it almost always makes an implicit disclosure that the patient has applied for or has received alcohol or drug abuse treatment services and thus the program is required to treat these contacts as disclosures and obtain patient consent prior to such contact. In most of these instances, the disclosure from the program is for treatment purposes and the additional Privacy Rule statements would not have to be added to the consent forms. Note that programs may add the Privacy Rule statements in all circumstances, and programs may find it more convenient to use only one kind of consent form.

The Privacy Rule defers to requirements in other applicable laws regarding the use or disclosure of health information regarding minors and, thus, does not change the rules in Part 2 regarding minors and consent. See 45 CFR §164.502(g). A minor must always sign the consent form for a program to release information even to his or her parent or guardian (42 CFR §2.14).[13] Some States require programs to obtain parental permission before providing treatment to a minor. In these States only, programs must get the signatures of both the minor and a parent, guardian, or other person legally responsible for the minor (42 CFR §2.14(c)(2)).

Revocation of Consent

Part 2 permits a patient to revoke consent orally (see 42 CFR §2.31(a)(8)); the Privacy Rule requires written revocation of an authorization (45 CFR §164.508(b)(5)). Substance abuse treatment programs must continue to honor verbal revocations but may want to obtain written revocation when possible or at a minimum document the revocation in the patient's record. Both Part 2 and the Privacy Rule allow the program to make a disclosure for services already rendered in reliance on a signed consent or authorization form. See 42 CFR §2.31(a)(8) and 45 CFR §164.508(b)(5)(i).

2. Other permissible disclosures under Part 2

Substance abuse treatment programs are accustomed to complying with Part 2's general rule prohibiting disclosure, unless the patient has consented in writing or the disclosure falls within one of the regulations' limited exceptions (*e.g.*, child abuse reporting, medical emergencies). In some instances, the Privacy Rule does not require a change in these practices. In others, the Privacy Rule will require some modification of programs' practices.

a. When little or no changes may be needed

Programs should generally continue to follow the rules in Part 2 regarding:

i. Internal program communications

Both Part 2 and the Privacy Rule allow for communications within programs on a "need to know" basis. Part 2 requires that the communication of information within the program (or to an entity with direct administrative control over the program)[14] be

[13] The only exception to this rule is when the program director determines that a minor applying for services lacks capacity for rational choice and that the minor applicant's situation poses a substantial threat to life or physical well being of the minor or any other person that may be reduced by communicating relevant facts to the minor's parent or guardian. See 42 CFR §2.14(d).

[14] In applying the Privacy Rule, programs should consider whether the program and the entity with "direct administrative control" over the program are two separate legal entities. If they are two separate legal entities, PHI flowing between the program and the other entity will generally be governed by the Privacy Rule's requirements regarding "disclosure" rather than "use" of PHI. However, the Privacy Rule recognizes that health care providers may have different organizational arrangements and has established different rules to reflect such arrangements. See the Privacy Rule's provisions regarding hybrid entities

limited to those persons who have a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment or referral for treatment of alcohol or drug abuse. See 42 CFR §2.12(c)(3). Similarly, the Privacy Rule requires programs to identify the staff persons or classes of persons in its workforce who need access to PHI, the categories of PHI they need access to, and any conditions appropriate to such access. See 45 CFR §164.514(d)(2)(i). The program must then make reasonable efforts to limit access of such persons or classes of persons to PHI based on these determinations. See 45 CFR §164.514(d)(2)(ii). Substance abuse treatment programs subject to the Privacy Rule will have to establish written policies to comply with the minimum necessary requirement of the Privacy Rule, although in practice, the programs should be able to operate as they have under Part 2 in this regard.

ii. Crimes on program premises or against program personnel

Part 2 permits programs to disclose limited information to law enforcement officers. Such disclosures must be directly related to crimes and threats to commit crimes on program premises or against program personnel and must be limited to the circumstances of the incident and the patient's status, name, address and last known whereabouts. See 42 CFR §2.12(c)(5). The Privacy Rule permits programs to disclose to law enforcement officials PHI that the program believes in good faith constitutes evidence of a crime that occurred on the program's premises. See 45 CFR §164.512(f)(5). It also permits any member of the program's staff who is the victim of a crime to report certain information about the suspected perpetrator to law enforcement officials. See 45 CFR §164.502(j)(2). Programs should continue to follow the rules established by Part 2.

iii. Child abuse reporting

Part 2 permits programs to comply with State laws that require the reporting of child abuse and neglect. See 42 CFR §2.12(c)(6). The Privacy Rule also permits such reporting. See 45 CFR §164.512(b)(1)(ii). However, Part 2 limits programs to making only an initial report; it does not allow programs to respond to follow-up requests for information or to subpoenas, unless the patient has signed a consent form or a court has issued an order that complies with the rule (see "Subpoenas and court-ordered disclosures," below). Programs should continue to follow the rules established by Part 2.

iv. Medical emergencies

Part 2 allows patient-identifying information to be disclosed to medical personnel who have a need for the information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires

---

(45 CFR §164.105(a) and (c)), affiliated covered entities (45 CFR §164.105(b) and (c)), and organized health care arrangements (OHCAs) (45 CFR §160.103 (definition of "business associate" and "OHCA"), 45 CFR §164.506(c)(5), and 45 CFR §164.520(d)).

immediate medical intervention. See 42 CFR §2.51. A program can disclose information only to medical personnel and must limit the amount of information to that which is necessary to treat the emergency medical condition. Immediately following the disclosure, the program must document the following in the patient's records:

- The name and affiliation of the medical personnel to whom disclosure was made;
- The name of the individual making the disclosure;
- The date and time of the disclosure; and
- The nature of the emergency.

These practices are not affected by the Privacy Rule.

v. Subpoenas and court-ordered disclosures

Part 2 permits programs to release information in response to a subpoena if the patient signs a consent permitting release of the information requested in the subpoena. When the patient does not consent, Part 2 prohibits programs from releasing information in response to a subpoena, unless a court has issued an order that complies with the rule. See 42 CFR Part 2, Subpart E. Subpart E sets out the procedure the court must follow, the findings it must make, and the limits it must place on any disclosure it authorizes.

The Privacy Rule permits a program to disclose PHI pursuant to a subpoena without a prior written authorization, if it receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to ensure that the individual has been given notice of the request for PHI and the opportunity to object, or reasonable efforts have been made to secure a qualified protective order. See 45 CFR §164.512(e)(1)(ii). The Privacy Rule has different requirements regarding court orders, but programs can comply with both Part 2 and the Privacy Rule by continuing to follow the Part 2's court order requirements. Unless the disclosure requires authorization under the Privacy Rule, the Part 2 consent form can be used.

b. When some change is required

i. Disclosures that do not reveal patient-identifying information

Part 2 permits a substance abuse treatment program to disclose information about a patient if the disclosure does not identify the patient as an alcohol or drug abuser or as someone who has applied for or received substance abuse assessment or treatment services. See 42 CFR §§2.11 and 2.12(a). This allows a program that is part of a larger entity, such as a hospital, to disclose information about a patient so long as it does not explicitly or implicitly disclose the fact that the patient is an alcohol or drug abuser. For example, a program that is part of a hospital could disclose to a public health department that a named patient has TB by identifying itself only as part of the hospital and not as a substance abuse treatment program and by taking care not to mention that the patient is in substance abuse treatment.

Many programs that are part of larger entities are accustomed to using this exception in Part 2 to gather information about patients from, for example, other health care providers, schools, and employers, or to refer patients to other providers.[15] Some of these practices by programs that are part of larger entities will continue to be permissible under the Privacy Rule, which does not require patients to authorize disclosures for purposes of treatment, payment or health care operations. The Privacy Rule also permits programs to share information about an individual's treatment or payment related to the individual's health care with persons involved in the individual's care. See 45 CFR §164.510(b).

The Privacy Rule also allows for certain disclosures to be made without authorization that are not for treatment, payment or health care operations. See 45 CFR §164.512. For example, the Privacy Rule permits a program to disclose, without the patient's prior authorization, to a public health department that the patient has TB when the health department is authorized to collect such information. However, any program that is accustomed to making "non-patient identifying" disclosures of information that do not identify the subject as a substance abuser and that are not for treatment purposes should consult the Privacy Rule directly to determine whether those disclosures continue to be permissible.

Part 2 does not permit freestanding programs to make inquiries about patients or refer patients to other providers without written consent. The Privacy Rule does not change this prohibition.

ii. Disclosures to agencies that provide services to programs

Disclosures to Qualified Service Organizations

Both Part 2 and the Privacy Rule recognize that substance abuse treatment programs sometimes need to disclose information about patients to persons or agencies that provide services to the program, such as legal or accounting services. The Part 2 regulations call such service providers "qualified service organizations" and permit programs to sign "qualified service organization agreements" (QSOAs) allowing them to disclose patient-identifying information needed by the organization to provide services to the program. See 42 CFR §2.12(c)(4). In the agreements, the outside service providers acknowledge that in receiving, storing, processing or otherwise dealing with patients' records they are fully bound by Part 2 and promise to safeguard the information, including resisting in judicial proceedings any effort to obtain access to the information, except as permitted by the Part 2 regulations.

Under the Privacy Rule, such outside service providers are "business associates" of the substance abuse treatment program and the program must have a business associate agreement with the business associate in order to share PHI needed by the organization

[15] As noted above, when a program makes an inquiry about, or refers, a patient, it is often making an implicit disclosure that the patient is in substance abuse treatment.

to provide services (see 45 CFR §§160.103 and 164.502(e)).[16] The Privacy Rule has different requirements regarding the content of the business associate contract (the HHS Office for Civil Rights has published sample contract language). See 67 Federal Register 53264 (August 14, 2002).

Substance abuse treatment programs must meet the requirements of both Part 2 and the Privacy Rule if they are going to continue to share information with lawyers, accountants and others that provide services to the program.

Transition Provisions: The Privacy Rule permits programs to continue to use current contracts with service providers until April 14, 2004, if the contract existed prior to October 15, 2002, and the contract is not subsequently renewed or modified. Any contract that is renewed or modified after October 15, 2002, must comply with the business associate contract requirements. See 45 CFR §164.532(d).

Disclosures to accreditation bodies

Part 2 permits disclosures to accreditation bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under either the QSO provision or the "audit and evaluation" exception, discussed below. The Privacy Rule, however, considers accreditation bodies business associates conducting health care operations on behalf of the covered entity. See 45 CFR §§160.103; 164.501. Substance abuse treatment programs subject to the Privacy Rule who undergo accreditation will have to sign business associate contracts with accreditation organizations. Additionally, substance abuse treatment programs must comply with Part 2, either by ensuring that the business associate contract contains all the requirements of a QSOA or by fulfilling the mandates of the audit and evaluation provisions.

iii. Audit and evaluation

Both Part 2 and the Privacy Rule permit programs to disclose patient-identifying information to qualified persons who are conducting an audit or evaluation of the program, without patient consent, provided that certain safeguards are met. The Privacy Rule requires that uses and disclosures be limited to the minimum necessary to accomplish the audit or evaluation. Each rule has its own additional requirements. Substance abuse treatment programs subject to both Part 2 and the Privacy Rule must combine those requirements. Three options result:

- If the audit or evaluation is conducted by a program or its employees, it is permissible under both sets of regulations; no patient consent or authorization is required. See 42 CFR §2.12(c)(3) and 45 CFR §164.502(a)(1)(ii).

[16] A memorandum of understanding would generally be used between government entities rather than a business associate contract.

- If the audit or evaluation is conducted by a "health oversight agency,"[17] the program may disclose patient-identifying information so long as the health oversight agency makes the written commitments required by 42 CFR §2.53(d) and the disclosure meets the requirements in 45 CFR §164.512(d). If the health oversight agency copies or removes patient records from the program, it must agree in writing to abide by the requirements of 42 CFR §2.53(b).
- If an audit or evaluation is conducted by an outside entity on behalf of the program as opposed to a "health oversight agency," the program must have a signed a business associate contract with the auditor or evaluator that satisfies the requirements of both the Privacy Rule and Part 2 by incorporating either the necessary QSO agreement requirements (as discussed above in II.B.2.b.ii) or the appropriate provisions of 42 CFR §2.53.

iv. Research

The Part 2 regulations and the Privacy Rule have different requirements for disclosures of health information to researchers. See 42 CFR §2.52 and 45 CFR §164.512(i). This will be the subject of additional guidance.

III. Other Changes Required by the Privacy Rule[18]

A. Patient Notice/Notice of Privacy Practices

Part 2 requires that programs notify patients that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records and give them a written summary of the regulations' requirements. See 42 CFR §2.22. The Privacy Rule requires that patients be given a notice of the program's privacy practices as well as their rights under the Privacy Rule. See 45 CFR §164.520. Programs subject to both rules can combine their requirements into a single notice.

1. Notice content

Accordingly, the combined notice must contain all the elements required by 42 CFR §2.22, and in addition, contain the following:

---

[17] Under the Privacy Rule, a "health oversight agency" is an agency or authority or the United States, a State, a territory, a political subdivision of a State or a territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such a public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance or to enforce civil rights laws for which health information is relevant (45 CFR §164.501). Disclosures to health oversight agencies when an individual is the subject of the investigation are prohibited under certain circumstances by the Privacy Rule (45 CFR §164.512(d)(2)).

[18] This last section addresses issues on which Part 2 is largely silent. Thus, these can be seen as new requirements imposed by the Privacy Rule to which programs now must adhere.

- A statement, prominently displayed stating: "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY;"
- A description in sufficient detail of the types of uses and disclosures that the program may make without the patient's consent or authorization.[19] For substance abuse treatment programs, these would include uses and disclosures:
    - In connection with treatment, payment or health care operations (include at least one example of each);
    - To qualified service organizations or business associates who provide services to the program's treatment, payment or health care operations;
    - In medical emergencies;
    - Authorized by court order;
    - To auditors and evaluators;
    - To researchers if the information will be protected as required by Federal regulations;
    - To report suspected child abuse or neglect; and
    - To report a crime or a threat to commit a crime on program premises or against program personnel.
- A statement that other disclosures will be made only with the patient's written consent or authorization which can be revoked, unless the program has taken action in reliance on the consent or authorization. ;[20]
- A statement that the program may contact the patient to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the patient;[21]
- A statement that it is required by law to maintain the privacy of PHI and to notify patients of its legal duties and privacy practices, including any changes to its policies;
- A statement that the program must abide by the terms of the notice currently in effect; a statement that the program reserves the right to change the terms of its notice and to make the new notice provisions effective for all information it maintains;[22] and a statement describing how it will provide patients with a revised notice of its practices;

---

[19] The Privacy Rule also requires that the notice contain information about any more restrictive law. For example, if State law further limits disclosure of HIV-related information, that restriction should also appear in the notice.

[20] Programs often need to provide PHI to criminal justice agencies that mandate patients into treatment. Under Part 2, such disclosures may be made pursuant to a non-revocable consent that complies with 42 CFR §2.35. Under the Privacy Rule, such disclosures may be made pursuant to an authorization or pursuant to a court order. In order to comply with both rules, programs may find it helpful to ask the court in such a situation to issue an order that the program disclose necessary information to the court and other law enforcement personnel.

[21] A substance abuse treatment program engaging in these kinds of activities must be careful in contacting the patient that it does not make any patient-identifying disclosures to others. If the program does not intend to contact the patient, they do not need to include this statement.

[22] This is also voluntary. However, if this statement is not included, any changes in privacy practices described in the notice will apply only to PHI the program created or received after issuing a revised notice reflecting such changes. 45 CFR §164.520(b)(1)(v)(C).

- The name or title and telephone number of a person or office the patient can contact for further information;
- A statement of the patient's rights with respect to PHI and a brief description of how the patient may exercise those rights, including:
    - The right to request restrictions on certain uses and disclosures of PHI, including the statement that the program is not required to agree with requested restrictions;
    - The right to receive confidential communications of PHI (such as having mail and telephone calls be limited to home or office location);
    - The right to access and amend PHI;
    - The right to receive an accounting of the program's disclosures of PHI;
    - The right to complain—free from retaliation—to the program and to the Secretary of Health and Human Services (HHS) about violations of privacy rights, and information on how to file a complaint with the program; and
    - The right to obtain a paper copy of the notice upon request.
- The effective date of the notice.

See 45 CFR §164.520(b).

2. Distribution of the Notice

Part 2 requires that programs provide the notice at the time of admission or as soon thereafter as the patient is capable of rational communication. See 42 CFR §2.22(a). The Privacy Rule requires that the substance abuse treatment program must provide the notice to a patient on the date of the first service delivery, including service delivered electronically, after April 14, 2003.[23] The program must also have the notice available on site for patients to request to take with them and posted in a clear and prominent location where it is reasonable to expect patients to be able to read it. Whenever there is a material change to the notice, the notice must be promptly revised, made available upon request, and re-posted as previously referenced. See 45 CFR §§164.520(c)(2); 164.530(i)(4)(i)(C).

The program must make a good faith effort to obtain patients' written acknowledgment of receipt of the notice, except in an emergency treatment situation, on the date of the first service delivery. If written acknowledgment is not obtained, the program must document its efforts and the reason it was not able to obtain the acknowledgement. See 45 CFR §164.520(c)(2)(ii).

Any program that maintains a web site that provides information about its services or benefits must prominently post its notice on the site and make it available electronically through the site. When patients agree, the program can provide the notice by e-mail. See 45 CFR §164.520(c)(3).

[23] There is an exception in emergency situations. If treatment is provided on an emergency basis, the program must provide the notice as soon as practicable after the emergency is resolved. See 45 CFR §164.520(c)(2)(i)(B).

B. Patient rights

The Privacy Rule provides patients with new Federal privacy rights, including the right to request restrictions of uses and disclosures of PHI, and the right to access, amend, and receive an accounting of disclosures of PHI. See 45 CFR §§164.522, 164.524, 164.526,164.528.

1. Right to request a restriction of uses and disclosures

The Privacy Rule requires that programs allow patients to request that the program restrict uses or disclosures of PHI for the purpose of treatment, payment or health care operations and for involvement in the patient's care and notification under 45 CFR §164.510(b). The program is not required to agree to a requested restriction. If, however, a program agrees to a restriction, the program may not then violate the agreed-upon restriction, except for emergency treatment purposes, so long as the program requests that the emergency treatment provider not further use or disclose the PHI. A covered entity may terminate the agreement to a restriction, effective after the patient has been informed of the termination. See 45 CFR §164.522(a).

The Privacy Rule gives the individual the right to request that communication of PHI be done by alternative means or to alternative locations (confidential communications). See 45 CFR §164.522(b)(1)(i). This might include the right to request that mail and telephone calls be limited to home or office location. The Privacy Rule requires programs to accommodate reasonable requests.

2. Right to access PHI

Neither Part 2 nor the Privacy Rule requires programs to obtain written consent from individuals before permitting them to see their own records. Likewise, neither rule prohibits a program from giving a patient access to his or her own records, including the opportunity to inspect and copy any records that the program maintains about the patient. 42 CFR §2.23. However, the Privacy Rule permits programs to require that such requests be in writing. See 45 CFR §164.524(b)(1). The Privacy Rule provides patients with a right of access to inspect and obtain a copy of their PHI. See 45 CFR §164.524(a)(1).[24] Certain information, however, is exempt from this right of access:

[24] The Privacy Rule requires access to information in a designated record set for as long as the PHI is maintained in the designated record set. "Designated record set" is defined as "[a] group of records maintained by or for a covered entity that is: (i) The medical records and billing records about individuals maintained by or for a covered health care provider; (ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals." 45 CFR §164.501. The program must document the designated record sets that are subject to access and the titles of the persons or offices responsible for receiving and processing requests for access (45 CFR §164.524(e)). It must retain the documentation for six (6) years from the date it was last effective, whichever is later (45 CFR §164.530(j)). Under Part 2, the information need not be contained in a designated record set. Thus, programs could permit access to all disclosable patient records.

- Psychotherapy notes;[25]
- Information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding; and
- Information that may be subject to or exempt from certain Clinical Laboratory Improvement Amendment (CLIA) provisions.

See 45 CFR §164.524(a)(1).

The Privacy Rule requires that programs respond to a patient's request for access within 30 days after receipt of the request (within 60 days if the information is not maintained or accessible on-site). The program may extend the deadline once by not more than 30 days, if within 30 days of the receipt of the request (or 60 days of receipt if the information is not on-site), the patient is provided with a written statement containing the reasons for the delay and the date by which it will permit access. See 45 CFR §164.524(b). If the program does not maintain the requested information, but knows where the requested information is maintained, it must inform the patient where to direct his or her request. See 45 CFR §164.524(d)(3).

If a program grants the patient's request for access to his or her records, it can charge the patient a reasonable, cost-based fee, consistent with the restrictions on fees as provided in the Privacy Rule. See 45 CFR §164.524(c)(4).[26]

Denial of Access

The Privacy Rule allows a program to deny a patient access without providing an opportunity for review of the denial, on the following grounds:

- The information is specifically exempted from the right of access by the Privacy Rule. See 45 CFR §164.524(a)(1);
- The program is a correctional institution or a provider acting under the direction of the correctional institution and denies in whole or in part an inmate's request to obtain a copy of his or her records if doing so would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of an officer, employee or other person at the correctional institution or responsible for transporting the inmate. See §164.524(a)(2)(ii));
- The requested information was created or obtained by a program in the course of research that includes treatment. The individual's access to such information

[25] The Privacy Rule defines "psychotherapy notes" as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." 45 CFR §164.501.

[26] Information obtained by patient access to his or her own record is subject to Part 2's restriction on use of the information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient. See 42 CFR §2.23(b).

may be temporarily suspended for as long as the research is in progress, provided that the individual has agreed to the denial of access when consenting to participate in the research and the program has informed him or her that the right of access will be reinstated upon completion of the research. See 45 CFR §164.524(a)(2)(iii);
- The requested information is subject to the Privacy Act and would be denied under the access provisions of the Privacy Act, 5 USC §522a. See 45 CFR §164.524(a)(2)(iv); or
- The requested information was obtained under a promise of confidentiality from someone other than a health care provider and such access would be likely to reveal the source of the information. See 45 CFR §164.524(a)(2)(v).

The Privacy Rule permits a program to deny patient access, provided that the patient is given the right to have such a denial reviewed, on the following grounds:

- A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person;
- The information makes reference to another person (other than a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person; or
- The request for access is made by the patient's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the patient or another person.

See 45 CFR §164.524(a)(3).

If the program's denial is based on one of the last three reasons, the patient has the right to have that denial reviewed by a licensed health care professional who is designated by the program to act as a reviewing official and who did not participate in the original decision to deny access. See 45 CFR §164.524(a)(4).

If the program denies a patient access to all or parts of his or her PHI, it must give the patient a timely denial written in plain language containing:

- The basis for the denial;
- If applicable, a statement of the patient's review rights, including a description of how the patient may exercise those rights; and
- A description of how the patient may complain to the program or to the Secretary of HHS. The description must include information regarding how the patient may complain to the program pursuant to the program's complaint procedures or to the Secretary, and must include the name or title, and telephone number of the contact person or office designated by the program to receive complaints.

See 45 CFR §164.524(d)(2).

A program that denies a patient access in part must give the patient access to any other PHI requested after excluding the information to which the program had reason to deny access. See 45 CFR §164.524(d)(1).

3. The right to amend PHI

The Privacy Rule gives patients the right to have the program amend their PHI or a record about the patient in a designated record set. See 45 CFR §164.526. The program must act on a patient's request for amendment within 60 days after it receives the request. The program may extend the deadline once by not more than 30 days if, within the 60 days, the patient is provided with a written statement of the reasons for the delay and the date by which it will respond. See 45 CFR §164.526(b)(2).

A program that accepts a patient's request to amend PHI must:

- Timely inform the patient of its decision to accept the amendment;
- Make the appropriate amendment by identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment; and
- If the patient agrees, make reasonable efforts to notify and provide the amendment within a reasonable period of time to:
    - Persons identified by the patient as having received the patient's PHI and needing the amendment; and
    - Persons, including business associates, that the program knows to have received the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely on such information to the detriment of the patient.

See 45 CFR §164.526(c).

A program must obtain patient consent on forms that comply with 42 CFR §2.31 before it provides any copies of the amendment to other persons or organizations.

Denial of Amendment

A program may deny a patient's request for amendment if it determines that:

- It did not create the information, unless the patient provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
- The information or record is accurate and complete; or

- The information that is the subject of the request is not part of a designated record set or would not otherwise be available for inspection under the Privacy Rule's request for access provisions.

See 45 CFR §164.526(a)(2).

If a program denies a patient's request to amend records, it must give him or her a timely denial, written in plain language, and contain:

- The basis for the denial;
- Notice of the patient's right to file a written statement of disagreement with the denial and how the patient may file such a statement;
- Notice that, if the patient does not submit a statement of disagreement, the patient may request that the program include his or her request for amendment and its denial with any future disclosures of the PHI that is subject to the amendment; and
- A description of how the patient may complain about the program's actions to the program or to the Secretary of HHS. The description must include information regarding how the individual may complain to the program pursuant to its complaint procedures or to the Secretary, and must include the name or title, and telephone number of the contact person or office designated by the program to receive complaints.

See 45 CFR §164.526(d)(1).

The program may prepare a written rebuttal to the patient's statement of disagreement. If it prepares such a rebuttal, it must provide a copy to the patient who submitted the statement of disagreement. This information (e.g. the statement of disagreement and rebuttal), or in some cases, a summary, must all be included in any subsequent disclosures of the information to which the disagreement relates as provided in 45 CFR §164.526(d)(3), (4), and (5).

The program must document the titles of the persons or offices responsible for receiving and processing requests for amendment. It must retain the documentation for six (6) years from the date it was created or last effective, whichever is later. See 45 CFR §164.526(f).

4. Right to an accounting of disclosures of PHI

The Privacy Rule provides individuals with the right to obtain an accounting of certain disclosures of PHI made by a program during the six (6) years prior to the request. See 45 CFR §164.528(a).

A program does not have to provide an accounting for any disclosures that were made:

- For treatment, payment, and health care operations as provided in 45 CFR §164.506;
- To the patient as provided in 45 CFR §164.502;
- Incident to a use or disclosure that is otherwise permitted as provided in 45 CFR §164.502;
- Pursuant to the patient's written consent (an "authorization" meeting the Privacy Rule's requirements at 45 CFR §164.508);
- For the facility's directory or to persons involved in the patient's care or other notification purposes as set forth by the rule at 45 CFR §164.510;
- For national security or intelligence purposes as provided by the rule at 45 CFR §164.512(k)(2);
- To correctional institutions or law enforcement officials having custody of an inmate or individual and as specified under 45 CFR §164.512(k)(5);
- As part of a limited data set in accordance with the rule at 45 CFR §164.514(e); and
- Before April 14, 2003.

See 45 CFR §164.528(a)(1). In addition, a program must temporarily suspend a patient's right to receive an accounting of disclosures to a health oversight agency or law enforcement official if the program receives notification that it would be reasonably likely to impede the activities of the agency or official. See 45 CFR §164.528(a)(2).

The accounting must be in writing[27] and include:

- The date of each disclosure;
- The name and address (if known) of the entity or person who received the PHI;
- A brief description of the PHI disclosed; and
- A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of a written request for disclosure, if any.

See 45 CFR §164.528(b)(2).

For substance abuse treatment programs, the following disclosures are typically made without patient consent and must therefore be included in an accounting of disclosures:

- Disclosures to health oversight agencies;
- Disclosures to researchers that include patient-identifying information;[28]
- Disclosures to public health authorities;[29]

[27] There are special provisions under the Privacy Rule that are applicable to accounting for recurrent disclosures and certain research disclosures. See 45 CFR §§164.528(b)(3) and (b)(4).
[28] There are special provisions under the Privacy Rule that are applicable to accounting for research. See 45 CFR §164.528(b)(4)).
[29] When a program authorizes access to an entire universe of records, e.g., for public health surveillance activities, the Privacy Rule's accounting requirement can be met without the program having to make a

- Court-ordered disclosures;
- Reports of patient crimes on program premises or against program personnel; and
- Child abuse and neglect reports.

Programs should establish mechanisms to document all disclosures for which they must account.

The accounting must be made within 60 days of the program's receipt of the request. The program may extend the deadline once by not more than 30 days if, within the 60 days, the patient is provided with a written statement of the reasons for the delay and the date by which it will provide the accounting. A program must respond to a patient's request for one accounting within any 12-month period without charge. For any subsequent request within a 12-month period, it may charge a patient a reasonable, cost-based fee. If the program imposes a fee, it must inform the patient of the fee in advance and give the patient an opportunity to withdraw or modify the request. See 45 CFR §164.528(c).

The program must also document the following:

- The information it was required to provide the patient;
- The written accounting it provided the patient; and
- The titles of the persons or offices responsible for receiving and processing requests for an accounting.

This documentation must be retained for six (6) years from the date created or last effective, which ever is later. See 45 CFR §164.528(d).

C. Administrative Requirements

1. Complaints about the program's privacy practices

Part 2 allows violations of those regulations to be reported to the United States Attorney for the judicial district in which the violation occurs. See 42 CFR §2.5.

The Privacy Rule establishes a process for individuals to file a complaint with the Secretary of HHS if they believe a program violated the Privacy Rule. The complaint must be written, either on paper or electronically, and filed with HHS' Office for Civil Rights within 180 days of when the complainant knew, or should have known, that the act or omission complained of occurred, unless a waiver is granted. The complaint must name the program and describe the violation of the Privacy Rule. See 45 CFR §160.306. Programs must also establish a process for individuals to make complaints about the program's privacy policies and procedures or the program's compliance with

---

notation in each medical record that has been accessed by public health authorities. See Office for Civil Rights, Frequently Asked Questions, www.hhs.gov/ocr/hipaa.

such policies and procedures or with the requirements of the Privacy Rule. See 45 CFR §164.530(d).

2. Other administrative requirements

Programs subject to the Privacy Rule are required to meet administrative requirements including:

- Designate a privacy official who is responsible for the development and implementation of its policies and procedures and a contact person or office responsible for receiving complaints and able to provide further information. See 45 CFR §164.530(a).
- Train all members of the workforce on the program's policies and procedures. Each new member of the workforce must receive training within a reasonable period of time after s/he joins the workforce. Whenever a workforce member's functions are affected by a material change in privacy policies or procedures, that person must receive additional training within a reasonable period of time after the material change becomes effective. The program must document all training and retain the records for a period of six (6) years after the training. See 45 CFR §164.530(b).
- Have in place appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. See 45 CFR §164.530(c).
- Establish written policies and procedures that identify the staff persons or classes of persons who need access to patients' PHI, the categories of PHI they need access to, and any conditions appropriate to such access. The program must make reasonable efforts to limit access based on these determinations. See 45 CFR §164.514(d)(2).
- Establish policies and procedures to ensure that, for disclosures of information that occur on a routine and recurring basis, reasonable efforts are made to limit disclosures to the minimum necessary to accomplish the intended purpose of the disclosure. See 45 CFR §§164.502(b) and 164.514(d)(3)(i). For "all other disclosures," the program must develop criteria designed to limit the information it discloses to the information reasonably necessary to accomplish the purpose for which disclosure is sought and review requests for disclosure on an individual basis in accordance with those criteria. See 45 CFR §164.514(d)(3)(ii). Programs must also develop policies, procedures and criteria to ensure that requests to other entities subject to the Privacy Rule for PHI are limited to information "which is reasonably necessary to accomplish the purpose for which the request is made." See 45 CFR §164.514(d)(4). The written polices and procedures must be retained for six (6) years after the last time they were effective. See 45 CFR §164.530(j).
- Establish and apply appropriate sanctions against members of its workforce who fail to comply with its privacy policies and procedures. See 45 CFR §164.530(e).

- Mitigate, to the extent practicable, any harmful effect that is known to the program that results from a use or disclosure in violation of its policies and procedures. See 45 CFR §164.530(f).
- Refrain from taking intimidating, threatening, coercing, discriminating, or other retaliatory action against any individual who exercises rights under the Privacy Rule, including filing a complaint, assisting in an investigation, compliance review, proceeding or hearing pursuant to the Privacy Rule, as well as any individual who opposes any act or practice made unlawful by the Privacy Rule, provided that he or she has a good faith belief that the practice is unlawful and the manner of opposition is reasonable and does not invoke an impermissible disclosure of PHI. See 45 CFR §164.530(g).
- Not require patients to waive their rights to complain to the Secretary of HHS or their other rights under the Privacy Rule as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits. See 45 CFR §164.530(h).
- Implement policies and procedures regarding PHI that are designed to comply with the standards, implementation specifications, and other requirements of the Privacy Rule, and maintain the policies and procedures in written or electronic form for six years from the date the document was created, or last effective, whichever is later. See 45 CFR §164.530(i) and (j).

D. Security of information

Part 2 requires programs to maintain patient written records in a secure room, locked file cabinet, safe or other similar container. The regulations also require programs to adopt written procedures to regulate access to patients' records. See 42 CFR §2.16.

Section 164.530(c) of the Privacy Rule requires programs to maintain reasonable and appropriate administrative, technical and physical safeguards to protect the privacy of PHI. The issue of security has been addressed in more detail through a separate Security Rule issued by HHS on February 20, 2003 that established the physical and technical security standards required to guard the integrity, confidentiality and availability of confidential information that is electronically stored, maintained or transmitted. See 68 Federal Register 8334. Covered entities must be in compliance with the Security Rule by April 20, 2005, except small health plans which have until April 20, 2006.

Conclusion

Compliance with Part 2 has given the substance abuse treatment programs extensive experience with protecting patient confidentiality. Although substance abuse programs will need to make some changes to their business practices, they have a good starting point to work from in achieving compliance with the HIPAA Privacy Rule. Substance abuse treatment programs should contact their respective State substance abuse agencies and/or provider organizations, as well as legal counsel for assistance in implementing practices that will comply with both Part 2 and the Privacy Rule.

For more information about the HIPAA Standards

http://www.hipaa.samhsa.gov is the SAMHSA website which provides information and links for all HIPAA standards.

Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164)
More information can be obtained from the Office for Civil Rights HIPAA website
http://hhs.gov/ocr/hipaa

Standards for Electronic Transactions (45 CFR Parts 160 and 162)
The Standards for Electronic Transactions can be obtained from the Center for Medicare and Medicaid Services (CMS) website at
http://cms.gov/hipaa/hipaa2/default.asp

Standard Unique Employer Identifier (45 CFR Parts 160 and 162)
http://cms.gov/hipaa/hipaa2/default.asp

Security Standards (45 CFR Parts 160, 162 and 164)
http://cms.gov/hipaa/hipaa2/default.asp

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Question & Answer Guide On California's Parental Opt-Out Statutes:

Parents' and Schools' Legal Rights And Responsibilities Regarding Public School Curricula.

A Publication from the California Safe Schools Coalition

1 Why was this question and answer guide developed?

Public school administrators, board members, and teachers in California may face the difficult task of balancing their responsibilities to make decisions about the content of curricular and other school activities, against parents' desire to control the content of the their children's instruction, and/or "opt out" of controversial aspects of the curriculum.

California's education laws are complex, and both parents and school administrators are sometimes misled by false claims about "parental rights." Specifically, some advocacy groups have inaccurately claimed that California public schools may not implement diversity or tolerance curricula without parental permission.

This question and answer guide was developed by the California Safe Schools Coalition to provide accurate, reliable information on the rights, duties, and options of public schools, teachers, parents and students under California law.

2 Who determines the curriculum in public schools, under California law?

The California Constitution guarantees each student the right to a free public education. The state sets a basic outline for public school education through the Education Code and through administrative frameworks issued by the state Board of Education on various curricular areas such as health and science. However, schools are governed primarily at the local school district level. Parents have a constitutional right to choose a private education for their children. If they elect to send their children to public schools, parents have very limited rights to prevent their children from receiving the entire range of instruction available in public schools.

3 Under California law, what rights do parents have regarding public school curricula?

Under California Education Code § 51101, parents and guardians have the right to:

- Examine the curriculum materials of the class.
- Work with the schools to adopt policies that outline how parents, staff and students may share in the responsibility for development and well-being of the students.
- Observe classrooms and meet with teachers.
- Have a school environment for their child that is safe and supportive of learning.
- Be informed about the above rights to participate in the education of their children.

4 Are there any curriculum topics that public school parents have the right to receive prior notice about and/or opt their children out of?

There are some topics that parents have a right to notice about and/or the right to opt their children out of, but, outside of these specific topics, parents do not have any general right to notice and the opportunity to opt their children out of the curriculum.

Parents must receive written notice about and may opt their children out of the following topics or subjects of instruction in public schools:

- Health, family life education, and sex education. Parents have the right to prior notice, an opportunity to inspect and review instructional materials, and an opportunity to request that their children not attend, "any class in which human reproductive organs and their functions and processes are described, illustrated or discussed, whether the class is part of a course designated 'sex education' or 'family life education' or by some similar term." California Education Code §51550.[1]

  Other sections of the Education Code provide narrower, more specific parental notice and opt-out rights in the area of health and sex education. For example, California Education Code § 51240 provides that parents may opt their children out of health, family life education, and sex education that conflicts with religious training or beliefs). Section 51555 provides that parents of children in grades k-12 must receive written prior notice of any instruction on sexually transmitted diseases, AIDS, human sexuality, or family life. Section 51820 provides that parents must receive notice and may opt their children out of venereal disease education classes.

- AIDS education. Schools must provide parents with written notice explaining the purpose and content of AIDS prevention instruction, and parents may request that AIDS prevention instruction not be given to their child. California Education Code § 51201.5. (As an alternative to this "opt out" process, school boards may choose to implement an "opt in" process, where written parental consent is required for each student prior to providing AIDS prevention instruction.)

- Guest Instructors on the topics of STDs, AIDS, human sexuality or family life. Parents must receive written notice before instruction on these topics is provided by an outside organization or guest speakers, either in individual classrooms, combined classes, or assemblies. California. Education Code § 51554.

- Questionnaires, Surveys, or Examinations. Parents must be notified in writing and give written permission before a student may participate in tests, questionnaires, surveys, or examinations containing questions about the students' or their parents' beliefs or practices in the areas of sex, family life, morality, and religion. California Education Code § 51513.

[1] However, this right to notice and opt-out does not apply to descriptions and illustrations of reproductive organs that appear in textbooks on physiology, biology, zoology, general science, personal hygiene or health. California Education Code § 51550.

Other than the specific topics and areas of instruction listed above, parents do not have a right to prior written notice and opportunity to opt out of any part of public school curricula, under California law.

5 Do parents have a constitutional right to prevent their children from receiving education in public schools on subjects they disapprove?

Almost never. Parents have filed a number of court cases seeking to prevent public schools from teaching their children controversial literature or subjects such as evolution, tolerance, or human sexuality, and have lost virtually every case. Courts have held that so long as the public school curricula are secular and reasonably related to educational goals, parents do not have veto power over the content of public school instruction. Parents do have a general right to control their children's upbringing, but if parents choose to place their children in public schools, parental rights are generally outweighed by the state's interests in educating students and avoiding disruption in the school curriculum.

When parents raise a specific objection to a part of the curriculum as violating their freedom of religion, the school should evaluate the nature of the claimed burden on religion to see whether an accommodation is feasible. Schools may wish to excuse students from non-essential activities (such excusing a Jehovah's Witness student from a Valentine's Day party) but are not legally required to excuse students from curricular activities such as science or diversity education. The interests of the school and student in education outweigh parents' interests in preventing their children from being exposed to ideas that conflict with religious traditions.

6 May schools avoid controversy by deciding not to provide any instruction on human sexuality?

No. California law requires that public schools provide instruction on AIDS and AIDS prevention at least once in junior high or middle school and once in high school. This instruction must emphasize that sexual abstinence, monogamy, avoidance of multiple sexual partners, and abstinence from intravenous drug use are the most effective means for AIDS prevention, but also must teach students other means of reducing the risk of transmission, including medically accurate information about condoms and other contraceptives. California Education Code § 51201.5.

Aside from this required AIDS prevention education, public schools are not required to offer sexuality education. If schools choose to have sex education classes, they must satisfy criteria set out in California law, including a requirement that students learn accurate information on methods of contraception and their success and failure rates.

7 Do parents have the right to notice about and to opt their children out of diversity education programs that include discussions of sexual orientation or other controversial topics?

No. Diversity or tolerance education programs that focus on preventing verbal harassment, threats and violence against students are not "sex education" or "family life" programs within the meaning of the California Education Code. Parents do not have a right to receive notice about or to opt their children out of such programs. However, schools may choose to give parents information in advance to explain the purpose and content of these programs and enlist parental support and participation.

Diversity and tolerance education programs can help schools fulfill their obligation under California law to provide safe and supportive learning environments for all students, and to prohibit discrimination and harassment on the basis of sex, sexual orientation, gender, ethnic group identification, race, ancestry, national origin, religion, color, or mental or physical disability. California Constitution Art. 1, § 28(c); California Education Code § 51101; California Education Code § 200-220; Title 5, California Code of Regulations, § 4900(a). (Schools can seek assistance from the State Board of Education in developing these programs, because it is responsible for developing policies, curriculum guidelines, teacher and administrator training programs, grants, etc., to promote appreciation of diversity, discourage discriminatory attitudes, and prevent and respond to acts of hate violence in schools. California Education Code §§ 201(f), 233 & 233.8.)

Including discussions about how it is wrong to harass, threaten, or harm another person because of his or her sexual orientation or gender identity in diversity education programs is not only permissible, but important in ensuring schools' compliance with anti-discrimination laws. So long as these programs do not include sexually explicit content (i.e. discuss the human reproductive organs and their functions), parents are not entitled to prior notice and the opportunity to opt their children out. Also, these programs must not include content that reflects adversely on any person's religious beliefs, under California Education Code § 51500 and § 51501, so they should avoid instructing students that any specific religious view concerning homosexuality or gender is correct or incorrect.

Thus, by carefully articulating the purpose and content of diversity education programs, schools can both fulfill their legal duty to ensure a safe and nondiscriminatory school environment for all students, and also avoid violating parents' notice and opt-out rights.

Introduction to Motivational Interviewing and Brief Intervention Techniques

Facilitators: Jan Ryan and Chuck Ries

Motivational Interviewing and Brief Intervention:

Preserving Choice

Jan Ryan and Chuck Ries

Session Overview

- Introduction to the Conceptual Framework
- Motivational Interviewing
  - Overview
  - Core principles
- Brief Intervention
  - Overview
  - Core Components/Steps
- Trying it Out
  - Case Examples and Hands On Exercise

I wonder…

- "By virtue of ignorance, I fell into reflective listening as a way of understanding the stories of these people with alcoholism. And it dawned on me eventually that the way you treat people had a large effect on the way they behaved,"

  Miller

On a scale of 0 to 10, how important is it for you to change _____?

0 _____ 10

- Answer is: 5
- Why are you at a 5 and not 0?

The answer to that question is their reason for change.

Findings on which MI is Based:

- People who are ambivalent often **do not respond logically**, and do not respond to logic. Example: Increasing negative consequences
- Why? **Psychological Reactance**: When a person perceives that his or her personal freedom is being infringed upon or challenged, they will do a problem behavior ***more often***, and find the behavior ***more attractive.***

Psychological Reactance

Efforts to force someone to resolve their ambivalence can actually:

1. **strengthen** a person's resolve to ***not*** **adopt a positive behavior** that you wish to promote, or
2. **strengthen a person's resolve to maintain a negative behavior that you are trying to eliminate.**

This is particularly true when the person perceives that making a change would lead to some loss of freedom.

What is Motivational Interviewing?

- Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. [Motivational Interviewing, William R. Miller, Stephen Rollnick, 1991]
- A way to improve a person's motivation to change, and their ability to actually make a change, by talking with them about their mixed feelings, and helping them to work through those to make a change. **[Tom, MI for Dummies]**

Provider's Behaviors = spirit of MI

- Seeking to understand the person's frame of reference, particularly via reflective listening
- Expressing acceptance and affirmation
- Eliciting and selectively reinforcing the person's own self motivational statements expressions of problem recognition, concern, desire and intention to change, and ability to change
- Monitoring the person's degree of readiness to change, and ensuring that resistance is not generated by jumping ahead of the client.
- Affirming the person's freedom of choice and self-direction

Four Principles of MI

During MI, a Provider meets with someone to talk about behavior change, putting into practice the following principles.

1. **Express empathy:** Use skillful listening and accept ambivalence about change as normal.
2. **Develop discrepancy (between present status and desired goals and values):** Help the person to voice the discrepancy between their current status/behavior and where they want to be.
3. **Roll with resistance:** Avoid arguing with the person about their current behavior.
4. **Support Self-efficacy:** Show that you believe the person can change. Let the person choose and carry out the change.

OARS – basic building tools

- **O**pen-ended questions
- **A**ffirmations
- **R**eflective Listening
- **S**ummarizing

Motivation is an interpersonal process

- "I think that our *clients* feel more respected. They will say to me that I am not trying to get them to do something. It is all about really listening to the clients and then helping them to make the change that they want to make, not that I want to make. I don't put forward my agenda—it has to be their agenda. We meet the *clients* where they are at and move from there."
- "The students like it and they recommend it to their friends, and if they are mandated into it, at the end they say, 'You know, this was helpful, I liked it,"

Open-ended Questions

- Cannot be answered with brief replies or "yes" or "no" answers.
- Conversational

The more adversarial the situation, the bigger the advantage.

- "With court mandated clients, for example, we find that this is so much better than trying to make anyone do something. It is not a way of tricking people. It is a way of engaging their own interest and motivation in what they want in life and putting that side by side with their current situation and saying, 'What do you want to do?' 'I want to change… I am not sure I want to.'" It all starts there, and a creative listener can tip the balance. (Miller)

Reflective listening

- Listener checks out his perception of the speaker's intended meaning so that the listener accurately understands the speaker's point of view.
- It sounds like…
- You're feeling…
- Different levels: repeating, rephrasing, paraphrasing

Martino

Denial is a reflection of the person they are talking to. It takes two to deny.

- "Nobody stands on the beach alone and denies. If you approach someone by saying, 'You're an alcoholic, and you had better stop drinking,' the natural human response is to deny. If you come to them in a respectful manner that assumes they make choices about their lives and it is in their hands, that they're smart people who have reasons for what they are doing and also have within them the motivation for change, you get a very different response…" (Miller)

Affirmations

- Recognition of effort
- Appreciation of Strengths
- Use of Positive Reframes

It is possible to resolve ambivalence in just **one** interview.

- "It's astonishing. I would not have believed it, had I not seen it in my own data, that you could talk to someone who had a self-destructive behavior pattern going on for a decade or more and, in the course of **a conversation**, see the person turn a corner." (Miller)

Without some discrepancy, there is no ambivalence.

- There is an interdependency between discrepancy and ambivalence. Without some discrepancy, there is no ambivalence. For some people, the first step toward change is to become ambivalent. **Ambivalence may look like an obstacle, but actually, it is ambivalence that makes change possible.** Motivational interviewing is like dancing. Rather than struggle against each other, the partners move together smoothly. The fact that one of them is leading is subtle and is not necessarily apparent to the other. Good leading is gentle, responsive, and imaginative." (Miller)

The "Decisional Balance Sheet"

Continue Drinking as Before		Abstain from Alcohol	
Benefits	Costs	Benefits	Costs
Helps me relax	Could lose my family	Less family conflict	Enjoy getting drunk
Enjoy drinking With friends	Bad example for my children	More time with my children	What to do about friends
	Damaging my health	Feel better physically	How to deal w/stress
	Spending too much $	Helps w/money problem	
	Impairing my mental ability		
	Might lost my job		
	Wasting my time/life		

What if we could just think, not feel?

- Radiolab
- WYNZ
- Choice: the story of Elliot

Brief Intervention

A strategy or set of strategies designed to motivate or help a person get to the next step …

- 1-4 sessions

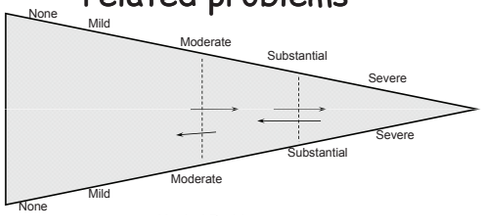
Brief Therapy

Involves a series of steps designed to help a person solve a problem

- 6-20 sessions
- focus is on present
- downplays psychodynamic factors
- focus is on changing behavior

M.Packard

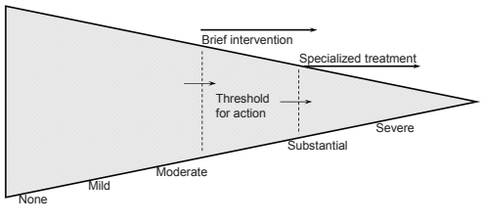
Consumption & alcohol related problems



Alcohol Problems

IOM, 1990

Spectrum of intervention response



Alcohol Problems

IOM, 1990

Populations likely to benefit from brief interventions:

1. Patients being seen in non-specialist settings:
   - ❑ primary care settings
   - ❑ private practice
   - ❑ ER's
   - ❑ criminal justice
   - ❑ EAP
   - ❑ schools

M.Packard

6 Active ingredients in brief interventions

F = feedback
R = responsibility
A = advice
M = menu of options
E = empathy
S = self-efficacy

M.Packard

5 Steps of Brief Intervention

1. Introduce issues in context of the person's health, life circumstances, consequences experienced, etc.
2. Screening, evaluating and referring to assessment.
3. Providing feedback
4. Talking about change and setting goals
5. Summarizing & getting an agreement for the next step.

M.Packhard

Types of Change Talk:

- Talk about:
  - Problem recognition
  - Disadvantages of keeping things the same
  - Advantages of changing
  - Optimism for change – HOPE
  - Intention to change

Get the person to talk about the disadvantages of keeping things the same

- ✓"What do you not like about the way you drink with your friends?
- ✓"What do you think will happen if you keep missing your classes?"

Problem Recognition and Concern

- In what ways has this been a problem for you?
- How much does this concern you?

Get the person to talk about the advantages of changing.

- ✓What would be good about having your child fully immunized?
- ✓If you could have your child fully immunized immediately, by magic, how might things be better for you?

Food for the Hungry

Get the person to talk about optimism for change – hope.

- ✓ What do you think would work for you if you decided to change?
- ✓ When else in your life have you made a decision to make a change like this and followed through with it? *["I decided to finish high school no matter how difficult it was."]*
- ✓ What is there about you that would make it easier for you to reduce your drug use? *["I'm very dedicated to do things that I decide to do."]*
- ✓ What makes you think that if you decided to quit using that you could do it? *["I would have the support of my father."]*

Get the person to talk about their intention to change

- ✓What would you be willing to try in terms of improving your choices about drinking?
- ✓Never mind how to make it happen right now, what do you *want* to happen in how you spend your weekend nights?

Provider's Choice = Person's Experience

Next Steps

- Two-part training series available through SDFSC TA Project
  - Brief Intervention
  - BRIMM
- Customized consultation and training available upon request

Sources for the Motivational Interviewing and Brief Intervention Presentation

Motivational Interviewing and Brief Intervention:

- ✓ **Motivational Interviewing, Second Edition: Preparing People for Change (Hardcover)** William R. Miller, Stephen Rollnick, Kelly Conforti
- ✓ **Motivational Interviewing With Substance Abusers — The Power of Ambivalance By Lynn K. Jones, DSW**
  Social Work Today **Vol. 7 No. 3 P. 34**
- ✓ Steve Martino Ph.D., New England Node and Christain Hopfer, M.D. **Introduction to Motivation Interviewing.** Blending Clinical Practice and Research, NIDA Clinical Trials Network
- ✓ **Using Motivational Interviewing in Health Promotion,** Tom Davis MPH, Director of Health Programs. Presentation to Food for the Hungry.
- ✓ Michelle Packard, Ph.D. Milton Erickson Foundation. **Brief Treatment of Substance Abuse Disorders: Why Neither Brief Nor Long is the Right Question,** December 7, 2006. (Blue BI slides)
- ✓ Websites:
  - ✓ www.motivationalinterview.org
  - ✓ www.mid-attc.org/accessed/mi.htm#1
- ✓ Motivational Interviewing in Health Care: Helping Patients Change Behavior (Applications of Motivational Interviewing): Helping Patients Change Behavior (Applications of Motivational Interviewing) by Stephen Rollnick, William R. Miller, and Christopher C. Butler (Paperback - 31 Jan 2008)

Appreciative Inquiry:

- G R Bushe, ◆Advances in Appreciative Inquiry as an Organization Development Intervention, *Organization Development Journal,* 13 [3] (1995), pp 14◆22.
- D L Cooperrider, ◆ Introduction to Appreciative Inquiry◆, in W French and C Bell (eds.), *Organization Development* (5th ed) Prentice Hall (1995).
- D L Cooperrider, ◆The ◆Child◆ As Agent of Inquiry◆, *Organization Development Practitioner,* 28 [1, 2] (1996), pp 5◆1 1.
- D L Cooperrider, ◆Resources for Getting Appreciative Inquiry Started: An Example OD Proposal◆, *Organization Development Practitioner,* 28 [1, 2] (1996), pp 23◆33.
- K Gergen, K, *The Saturated Self* Basic Books (1991).
- S Hammond, *The Thin Book of Appreciative Inquiry.* Plano, TX, Thin Book Publishing (1998).
- Hammond and Royal (eds) *Lessons From the Field: Applying Appreciative Inquiry* Plano, TX, Practical Press, Inc. (1998) and Distributed by Mellish & Associates in Australia.
- Mellish & Associates website http://www.mellish.com.au Appreciative Inquiry resources (1999).
- L Mellish, *Progressive reflections on Doctorate of Education research: An appreciative inquiry into organisational change and consultancy practice* ,Poster session presented at The Australian Association for Research in Education Conference December Brisbane (1997).
- L Mellish and B Limerick, *Reclaiming our imaginative competence* Paper presented at Australian Human Resources Institute National convention May Brisbane (1997).

Media:

Radio: RadioLab, WNYZ New York Public Radio, Choice Podcast
Music: 50 Ways to Leave Your Lover, Paul Simon
Film Clips: Mike Rhodes, Film Clips

Strategies for Implementation and Adaptation: Successes, Challenges, and Lessons Learned

- Project Success: Jan Ryan and Chuck Ries
- Strengthening Families: Rocco Cheng, Angela Da Re, and Judy Strother- Taylor
- Foster Youth: Dustianne North and Jerry Sherk

Project Success

Facilitators: Jan Ryan and Chuck Ries

Project SUCCESS Core Components

Professional Project SUCCESS Counselor

- Previous supervised counseling experience
- ATOD prevention training
- Knowledge of adolescent development
- Minimum education of a bachelors degree; masters preferred
- Program supervision by AOD prevention supervisor
- Day to day administrative supervision by principal
- One counselor implements all aspects of the program

Professional AOD Prevention Supervision

- Minimum education of a bachelors degree; masters preferred
- Meet with PSC two times monthly at the school for individual supervision
- Meet with PSC two times monthly for small group supervision
- Periodic contact between supervisor and building principal

Outreach and Mailings (first month of school)

- Letters go out to parents introducing the program/counselor on principal's stationary
- Classroom presentations
- Visits to outside agencies
- Meet with parents and community leaders (PTA, Substance Abuse Prevention Task Forces)
- Meet faculty
- Faculty presentation

Prevention Education Series

- Precedes Assessment
- Cover all four topics in order
- 6-8 sessions

Assessment for Services

- Minimum 40-45 minutes to assess individual, family, AOD issues, and need for treatment or other services

Individual Counseling and/or Referral

- Appointments on rotating schedule

Counseling Groups

- Newcomers
- COSAPs
- Must do at least one of the following the first full school year of the project: Parents, Peers and Partying; Abusers; COSAPs/Abusers
- Seniors
- One of each group by the second year of the project
- Cannot combine non-users and abusers
- Rotating schedule

Environmental Strategies

- Universal Prevention School wide activities

PROJECT SUCCESS PROGRAM IMPLEMENTATION CHART

Outreach and Mailings
Project SUCCESS Counselor becomes part of the school & community.

School Wide Awareness Activities

Prevention Education Series - Sept/Oct & Jan/Feb

Topics

- Being an Adolescent
- Alcohol, Tobacco and Other Drugs
- Family Pressures and Problems
- Skills for coping

Logistics

- 8-10 Adolescents
- 8 Class Periods
- Coordinated with Health Teacher to avoid Repetition

Assessment for Services

- Minimum 40-45 minutes:
  to assess for individual, family, AOD issues, and need for treatment
- Orientation to groups,
- May take up to three sessions

Routes to Entry: Individual Sessions
- PSC
- Self-referral
- Prev. Ed. Series
- Child Study Team
- Staff
- Peer
- Mandatory

Individual Sessions
- One-to-one (counseling COSAPs Substance Abusers)

Referral
for Substance Abuse or Mental Health Treatment or other services in the community

Counseling Groups

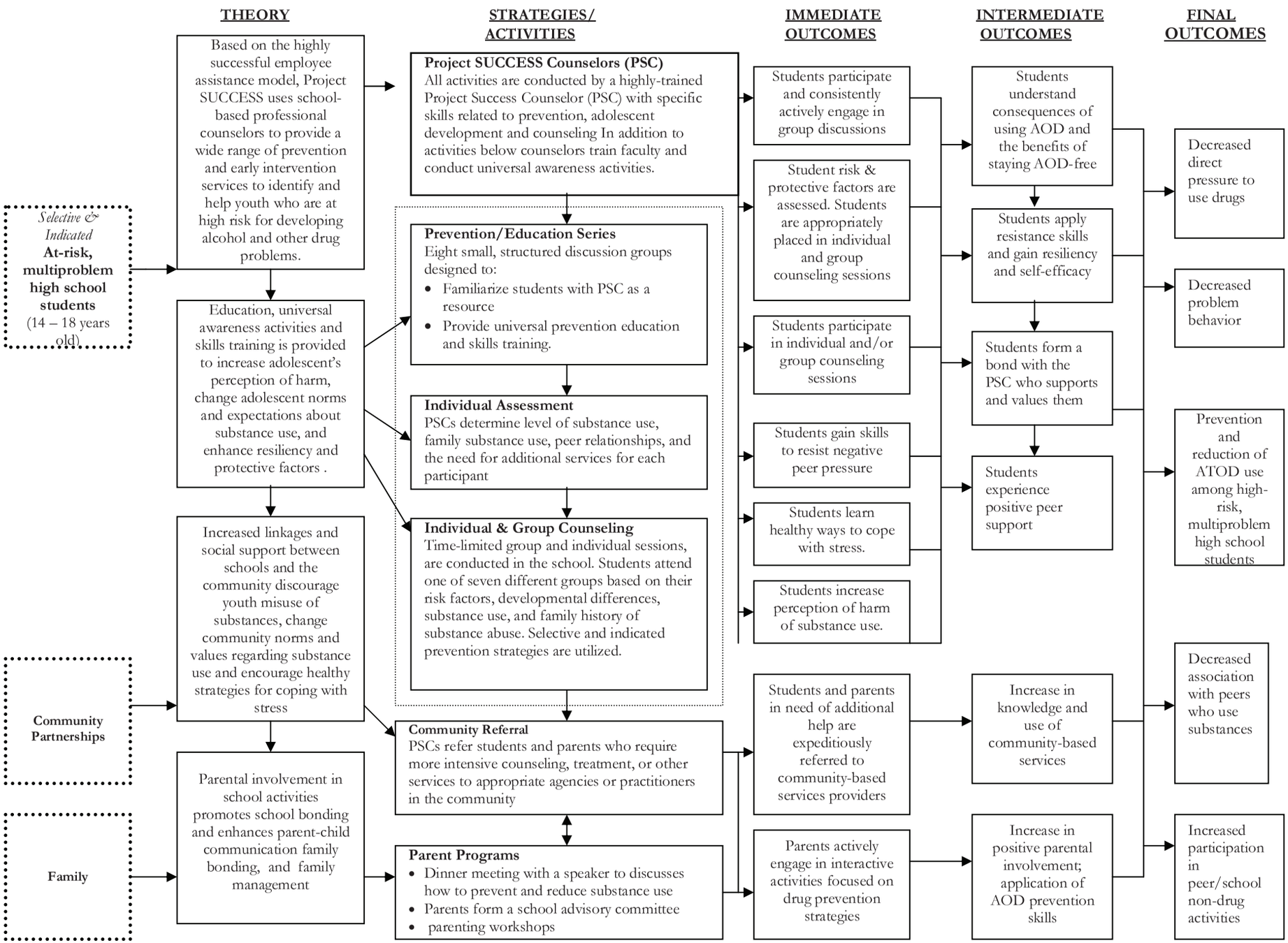
Prevention
- Newcomers
- COSAPs
- Seniors
- Non Users
- Assessment & Education
- Siblings

Intervention
- Assessment & Education
- Parents, Peers & Partying
- Substance Abusers
- COSAPs/Substance Abusers

Logistics
- 4-8 Adolescents
- During School
- Highly Interactive
- Professionally Led
- Closed Membership
- 6-12, 40 Minute Sessions
- Once a Week

Parent Programs

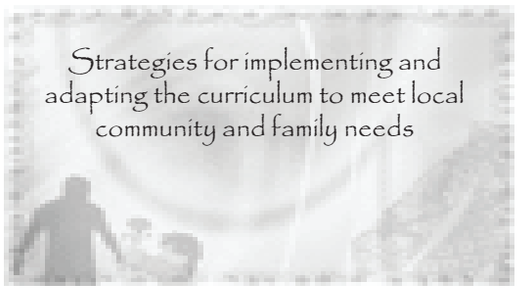
Project SUCCESS Logic Model–**Ellen Morehouse**



Strengthening Families

Facilitators: Rocco Cheng, Angela Da Re, and Judy Strother-Taylor

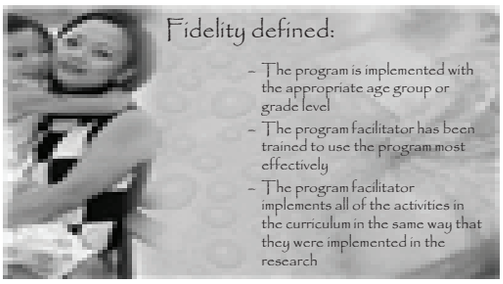
Strengthening Families Breakout Session



Overview

Core Components

Fidelity



Fidelity defined:

- The program is implemented with the appropriate age group or grade level
- The program facilitator has been trained to use the program most effectively
- The program facilitator implements all of the activities in the curriculum in the same way that they were implemented in the research

Common Implementation Challenges - Recruitment

- Remember the important purpose of the program
- Use positive terminology
- Establish the need for family programs by sharing information and data
- Involve the entire community - a media and informational blitz.
- Network with other agencies and groups - enlist their support
- Enlist teacher or school counselor encouragement.
- Provide colorful and attractive displays at school conference time - any other time parents are at the school, at church events, agency meetings.
- Include information about child care, food, transportation, and monetary incentives in all promotional material.
- Above All give PERSONAL INVITATION!

Other Common Implementation Challenges

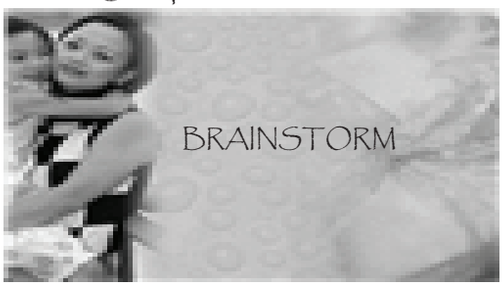
- Retention

What other Challenges do you see?

Effective Strategies for adaptation

- Court-referred youth
- Families in low-income housing projects
- Churches
- Native American groups
- Asian families (Hmong)
- Hispanic, including non-English speaking parents
- Families with older teens
- Families with mental health problems

Your Experiences, Challenges and group Recommendations



Agenda

Section 1 (10 mins.)

- Overview and introductions
- Icebreaker/transition
    - Circle of compliments (from curriculum)
      Start with a round of compliments. Each person gives a short compliment to the person sitting next to him or her. Compliments can be on anything from clothing, color of eyes, skills, etc. If a youth cannot come up with a compliment within about 15-20 seconds, a group leader should give the person a compliment
    - Knot game (from curriculum)
      Members of each group stand in a circle. They are to reach across the circle and hold hands with two other group members. (They are not to hold both hands of one person or either hand of the person next to them.) Then each group tries to untangle the knot by going under and through linked hands to unwind the knot.

Section 2 (30 mins)

- Core Program components (waiting for developer)
- Fidelity
    - Definition of Fidelity of implementation:
        - The program is implemented with the appropriate age group or grade level
        - The program facilitator has been trained to use the program most effectively

        - The program facilitator implements all of the activities in the curriculum in the same way that they were implemented in the research
    - The most effective way to monitor fidelity is to have trained observers use a checklist of activities for a given session. Feedback from these observations can be used to improve fidelity of implementation.
    - Only by implementing the program in the same way in which it was tested can we expect to achieve the same positive results

- Common Implementation Challenges
    - Recruitment
    - Retention
    - ?

- Effective Strategies for adaptation
    - In addition to the schools and prevention agencies who typically implement the SFP 10-14, a variety of other groups around the country have successfully used program:

        - Court-referred youth
        - Families in low-income housing projects
        - Churches
        - Native American groups
        - Asian families (Hmong)
        - Hispanic, including non-English speaking parents
        - Families with older teens
        - Families with mental health problems

        While these groups have not received the large grants needed to complete a scientific study of the program (i.e. random assignment, control group, follow-up evaluations), most have conducted pre- and post-tests, using the surveys included in the manual. Based on analyses of these surveys, parents and youth in these groups seem to have made significant gains in specific targeted behavior.

30 mins

- Brainstorm grantees experiences, challenges and recommendations
    - Grantees have a Q&A session and group brainstorm with group facilitators and each other covering their specific questions, concerns and challenges.

Strengthening Families Recruitment Ideas

Typical methods of recruitment include family-focused newsletters and local newspapers, flyers, and announcements through local media. It is recommended to recruit a small group from the target audience to serve as a local recruitment team. Personal invitations from familiar people are more likely to be effective. Additionally, human services providers may use the program for clients.

Remember the important purpose of the program:

- Build skills in parents and youth
- Reduce risk for serious problems
- Build stronger families
- Create stronger, safer communities

Use positive terminology:

- Help your kids have a bright future.
- Help our youth get ahead.
- Come spend some special time with your child.
- Learn ways to build on your strengths as a parent.
- Help your child be successful in the teen years.
- The sessions are fun and fast-moving.

Establish the need for family programs by sharing information and data.

Involve the entire community - a media and informational blitz.

Network with other agencies and groups - enlist their support:

- Churches
- Service organizations (Kiwanis, Lions, etc.)
- PTA/PTO
- Youth organizations (4-H, Boy and Girl Scouts)
- Extension Advisory Councils
- Teachers of 6th graders
- Human-service agencies

Enlist teacher or school counselor encouragement.

Provide colorful and attractive displays at school conference time - any other time parents are at the school, at church events, agency meetings.

Include information about child care, food, transportation, and monetary incentives in all promotional material.

The most important part of recruitment - a PERSONAL INVITATION!

- Invite 8-10 parents to an informational meeting. Show the promotional video and a few sample activities.
- Enlist their support as "program shepherds" to brainstorm recruitment ideas and invite other parents.
- School staff, extension staff, pastors, agency staff all give personal invitations.
- Keep track of who has been contacted.
- Team members identify families not likely to be reached by the above personal recruitment and visit, call, talk about the program in the grocery store and on the street.

Do's

Use positive language:

- "Help your youth have a bright future."
- "Help your kids get ahead."
- "Have fun together as a family."

Work together with other agencies. Gather a group of professionals - church, school, extension, human service agencies.

Provide childcare, food and transportation.

- Childcare is necessary so that families with younger children can attend.
- Transportation may make the difference for some families.
- Meals may be provided by local service clubs, churches, or food establishments.
- Snacks may be brought by families.

Don'ts

Do not depend on one agency or group for all the contacts with families.

Do not depend on fliers, announcements, posters, or radio spots. These may get their attention but will probably not get them to commit to coming. A personal invitation works best.

Do not depend on families to provide their own childcare.

Do not assume that if grant funds do not allow meals, there is no way to have any food.

Understand that it takes time to get the program going in a community. Recruitment is generally harder the first time the program is held. Some groups hold the program with smaller groups the first time or two and find that, as the word spreads, it becomes much easier to recruit.

Do not give up holding the program if you do not get a full group the first time.

Do not describe the program as for "at risk families."

Do not tell parents they need to strengthen their skills.

Foster Youth

Facilitators: Dustianne North and Jerry Sherk

Recruiting, Engaging, and Retaining Youth and Families

Facilitators: Rocco Cheng, Ph.D.

Recruiting, Engaging, and Retaining Youth and Families

Rocco Cheng, Ph.D.

Session Overview

- Brief Review of Context
- Overview of Research-Based Strategies
- Concrete Tips and Case Examples
- Learning Community Forum
  - Group sharing of successful strategies

Session Objectives

- Increase knowledge of effective strategies for recruiting, engaging, and retaining participants.
- Identify current successes and challenges to recruitment and retention.
- Enhance sensitivity towards individuals and families being served.
- Enhance cross-sharing of successful strategies .
- Identify next steps

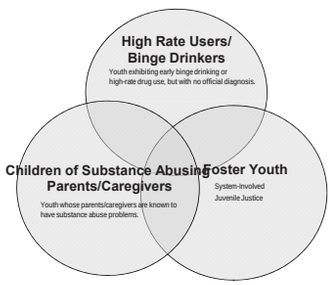
I. Brief Review of the Context

- Who is being served
- Under what conditions, and
- In what settings

Who is Being Served?

- High Rate/Binge Drinkers
  - 12 grantees (2-5 grantees "at-risk of")
- Children of Substance Abusing Parents
  - 4 grantees
- Foster Youth
  - 2 grantees

Priority Populations



Age Range

- Age ranges from elementary to high school
  - From 6 years of age to 18 years of age
  - At least 11 grantees are serving H.S. students
  - At least 9 grantees are serving M.S. students
  - At least 4 grantees are serving Elementary students
- A considerable portion of grantees (n=7) are serving a broad age range
  - Developmental adaptations of services will need to be considered

Target Participation Levels

- Ranges from 30 to 150 a year for more intensive services.
  - A considerable portion of grantees identified serving at least 100 youth and/or families in the first year.
  - These are ambitious numbers for the first year of a project.
- Broader services are proposed to larger target groups including school and district-wide services.
- Target retention and program completion rates are less clearly noted in the original grant applications

What Services are Being Provided?

- Project Success
  - 8 grantees
- Family Strengthening
  - 4 grantees
- Aggression Replacement Therapy (ART)
- Basics
- CASASTART
- CMCA/CT
- Friday Night Live
- Project Alert
- Reconnecting Youth
- Sembrando Salud
- Seven Challenges

In What Settings?

- School-Based
  - The majority of grantees are providing at least a portion of the services at school sites.
    - At least 8 grantees are providing services at alternative and continuation schools
- Community-Based
  - A considerable number of grantees are integrating community-based services.
- Home Visits
  - At least 2 grantees are conducting home visits

What This Means

- Populations overlap greatly; whichever group you choose to target
- These youth may face *multiple* risk factors; be familiar with *all* of their needs
- Youth will vary as to particular issues they face, and the continuum of services they receive
- These youth may be served via several *types* of infrastructure:
  - Child welfare and juvenile justice systems
  - Substance abuse programs for youth and parents
  - Runaway and homeless youth outreach services

Recruitment Considerations

- May be more difficult to identify, outreach, and recruit appropriate participants
- Important to identify program inclusion as well as exclusion criteria
- May be difficult to obtain parental consent and/or engage parents/caregivers
- Target recruitment goals are ambitious
- Program retention and attrition rates are important to monitor
- Importance of effective cross-system referral systems

Service Considerations

- Developmental adaptations may need to be considered
- Importance of inclusion and exclusion criteria
- Importance of service referral systems

II. Overview of Evidence-Based Strategies

Recruitment Frameworks

- **Proactive Strategies**
  - **Actively seeking out potential participants**
    - **Presentations**
    - **Personal Contacts**
- **Reactive Strategies**
  - **Passive program information dissemination**
    - **Radio announcements, flyers, newsletters**
    - **Call-in lines**

Research Findings

- Reactive recruitment strategies added to multiple proactive strategies were more effective, more efficient, and less costly than proactive recruitment alone.
- Close monitoring combined with the use of multiple recruitment methods and flexible recruitment plans can lead to successful, efficient, and low-cost recruitment.

Research Findings

- In general, the literature supports proactive approaches over reactive approaches when used alone.
- However, a combination of approaches is generally recommended.
- Ultimately, effective recruitment requires a a variety of methods utilized on an on-going basis.

Social Marketing Approach

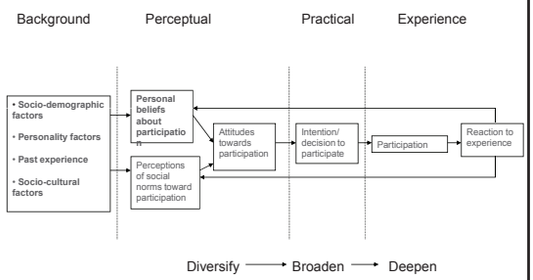
Three Major Ways to Build Participation

- Diversify Recruitment Approaches
  - For those disinclined to participate
- Broaden Recruitment Approaches
  - For participants that are inclined to participate but don't have the information
- Deepen Recruitment Approaches
  - Utilization of current/previous participants for outreach

Building Participation

- What's the Message?
  - Diversifying Recruitment
    - Focus on What's in it for Me?
      - Perceptual
  - Broadening Recruitment
    - What does the program have to offer?
      - Practical
  - Deepening Recruitment
    - Now What?
      - Experience

Participation Model



McCarthy, Jinnet

Importance of Recruitment and Retention Studies

- Ease of recruitment is indicative of the feasibility of the program service design and the appeal of the intervention for potential participants.
- High retention can be indicative of the utility of the design and desirability of the services.
- Low participation can be evaluated to identify the degree of fit for the target community.

Importance of Culture

- What is Culture?
  - *"The body of learned beliefs, traditions, principles and guides for behavior that are commonly shared among members of a particular group. Culture serves as a road map for both perceiving and interacting with the world".*

Core Steps Towards Cultural Competence

- Learning about important cultural components;
- Learning about own culture through examining cultural assumptions and values and your perspectives on them;
- Learning about the individual participants in your program;
- Learning as much as possible about important aspects of their cultural backgrounds with a focus on ATOD-related issues.
- Being aware of potential stigma and labeling

III. Concrete Tips and Strategies

First Impressions

- Who are we and what do we represent?
  - Youth's eco-system
  - New element in the system
  - Are services seen as a problem, solution, consequence?
  - Are services provided with sensitivity and respect for individuals and families?

First Impressions

- The first impression and perception of the program and it's staff may make or break the program
  - Culturally and linguistically appropriate materials
  - What is your creditability in the community? Or What is your level of endorsement?
  - How do you represent your program
    - Who is it for and who else is there?
    - Who is NOT there?
  - What is it in for me/my children?

First Impressions

- Before joining, it is important to create a sense of comfort for potential participants to be associated with the program
  - Am I just another number to you?
  - Focus on personal needs and provide individualized care
  - Help participants understand the importance of associating w/ the program
    - may get them what they need/want for themselves/children

Enhance Program Credibility

- Importance of program reputation & word of mouth
- Build healthy collaborative relationships
- Establish and nurture referral sources:
  - Schools, SARB, faith-based organizations, AOD treatment centers for parents (for COSAPS)
- Help participants understand the service relationship
  - Collaborative yet independent
  - Non-evaluative
  - Confidential

Address Negative Stigmas

- Normalize the struggle participants go through
  - Address stress, trauma, and losses
  - Address shame and saving face issues
- Reframe (their struggle/effort)
  - At-risk vs. At-promise
- Use peer testimony
  - Identify examples how others overcame similar situations
- Provide a sense of hope

Encourage Family Involvement

- Participants may bring their parents, children, and/or friends
- Use language that is understandable to parents and family members
- Identify key decision makers in the family
  - Engage him/her
  - Respect family hierarchy
- Obtain buy-in from family members so they can be your ally

Retention: The Top 10 List

- Food
- Transportation: convenient location
- Accessible and flexible times
- Provision of childcare (as appropriate)
- Engaging and hands-on activities
- Relevant information
- Practical assistance
- Program identity/promotional items
- Social recognition
- Solicit their input

Foster Program Identity

- Help participants develop a strong sense of identity to the program
  - The program name should have create a positive connotation
    - *IMPACT!,* Asian MASTERY, CAFEN-East
  - Make the space comfortable and culturally relevant
  - Other ways to promote program identity
    - Program banners
    - Logos
    - Uniform/t-shirts
    - Buttons

Accessibility of Services and Staff

- When and where can they find you in need
  - Bilingual business cards
  - Bilingual receptionist and greeting on voice mail
  - Extended "office hour?"
  - Other approaches: do they know how to use it?
    - Pager
    - E-mail

The Critical Role of Staff

- Elicit long-term commitment of staff and volunteers
  - Participants feel a sense of stability by seeing same reliable people in the program
  - Make sure there is a good match between staff and program
- Designate staff responsibility for recruitment and retention

Interview Dropouts

- Identify reasons participants leave the program
  - Can any program changes be made?
- Help modify the program and make it easier for future participants
- If all fails, still thank the interviewees for their contribution to the program/future participants
- Leave the door open

Be Mindful About Program Closure

- If the program is successful, closure can be painful and traumatic
  - Consistency
  - Source of support and encouragement
- Need to start thinking about program closure from the beginning
- Saying good good-bye

IV. Learning Community Forum: Case Examples and Cross-Sharing of Successful Strategies

Group Discussion

POPULATION 1

High Rate Users/Binge Drinkers

- Level of protectiveness of caregivers (if any) will vary and may be erratic
- Receptivity to services by family will vary and may be erratic; could be dealing with non parents, unrelated adults and those with exploitive relations to youth
- Requirements for confidentiality may be imposed by the youth in order to accept treatment; documentation such as personalized contracts can address safety and liability issues
- Chance of breakdown of services is high due to transience and high constant danger
- Less red tape
- High potential for court involvement
- May include homeless/runaway youth and those in hard to penetrate situations

POPULATION 2

Children of Substance Abusing Parents/Caregivers

- Exhibiting substance abuse behaviors
- Families may or may not be protective of youth
- Receptivity to services by family will vary
- Typically more lax requirements for documentation and confidentiality; safety and liability concerns urge caution regardless
- Chance of breakdown (family fails to provide transportation, etc.)
- Less red tape
- No court involvement at the time of referral but situation may change

POPULATION 3

Foster Youth

- May be served regardless of previous/current exposure to substance issues
- Often removed from home, but not necessarily; this can change
- System, caregivers, and biological families may be highly protective
- Receptivity of caregivers to services will vary, but mandated to provide for needs and services
- Detailed accountability and confidentiality requirements
- High chance of system breakdown, red tape
- Court involvement

In Summary

- Share common challenges
- Document successful strategies
- Identify future areas for technical assistance
- Discuss opportunities to share with peers

RECRUITMENT FRAMEWORKS

NOTES

Proactive Versus Reactive Strategies

- Proactive Recruitment refers to the efforts made by program staff to attract potential youth by making personal contacts to the youth and/or their families. This includes in-person discussions, presentations, or other forms of direct contact. For example:

    - *Involving Participants in Proactive Recruitment* A community-based organization in Chinatown, Los Angeles identifies key leaders among program participants. The leaders—parents of program youth—are well-networked in the community and personally introduce new, potential families to program facilitators. This positive word-of-mouth amongst current or alumni participants with potential participants can be a powerful recruitment tool.

- Reactive Recruitment refers to passive program dissemination, such as flyers, announcements, emails, newsletters and other forms of advertisement. Reactive recruitment relies on potential program members to respond to advertisements and initiate contact.

Social Marketing Approach

- The social marketing framework applies principles from marketing research to get "individuals or groups to change behavior in order to improve the quality of life for themselves, or the community as a whole" (Social Marketing National Excellence Collaborative, 2004), and is particularly useful in health promotion projects. This approach campaigns a set of social norms in order to outreach to youth and effect positive behavior.

  For more information on social marketing, see the Social Marketing National Excellence Collaborative's Turning Point series, "The Manager's Guide to Social Marketing: Using Marketing to Improve Health Outcome", 2004. Available online at www.turningpoint.org.

    - A current campaign that employs the Social Marketing approach is *The Truth*, a youth-geared anti-smoking project of the American Legacy Foundation. *The Truth* utilizes creative television ads and interactive websites to educate youth on how the big business of cigarettes profits from increased numbers of smokers. Visit them on the web at www.thetruth.com and www.whudafxup.com.

NOTES

RESEARCH FINDINGS

Successful Recruitment of Minorities into Clinical Trials: The Kick It at Swope Project

- Study Issue: Ethnic minorities are often underrepresented in clinical trials and recruitment is challenging. Developing and communicating effective and efficient recruitment strategies is a critical component.

- Methods: Kick It at Swope was a randomized trial that evaluated smoking cessation among 600 adult African Americans who smoked 10 or more cigarettes a day. A combination of proactive (in-person appeals by study staff and health care professionals) and reactive (disseminating information that asked participants to contact a hotline) recruitment strategies were employed over 16 months

- Results: Reactive recruitment strategies added to multiple proactive strategies were more effective, more efficient, and less costly than proactive recruitment alone. Note: More enrollees were recruited in the reactive phase (*n*=534) than in the proactive phase (*n*=66), and those enrolled in the reactive phrase reported significantly higher levels of education and income, better health, and significantly lower indicators of depression and life hassles, compared with those recruited in the proactive phase.

- Key Finding: Close monitoring combined with the use of multiple recruitment methods and flexible recruitment plans can lead to successful, efficient, and low-cost recruitment.

Kick It at Swope abstract information available at www.pubmed.gov.

*** In general, the literature supports proactive approaches over reactive approaches when used alone. However, a combination of approaches is generally recommended.**

RECRUITMENT UTILIZING THE SOCIAL MARKETING APPROACH

NOTES

Three Major Ways to Build Participation

- **Diversify Recruitment Approaches**
  - For those disinclined to participate
  - Focus on the question of, What's in it for Me?
    - Perceptual

- **Broaden Recruitment Approaches**
  - For participants that are inclined to participate but don't have the information
  - What does the program have to offer?
    - Practical

- **Deepen Recruitment Approaches**
  - Utilization of current/previous participants for outreach
  - Now What?
    - Experience

Alignment of Goals, Target Populations, and Relevant Factors

Goal	Diversify	Broaden	Deepen
Target Population	Disinclined	Inclined	Current Participants
Strategy	Perceptual	Practical	Experience

- Ease of recruitment is indicative of the feasibility of the program service design and the appeal of the intervention for potential participants.

- High retention can be indicative of the utility of the design and desirability of the services.

- Low participation can be evaluated to identify the degree of fit for the target community.

NOTES

IMPORTANCE OF CULTURAL COMPETENCE

What is Culture? *The body of learned beliefs, traditions, principles and guides for behavior that are commonly shared among members of a particular group. Culture serves as a road map for both perceiving and interacting with the world.*

To be culturally competent, then, not only means respecting the various cultures of the population served, but learning the important role that culture plays in structuring youth's and families' lives and perceptions. Cultural competence goes beyond the provision of "ethnic" food and surface recognition of cultural holidays, but into tailoring program services and implementation to really relate to and *work* for the youth and families being served.

Developing cultural competence is an on-going, work-in-progress that requires a commitment to recognizing and addressing power dynamics built upon racial, gender, class and other potential hierarchies.

Cultural Competence: Definition and Conceptual Framework

Cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (adapted from Cross et al., 1989)

Taken from the National Center for Cultural Competence, "Conceptual Frameworks / Models, Guiding Values and Principles", available online at http://www11.georgetown.edu/research/gucchd/nccc/.

A Four-Step Model to Cultural Competence

NOTES

1) **Learning about culture and important cultural components**

Learn the cultural norms of the youth's family and community. How can I respect those cultural norms when interacting with youth and families?

Meet the youth and their families on a level at which they are comfortable. This means being aware and responsive to culturally-specific communication styles, language barriers, gender dynamics and potential generational differences.

It is important to learn about your specific population's community, including specific regional characteristics. When working with Filipino American adolescent boys in Los Angeles, for example, learning about culture does not necessarily refer to beliefs and practices in the Philippines, but those within an American or Los Angeles context.

Don't be shy about asking for help when working with a culture or community with which you are unfamiliar, though this should be done in a respectful manner. Recognizing your own limitations allows more room for developing cultural competence.

2) **Learning about your own culture through a process of self-assessment that includes examining your culture's assumptions and values and your perspectives on them**

One of the foremost important aspects of cultural competence is the ability to recognize one's own assumptions about a particular group and to unlearn those stereotypes. How might your identity affect your interactions with your program youth and their families, and vice versa? What power dynamics might be present because your identity, as a professional or a different racial or gender identity, contrasts to those you serve?

Self-assessment must occur on both structural and interpersonal levels in order to ensure that youth and their families are appropriately and positively served. How might your relationship with your youth and their families reflect larger class, race, or gender relations? How can you ensure that these dynamics are appropriately addressed to creative a safe and enriching space?

3) **Learning about the individual participants in your program**

To really develop cultural competence means learning about your youth as individuals. Getting to know them and their families establishes a solid foundation.

In order to continue to build trust, think about other ways that you can be involved with the youth and their families outside of a prevention setting. Community involvement, in arenas such as sports or church, can provide another venue for you to establish positive relationships with your youth. This will help the youth and their families from seeing you as a representative of the establishment (government and institutions) with which they may be intimidated or have had bad experiences.

Reciprocity is also a key factor. While maintaining boundaries is a basic principle, opening up and letting them get to know you facilitates further development of trust and positive exchange.

NOTES

4) **Learning as much as possible about important aspects of their cultural backgrounds with a focus on ATOD-related issues**

What does the existing ATOD research say about the population you serve? What are proven methods and program strategies that address ATOD prevention while maintaining cultural integrity?

Additional Resources for Building Cultural Competence:

Advocates for Youth. "A Youth Leader's Guide to Building Cultural Competence", www.advocatesforyouth.org, 1994.

California Institute of Mental Health, Center for Multicultural Development, online at: http://www.cimh.org/projects/multicultural.cfm

Nieto, Sonia. *The Light in Their Eyes: Creating Multicultural Learning Communities*. New York: Teachers College Press, 1999.

Ladson-Billings, Gloria. *The Dreamkeepers: Successful Teachers of African-American Children.* San Francisco, CA: Jossey-Bass, 1997.

BEFORE PARTICIPANTS ENTER THE PROGRAM

NOTES

When marketing your prevention program to new families, community members, or other stakeholders the first impression and perception of the program and its staff is critical. This first impression for a family, and the degree to which they feel comfortable or uncomfortable, can literally make or break their decision to participate.

When your program team is beginning to enter the recruitment phase, careful consideration and planning should take place around the following questions or considerations:

- Where are the ideal recruitment locations or mediums to outreach to your target community? Who are the families and youth that are best suited for your services and what is the best way to communicate with them?

- What are the key messages that you want to communicate about your program? How do you want your program represented within a brief snapshot? What are the critical services and how can they be marketed effectively to your target families?
    - What are the services being offered? Who are they for? And how can participants expect to benefit from the services?

- Are your program materials culturally and linguistically appropriate for your target community? Do materials need to be translated? If materials are not translated, how will this impact your recruitment efforts and the manner in which families are informed about the program?

- How credible is your service agency or program within the target community? Does your agency/program have a history of successfully serving the community or is this a new community in which you are trying to gain credibility?

- How can the participants expect to benefit from the program? What is in it for them? What can they expect and not expect to receive from the program?

First Impressions Can Make a Difference: Friday Night Live Mentoring Case Example

- Initial connotation was almost always negative if protégés (middle school mentees) were informed about the program by the school counselor or principal. The middle school students reported that if they were initially called into the counselor or principal's office to discuss joining the mentoring program they thought they were "in trouble" and associated the program as being for kids "that were in trouble".
- Initial connotation was typically positive if the protégés were recruited by a favorite teacher or sent an invitational letter. When this recruitment method was utilized the middle school students felt they were chosen to participate in the program because they were "special" in some way. Their initial view of the program was positive and they thought they would have "fun" participating.
- For adults, participation is typically viewed as voluntary. However, maintaining a perception of "voluntary" participation is also critical for youth. It is important for youth to feel a sense of empowerment regarding their participation and this will facilitate their overall buy-in and personal investment in the program.

NOTES

In addition to the manner in which the program is presented to a youth or family it is also important to create a sense of comfort for participants. Participants will be more willing to invest their time and participate when they feel welcomed into the program environment, there is a general regard for their personal safety, and genuine concern for their well being amongst the program staff. Program teams can reflect on the following questions or concerns in order to ensure a safe and welcoming environment for families:

- Do participants feel as if they are just another number or do they feel valued?
- Do participants feel that their personal needs are being met? To what degree are services client focused versus predetermined and prescribed? If services are primarily predetermined, such as curriculum based services, can some level of flexibility and/or individualized accommodations be integrated?
- Do the participants feel a sense of affiliation with the service agency and/or program?
- Are the participants able to recognize the personal benefits for them and/or their family which are associated with participating in the program?
- Do the participants feel comfortable disclosing information? Are they aware of and comfortable with the confidentiality agreements?
- Do the participants feel that their behaviors are being judged? Or is there a sense of neutrality and objectivity?

A number of concrete tips and strategies for reaching out to youth and families are provided on the next few pages. These tips will assist prevention providers in ensuring that recruitment strategies are culturally appropriate and foster the engagement of youth and families in prevention services.

REACHING OUT TO FAMILIES

NOTES

Tip 1: Clearly communicate to parents in a language they understand that the program values their participation and input.

- This should be a clear and consistent message during all recruitment contacts.

Tip 2: Involve (and train) all program staff in creating an environment that makes parents feel welcome and respected.

Tip 3: Taking care of shame: "Saving Face"

- Normalize the struggle participants go through
  - Address and acknowledge acculturation stress and losses
  - Validate their feelings and acknowledge their experiences
- Identify examples of how others have gone through similar situations. The use of personal testimonies and guest speakers can be very powerful.
- Assist participants in regaining a sense of hope and personal empowerment to make changes in their lives
- Stress the importance of and assurance of confidentiality
- Reframe participants' struggles and their efforts to overcome those struggles

Overcoming Negative Social Stigma:
APCTC Mental Health Program Findings

Mental health service providers found that it was challenging to directly recruit or address mental health issues with the Asian populations they were targeting for services. In general, they found there was a negative social stigma in the Asian community regarding soliciting or receiving mental health services. Overtime, the staff honed their recruitment efforts and were effectively able to provide services to those in need. The following represent some of their recruitment strategies:

- Extreme sensitivity in language utilized for brochures and flyers
- Use of community (particularly faith-based) leaders
- Use of community specific press-releases, news and radio advertisements, and newsletters—with an emphasis on alumni reports and personal testimonies from previous participants representative of the community
- Indirect recruitment through other family members. It was found that self identification and referral was not effective; however, other family members were willing to identify the need for services.
- Paired dissemination of mental health brochures and recruitment with health booths at fairs. Community members were much more apt to approach a health booth to have their blood pressure taken and then could also receive information or ask questions regarding mental health services.

NOTES

Tip 4: Be strategic and thoughtful about where the services are being provided.

- Staff should be familiar with community and target population "anchor" sites. (i.e. local hang-outs, businesses or service providers frequently used by target population.)
- When recruiting in the field, staff should be able to identify well-known locale in relation to intervention site. (Across from Wal-Mart, in back of Casa Garcia Restaurant, corner of 3rd & Broadway)
- All flyers or invitations should include user-friendly maps or explicit directions.

"Social Marketing as a Framework for Recruitment: Illustrations from the REACH Study" found that the more accessible the location of intervention *and* recruitment, the more likely participants were to enroll long-term into the program. The intervention and recruitment sites included appropriate and neutral locations where the cultural group served felt comfortable.

Nichols, et. al., Journal of Aging and Health, 16(5), 2004.

Tip 5: Be aware of the program and service agency history in the community

- Agency/program history in the community and previous work with the target population is important. Know your agency's history. Know what the community thinks and be prepared with "talking points".
- Poor experience, inconsistency or negative publicity can ruin a program's reputation.
- Know who the gatekeepers are and establish working relationships with them, when possible incorporate them into your program, guest speakers, resources, field trips.

Tip 6: Personal contacts are extremely effective! (When the right tone and message are provided)

- Flyers are probably the easiest, but not necessarily the most effective way to engage parents
- Develop positive relationships and connections with parents.

Tip 7: If parents don't come to you, go to them.

- Identify community-based organizations, faith-based organizations, and/or other social service providers who have already developed positive relationships and trust with those in the target community.

Tip 8: Use a strengths-based, positive approach when working with parents.

Tip 9: Don't be afraid to share power and solicit input from parents.

Case Example: Chinatown, Los Angeles

A community-based organization that serves Chinatown, Los Angeles, is, in part, comprised of educators who teach in the Los Angeles Unified School District. These elementary school teachers have built strong relationships with the students and their families, so that the parental decision to allow their children to attend the organization's workshops is based on an existing, trusted relationship.

To maintain and recruit more families, the organization makes home visits to families in the Chinatown area. Being culturally responsive to the diverse community is a conscious effort; not only do Chinese families of various generations reside there, but Cambodian, African American, Vietnamese Chinese, and Latino families call Chinatown their home. Bringing a translator, an offering of food, or other respectful gestures show families that the organization is willing to "meet them on their level."

Tip 10: Have high expectations for participants!!!

- They can be a valuable resource for the program and the community.

Tip 11: One recruitment method is not enough

- Utilize multiple referral sources
- Utilize multiple mediums (i.e. flyers, personal contacts, newsletters, public advertisements)
- Utilize a combination of pro-active and reactive strategies

Tip 12: Utilize people who are enthusiastic, believe in the program, and can "sell" the program.

- In many cases these may be other participants

Tip 13: Use of appropriate language(s)

- Invest and allocate appropriate resources for translation of all recruitment materials and of hiring appropriate bi-lingual (in some cases tri-lingual staff).

Tip 14: Utilization of appropriate screening instruments

Tip 15: Provide some elements of familiarity by linking the contact to institutions or individuals known to the potential participants (Prinz et al).

- Any subsequent contacts should reference the initial contact to make it easier for the participant.
- The initial contact should be flexible, casual, and positive.

"Program administrators, teachers, and other program staff can effectively recruit participants by understanding the goals and objectives of the program and communicating with them in simple and direct ways so that participants understand what they will gain through their participation."

NOTES

NOTES

OTHER CULTURAL CONSIDERATIONS

Sometimes cultural differences can lead to discomfort in participation.

For example, it takes time for immigrant parents to understand their rights and responsibilities in a system that is new to them.

- May view program staff (particularly if associated with the school) as authority figures
- Invitations to the program (school) can be seen as a sign of respect

Some parents may be hesitant to participate due to their undocumented status or perception of anti-immigrant sentiments in the community.

In other cultures, parents may bring their younger children with them when they volunteer at school, when they come to parent meetings, and/or during other school events.

- The provision of child care should be considered from the beginning of the recruitment process

Food can be seen as an integral part of celebration/group activities and expected to be shared with everyone participating.

Gender roles can be more clearly defined.

- Traditionally with mothers having more involvement in issues concerning education/programs for children.

Extended family members may be integrated in the decision process for joining the program.

- Be open to other family members (e.g. Grandparents, Aunts) being a part of the recruitment process and be sensitive to their role in the family.

QUESTIONS TO CONSIDER

- What expressions, gestures and body language commonly accompany communication? Is eye contact considered polite or rude? Is usual tone of voice soft or loud? How close do people stand next to each other when speaking? Is touching acceptable?

- Do all members of the family have the same right to speak? Do some members have fewer rights? Are there gender differences? Do children speak freely or are they reserved?

- Is the family structure nuclear or extended? If extended, who is considered a member of the family? Do family members have to be living in the household?

- Who has authority in the home? Who has the ability to make final decisions? Is the mother able to make decisions unilaterally about the children participating or does the father or grandparents need to be involved in the decision to participate in the program?

- Are family members expected to be involved in other family members' decisions?

The Prevalence of "Children in Charge":
1.5 and 2nd Generation Youth Responsibilities

For some working-class immigrant families, children may bear many responsibilities that we expect to be taken on by parents. Parents who have limited English skills and/or work long hours often rely on their eldest children to make household decisions, care for younger siblings, and communicate with institutions, such as the school, companies, banks, and so on.

Making the entire family feel respected, then, requires that both parents and youth feel empowered. That may mean bringing in a translator to let parents make fully informed decisions about their family's participation and recognizing the added responsibilities that 1.5 generation (that is, youth that migrated to the U.S. in their childhood) and 2nd generation (children of immigrants) often face.

NOTES

NOTES

USING COMMUNITY CONNECTIONS: Case Examples

- La Frontera Center: This community-based agency was able to successfully service three populations within their community (Russian, Serbo-Croatian, and Central American) concurrently using culturally adapted and modified versions of the Family Strengthening curriculum. Overtime, the program was able to maintain high recruitment and retention rates with families for each of the ethnic specific cohorts. The program staff reported that it was critical to recruit local community members who were representative of each of the target groups as curriculum trainers and recruitment specialists.

- Arizona Mexico Border Health Foundation: This community-based agency has successfully implemented and honed a Promotora Model for the provision of family-based prevention services in the Arizona/Mexico border regions. The Promotora Model utilizes people within the community to do the recruiting and educating. These are the people who are going through the situation; they are living the problems, so they are the ones who can provide the solutions. The model required quite a bit of door-to-door outreach within the community and conveniently located services that were translated and culturally specific.

- Asian Pacific Counseling Center: This mental health and prevention service agency successfully utilized opinion leaders within the community to conduct active outreach to families.

"Social Marketing as a Framework for Recruitment: Illustrations from the REACH Study" identified referrals from partnering community organizations as a successful recruitment source. Organizations that are geared toward particular ethnic communities reduce the stigma attached to intervention services.
Nichols, et. al., Journal of Aging and Health, 16(5), 2004.

IN SUMMARY

- Building participation can involve different tactics for different populations. Be aware that there is no one answer and that the reality is a variety of recruitment tactics and mediums will be needed in order to be effective. Preplan and be willing to invest resources into a comprehensive recruitment plan.
- Invest time in order to understand target audience motivations and barriers for participation. Without these pieces of information you will not be able to develop an effective marketing and recruitment plan.
- Understand where target audience is in the decision-making process to participate
- The information process is a two-way street. Don't forget to ask participants what they want from a program and what would motivate them to participate or not to participate.
- Get to know your community. Having an in-depth understanding of the community strengths and risk-factors is very helpful in ensuring that program services are relevant and needed within the community.
- Explore collaborative relationships and the establishment of formal referral partnerships with other service or community-based agencies.

NOTES

CONCRETE TIPS FOR ENGAGING AND RETAINING PARTICIPANTS

NOTES

Program success is not only dependent on the recruitment of new, potential participants, but on the retention of existing participants. Maintaining a core group of youth and families requires periodic evaluation and self-assessment to ensure that a best effort is made to provide culturally appropriate and culturally sensitive services. Important to this process is continual education, the openness to learn more about participant needs, and adapting the program to match youth and family responses to existing services.

Below are concrete tips we compiled to help ground your retention efforts. These tips focus on actively engaging participants to be invested and empowered participants in your program.

Involve Parents and Family Members

- Participants may show up w/ their parents/children and/or friends. Be open to additional family members and ensure that they feel welcome. Non-western cultures tend to be more collectivistic and identify more as family units as compared to the emphasis on individuals in the dominant American society.

- Find out the key decision makers in the family and engage him/her
    - Respect the family hierarchy
    - Address to the parents directly even when translation is needed. Doing so will help parents feel empowered and that their needs and thoughts are being heard.

- Get the buy-ins from parents/family members so they can be your ally in working with youth. This facilitates consistency for youth between the program and the family household.

Help Participants Develop a Strong Sense of Program Identity

Doing so will help participants feel invested in your program. Youth gain a sense of rootedness in the program, and parents become concerned not only for their child's well-being, but the success of the overall program. Positive involvement in your program makes for positive morale among participants as well as service providers.

- Get a good name for the program. Developing a reliable reputation in the community is important at an agency-level as well as practictioner-level.

- Make the space comfortable and culturally relevant. This may include displaying posters with people of different ethnicities, genders, and cultures, implementing various, relevant cultural practices, and openly expressing that your program is a safe space for diversity to thrive in.

- Create program banners, logos, uniform/t-shirts, buttons to invigorate your program with an identity. Getting youth input and involvement in this process will reinforce the participants' sense of program identity.

NOTES

A Demonstration of Cultural Competence
Gertrude Wilson: A Teacher with 40 Years of Experience

"Winston worked hard to involve parents in her classroom. She created an 'artist or craftsperson-in-residence' program so that the **students could both learn from each other's parents and affirm cultural knowledge**. Winston developed a rapport with parents and invited them to come into the classroom for 1 or 2 hours at a time for a period of 2-4 days. The parents, in consultation with Winston, demonstrated skills upon which Winston later built.

For example, a parent who was known in the community for her delicious sweet potato pies did a 2-day residency in Winston's fifth grade classroom. On the first day, she taught a group of students how to make the pie crusts. They placed them in the refrigerator overnight and made the filling the following day. The finished pies were served to the entire class.

The students who participated in the 'seminar' were required to conduct additional research on various aspects of what they learned. Students from the pie baking seminar did reports on George Washington Carver and his sweet potato research, conducted taste tests, devised a marketing plan for selling pies, and researched the culinary arts to find out what kind of preparation they needed to become cooks and chefs. Everyone in Winston's class was required to write a detailed thank you note to the artist/craftsperson.

Other residencies were done by a carpenter, a former professional basketball player, a licensed practical nurse, and a church musician. All of Winston's guests were parents or relatives of her students. She did not 'import' role models with whom the students did not have firsthand experience. She was deliberate in **reinforcing that the parents were a knowledge and capable resource**."

Excerpt from Gloria Ladson-Billings, "But That's Just Good Teaching! The Case for Culturally Relevant Pedagogy" in Theory into Practice *34(3), 1995: 159-165.*

A Community-Based Example

Looking to parents as experts on their children and community, and involving them into components of the program has been a working model for Los Angeles-based organization. For a youth-led documentary project, parents were interviewed on their experiences as immigrants and marginalized people of color. Parents, youth, and their siblings were invited to watch the documentary films, celebrating over food and allowing families to network with one another.

Provide Rewards for Staying in the Project

- Free Food
  - Food as incentives can provides opportunity to gain trust of families, offer familiar foods, ask for input on what to serve, and where to purchase.
  - Food vouchers to local grocery stores, telephone calling cards, bus passes, movie passes, gift cards to locally-owned businesses and restaurants, or popular stores, such as Target, Barnes & Noble.
- Relevant information and fun activities. These should be easy to understand for families from different cultures. The cultural capital that develops for American-born youth and adults with resources is often missing for underserved, English language learners, or immigrant youth and families who are not familiar with mainstream games and activities. Assuming that youth and families have exposure to activities as simple as a card game can be intimidating. Make sure the implementation of fun activities and information is appropriately and enthusiastically executed.
- Rewards
  - Stickers and special treats
- Social Rewards
  - Affirmation
  - Support and encouragement
- Incentives are a great way to get baseline & follow-up data collected.
- Offer door prizes for participants who arrive on time, complete assignments, bring family/friends.

The Boys & Girls Clubs' Family Advocacy Network (FAN) Club was the focus of a 3-year Penn State drug-prevention program study. In order to provide leadership and support to participating parents, the FAN club offered four types of activities:

Basic Support Activities—helped families cope with daily life or with particular crises. For example, the FAN Club coordinator accompanied parents to social service agencies and offered support or assisted parents with their children's school.

Parent Support Activities—these mostly social activities were selected by the parents to combat social isolation. They included pot luck dinners, picnics, crafts, pool parties, coffees and other activities open to parents alone or parents and children.

Educational Program Activities—these parent-selected activities provided education, knowledge or enrichment experiences through speakers who discussed Black History, Puerto Rican culture, AIDS, gang prevention and health.

Leadership Activities—parents voluntarily planned and implemented these activities which included monthly meetings, fundraising, club-wide dinners, and the Boys & Girls Clubs' summer lunch program. Families also visited nursing homes and prevention program graduations.

Excerpt from a news release, "Involving Parents In Teen Anti-Drug Programs", Penn State University, 10-27-1997.

NOTES

NOTES

Tips for Working with Youth

- Be honest, consistent & follow through with everything stated.
- Provide participants with valuable role models. Include stakeholders, chamber of commerce members, local club & association members who can assist with job training, internships, scholarships and good advice for their futures.
- Visit local "hidden treasures" free and/or interesting businesses, college/ university campus, libraries, bookstores, specialty shops or the "best place to watch the sunset." Exposing youth and families to mainstream establishments helps them to gain the cultural capital that often necessitates navigating through institutions with success. For example, you can demystify the institution of higher education by giving youth an in-depth campus tour and providing a college application workshop that covers relevant factors such as the financial aid process. Or, take youth to a library computer lab to increase their knowledge of the internet, how to use it, and current youth cyber culture.

Increase Staff Availability

- When and where can they find you in need
  - Bilingual business cards
  - Bilingual receptionist and greeting on the voice mail
  - Extended "office hours"
  - Other approaches: do they know how to use it?
    - Pager
    - E-mail. Many families do not have home access to the internet, may not have email addresses, or know how to navigate internet technologies.

Establish and Maintain Clear Roles and Boundaries with Youth and Families

Establishing connections with families and gaining trust is the first step in effectively engaging participants in your program. However, establishing appropriate roles and boundaries is also important. Situations may appear in which your role as a professional crosses over to a more intimate, family-friend level. Be conscious of how your roles cross and the potential effects they may have on your relationship with the youth and family. Assess your relationships with families as they develop over time. Examples of situations in which boundaries become an issue include:

- Teacher vs. friend
- Gift-giving
- Included as a family member
- Invitation to family celebration
- Meeting outside of the program

Appropriate Roles: Case Example

- AAU—Hmong mentors
- OCBF—Latinas mentoring Latinas

Elicit Long-Term Commitment from Staff
Participants feel a sense of stability by seeing same reliable people in the program. Creating a strong program identity for participants is important, and it is also an important point of investment for staff. Staff members should feel valued and integral to the success of the program and its participants.

Designate Clear Staff Responsibilities

- Follow up when they miss the meeting.
- Provide needed assistance to eliminate reasons for not coming.

Utilize Collaborative Relationship with Schools

- Enhance the creditability of the program and its staff
- Find a champion: get the endorsement of school administrators or teachers
- Help participants understand the collaborative yet independent nature between school and program
- Non-evaluative

Evaluation Can Provide Valuable Information

- Conducting exit Interviews can be very informative in determining reasons why participants are leaving the program.
    - Find out reasons for leaving the program and see if there is anything you can do
    - Help modify the program and make it easier for future participants
    - If all fails, still thank the interviewees for their contribution to the program/future participants
    - Leave the door open
- Conducting focus groups mid-year is a way to collect information about how satisfied participants are with services and ways to improve services.
- Tracking Procedures are critical:
    - Obtain primary and secondary contact information at beginning of program.
    - Update contact information on a regular basis.
    - School personnel can be a good source for contact information.

NOTES

NOTES

IN SUMMARY: TIPS FOR WORKING WITH YOUTH AND FAMILIES

- Transportation
- Child Care
- Food
- Incentives
- Establishing personal connections with participants
- Provision of engaging and relevant activities
- Soliciting participant input and feedback regarding services
- Service linkages and referrals
- Assess for mobility during screening process
- Incorporate program commitment/expectations into screening process
- Be realistic about attrition rates and over recruit if appropriate
- Non-threatening and culturally sensitive evaluation methods

Overview and Status of Proposed Statewide Evaluation

Facilitators: Christina Borbely, Ph.D. and
Kerrilyn Scott-Nakai

Status of Proposed Statewide Evaluation

SDFSC Grantee Learning Community ~ December 10-11, 2008

Kerrilyn Scott-Nakai & Christina Borbely, Ph.D.
Center for Applied Research Solutions (CARS)

Doubletree Hotel Sacramento, CA

Session Overview

- I. Background and Current Status
- II. Overview of Potential Statewide
  - Evaluation Components
  - Design and Methodology
  - Short-Term, Intermediate, and Long-Term Outcomes
  - Measures
- III. Potential Roles and Responsibilities
  - Grantees and Local Evaluators
  - CARS/SDFSC TA Team
- IV. Next Steps

I. Background and Current Status

Background

- Despite the use of a common reporting format, it has been difficult to compile aggregate data from Round I and II grantee reports.
  - Lack of common collection and reporting on recruitment, participation, and attrition rates
  - Variations in the collection of implementation and fidelity data
  - Lack of common collection, reporting, and analysis of short-term, intermediate, and long-term outcomes.
- This directly limits the ability to make statements regarding broad level impact of the initiative.

Background

- At the state level, ADP and CDE jointly report on outcomes using the California Healthy Kids Survey Data
- Historically, there has not been a statewide or cross-site evaluation process specific to Round I and Round II SDFSC Governor's Program Grantees
- To date, ADP SDFSC grantees collect and report on a variety of locally defined outcomes, using a variety of measures
- Intensive levels of customized TA support have been provided to grantees on an individual basis over the past 5 years.

Other Considerations

- In previous years, substantial reductions to the U.S. Department of Education federal funding for state level SDFSC initiatives have been proposed.
  - Some of these proposed reductions have focused specifically on the Governor's portion of the funds.

More Recent Cohort III Activities

- During the new grantee meeting, the concept of a statewide evaluation design was proposed.
  - In preparation, an initial review of all grantee applications was conducted
  - A summary of proposed local evaluation designs and measures was provided
  - As originally conceptualized, all grantees would participate and a common set of outcomes and measures would be provided by the TA team
  - It was unclear at that juncture whether the state would require grantee participation
  - The idea received mixed reviews by grantees

Current Status

Status of proposed cross-site evaluation activities:

- Voluntary participation by grantees
- Grantees (in collaboration with their local evaluators) will determine if beneficial
- Process to be grantee-led (not ADP or CARS-led) initiative
  - With heavy contributions from local evaluators
- Supported/facilitated by CARS for ADP
- Potential indicators and measures developed (in collaboration) for grantee-review

SDFSC Local Evaluation

Common Designs & Measures

- Pre/post surveys; retrospective surveys
- Focus groups & youth-led focus groups

Common Challenges

- Buy in of project staff
- Tracking participants (e.g. identity; over time; dosage)
- Demonstrating true impact (i.e. measuring change)
- Accessing data (e.g.archival; parents/teachers)
- Storing & processing data
- Putting findings to use

Benefits of Statewide Evaluation Design

- **Create common ground to enhance:**
  - Dialogue and peer learning
  - Advances in practice
- **Demonstrate statewide impact of SDFSC initiative**
  - Advance the SDFSC initiative
  - Enhance sustainability under scrutiny at federal funding level
  - Contribute to and complement information collected and reported on by CDE
- **Advance knowledge regarding effective prevention practices for working with the specific populations:**
  - Children of known substance abusers
  - Youth in foster care
  - Homeless youth
- **Streamline local and statewide evaluation efforts**
  - Compatibility with NOMS
  - Compatibility with CDE CHKS

Challenges of Cross-Site Evaluation Design

- **Streamlining a variety of needs, preferences, & priorities**
- **Fidelity of evaluation implementation**
  - Standardized data collection
    - Timeline, Setting, Method
- **Efficient processing of data**
  - **From local sites and CARS**
- **Timely turnaround of data into "findings"**

II. Overview of Proposed Statewide Evaluation Components

Statewide: Proposed Evaluation Design

- Proposed pre, post/follow-up assessment (as applicable)
  - Baseline (at beginning of each cohort or at program entry)
  - Post/follow-up assessment on standardized cycle (i.e. every 6 or 9 months)
  - Need to consider start-up and school schedule
- Propose the youth to be the primary focus
  - Family data collected for Family Strengthening sites and other as applicable
  - Community data collected for sites as applicable
- Comparisons
  - Cross-site
  - Cross-population groups and/or by curricula (i.e. Project Success and Strengthening Families)

Statewide: Proposed Outcomes

- Long-Term
  - Core Constructs: Ever Use and 30 Day Use
  - Supplemental Constructs: Binging Rates, Attendance/Suspensions
- Intermediate
  - Core Constructs: AOD Harm Perception, Attitudes Towards AOD, Peer Attitudes Towards AOD, School Connectedness
  - Supplemental Constructs: Adult, Family, and Community Connectedness, Refusal Skills, Leadership Skills
- Short-Term (Process)
  - Core Constructs: Recruitment, retention, program completion rates, and referral rates
  - Supplemental Constructs: program fidelity, participant satisfaction

Statewide: Potential Measures

Youth Measures

- CHKS
  - Subset of Module A--Core
  - Subset of Module B Resiliency
  - Subset of Module C AOD
- Project Success Survey
  - Skill building subscales
- Strengthening Family Survey
  - Skill building subscales
- Youth Development Survey (FNL/YLI)
  - Leadership and Advocacy Scales

Parent Measures

- Strengthening Family Survey—Parent Interview Questionnaire

Community Measures

- Work with grantees/local evaluator to develop

Statewide: Potential Measures

Process

- Attendance/participation rates
- Recruitment/retention rates
- Fidelity checklists
- Site Visits (FNLM Model)
  - Participant focus groups
  - Staff interviews

Archival

- School Records
  - GPA, suspensions, expulsions, attendance
- CHKS data

III. Potential Roles and Responsibilities

Potential Role of SDFSC Grantees

- Determine design, outcomes, and measures.
  - Dedicate time for staff and local evaluator to participate in statewide evaluation process
  - Access resources and support from CARS
- Administer and collect data on agreed upon core statewide evaluation measures
  - Supplement with local measures as desired
- Submit data to CARS in designated format and in designated timeframe
  - Work with CARS team for data cleaning and verification process

Potential Role of SDFSC TA Team

- Gather and integrate grantee, local evaluators, and ADP input
  - Create and facilitate medium for soliciting feedback and input regarding the design, outcomes, and measures
- Provide Options for and/or develop standardized evaluation methods
  - Design & Measures
  - Data Collection and Administration Protocol
- Store and process data
- Analyze data
  - By grant, by target population, and State-level findings
- Report findings
  - To local grantees, to ADP, to USDOE, to prevention community

IV. Next Steps and Discussion

Steps for Moving Forward

- Determine direction of voluntary cross-site evaluation.
- Identify grantee-driven, voluntary process for developing cross-site evaluation.
- CARS hosts Evaluator Track (Day 2) for local evaluators and interested parties to facilitate discussion regarding cross-site evaluation
- CARS will provide ongoing support and guidance regarding the statewide evaluation process (as determined by grantees)

Discussion

- What is the interest level in a grantee-driven, voluntary cross-site evaluation?
- Is a grantee cross-site evaluation subcommittee a viable approach?
- Other

Overview of Local Evaluation Components and Peer Learning Forum

Facilitator: Christina Borbely, Ph.D.

SDFSC Annual Conference Evaluators' Track

SDFSC Grantee Learning Community – December 10-11, 2008

Christina Borbely, Ph.D.
Center for Applied Research Solutions

Doubletree Hotel Sacramento, CA

Session Overview

Morning Agenda

- **Overview of Local Evaluation Components**
  - Design and Methodology
  - Short Term, Intermediate, and Long-Term Outcomes (by construct)
  - Measures
- **Peer Learning Forum**
  - Key evaluation challenges
  - Key evaluation successes
  - Lessons learned/Resources gained

Afternoon Agenda

- **Review of Potential Statewide Evaluation Components**
  - Design and Methodology
  - Short-Term, Intermediate, and Long-Term Outcomes (by construct)
  - Measures
- **Discuss Next Steps**

Overview of Local Evaluation Components

SDFSC Local Evaluation Methods: A Historical Overview

Designs & Measures

- Pre/post surveys
- Retrospective surveys
- Focus groups & Youth-led focus groups

SDFSC Local Evaluation Design

- **Pre and Post Design**
  - Majority
- **Follow-Up Data**
  - few grantees
- **Comparison or Control Group**

Local: Proposed Outcomes Long-Term

- Most Common Long-Term Outcomes
  - AOD Use (Ever Use, 30 Day Use, and Binging Rates)
- Other Frequent Long-Term Outcomes
  - School Attendance/Suspensions
  - School Grades
- Other Less Frequent Long-Term Outcomes
  - Decrease in problem behaviors (i.e. fighting)
  - Decrease access to access to AOD

Local: Proposed Outcomes Intermediate

- Most commonly proposed intermediate outcomes include:
  - Attitudes Towards Drugs
  - Harm Perception
  - Connectedness: Adult, School, and Community
  - Youth leadership
- Less commonly proposed intermediate outcomes include:
  - Refusal skills
  - Interpersonal and pro-social skills
  - Developmental assets
  - Coping strategies
  - Awareness of personal assets
  - Stress management

Local: Other Proposed Outcomes

- **Family Outcomes**
  - Family bonding/connectedness
  - Family communication
  - Parental involvement/skills
  - Parental awareness/knowledge/identification of AOD issues
- **Service Outcomes**
  - Identification/screening of AOD issues
  - Referral for treatment and/or other services
  - Availability/access to prevention/early intervention services

Local: Evaluation Measures

Youth Measures
- Locally Developed Survey
- Project Success Survey
- Strengthening Family Survey
- CHKS
- Youth Development Survey (FNL/YLI)
- California Student Survey
- California Health Interview Survey
- SASSI
- 40 Developmental Assets Checklist
- EP Survey

Parent Measures
- Strengthening Family Survey
- Parenting Skills Survey (locally developed)
- Parent University Survey

Community Measures
- Community awareness, attitude, access, prevalence surveys
- CalOMS data

Local: Other Measures

Process

- Attendance/participation rates
- Recruitment/retention rates
- Youth/Parent/Teacher Focus Groups
- Youth/Parent/Teacher Interviews
- Youth/Parent Satisfaction Surveys
- Home visit data

Archival

- School Records
  - GPA, suspensions, expulsions, attendance
- Probation Records
- CHKS data

Peer Learning Forum

Common Evaluation Challenges

- Accounting for "dosage"; multi-tier services
- Collecting data from same participants over time
- Collecting measures from adults (participants or as sources of information on youth)
- Using findings other than for required reporting

Evaluation Successes

- Our favorite evaluation tool is…
- What really worked was…
- We/I always…

Lessons Learned Resources Gained

- Best advice
- If you had to do it over again…
- Don't reinvent the wheel…

Evaluation TA Services Provided

- **Graduated Training Series**
  - Basic to advanced-level topics
  - Statewide & Regional workshops
- **Individual Technical Assistance**
  - Evaluation plans
  - Measure development
  - Data analysis
  - Support for evaluation reports
- **Resources**
  - Prevention Briefs
  - Measures
  - Evaluation tools

Afternoon Session

Potential Statewide Evaluation

- Yet-to-be designed
  - Potential design, outcomes & measures
- Voluntary participation
- Grantee-driven with support from CARS/ADP

Review of Proposed Statewide Evaluation Components

Potential Evaluation Questions

- What are the baseline characteristics of youth and families receiving services? Do they differ by group?
- What are effective strategies for working with each of the priority groups?
  - Are there particular strategies that are more effective than others?
- What is the impact of the Governor's Program on California youth and families?
  - To what extent are local grantees demonstrating positive participant outcomes?
  - To what extent does this vary across grantees?

Potential Evaluation Questions

- How many youth and families are served by this initiative?
  - Are the participation rates lower or higher than expected?
  - To what extent is the initiative serving youth and families that are not receiving other prevention services?
- To what extent are youth and families being retained and completing services?
  - Does this vary by site or by population group?
- To what extent are youth being screened and referred to other services (as needed)?
  - What proportion of youth are being referred to treatment?
  - What proportion of youth are being referred to mental health?

Proposed Evaluation Design

- Proposed pre, post/follow-up assessment (as applicable)
  - Baseline (at beginning of each cohort or at program entry)
  - Post/follow-up assessment on standardized cycle (i.e. every 6 or 9 months)
  - Need to consider start-up and school schedule
- Propose the youth to be the primary focus
  - Family data collected for Family Strengthening sites and other as applicable
  - Community data collected for sites as applicable
- Comparisons
  - Cross-site
  - Cross-population groups and/or by curricula (i.e. Project Success and Strengthening Families)

Proposed Outcomes

- Long-Term
  - Core Constructs: Ever Use and 30 Day Use
  - Supplemental Constructs: Binging Rates, Attendance/Suspensions
- Intermediate
  - Core Constructs: AOD Harm Perception, Attitudes Towards AOD, Peer Attitudes Towards AOD, School Connectedness
  - Supplemental Constructs: Adult, Family, and Community Connectedness, Refusal Skills, Leadership Skills
- Short-Term (Process)
  - Core Constructs: Recruitment, retention, program completion rates, and referral rates
  - Supplemental Constructs: program fidelity, participant satisfaction

Potential Measures

Youth Measures

- CHKS
  - Subset of Module A--Core
  - Subset of Module B Resiliency
  - Subset of Module C AOD
- Project Success Survey
  - Skill building subscales
- Strengthening Family Survey
  - Skill building subscales
- Youth Development Survey (FNL/YLI)
  - Leadership and Advocacy Scales

Parent Measures

- Strengthening Family Survey—Parent Interview Questionnaire

Community Measures

- Work with grantees/local evaluator to develop

Statewide: Potential Measures

Process

- Attendance/participation rates
- Recruitment/retention rates
- Fidelity checklists
- Site Visits (FNLM Model)
  - Participant focus groups
  - Staff interviews

Archival

- School Records
  - GPA, suspensions, expulsions, attendance
- CHKS data

Next Steps

Discussion

- Decision to proceed
- Roles and responsibilities
- Timeline

Summary

THANK YOU!

Christina Borbely
cjborbely@sbcglobal.net

CARS
www.cars-rp.org
(707) 568 3800

Review of Proposed Statewide Evaluation Components and Action Planning

Facilitator: Christina Borbely, Ph.D.

SDFSC EVALUATION RESOURCE SECTION 2008

MEASURES
LOGIC MODELS
EVALUATION PLANS
EVALUATION REPORTS

- All materials provided by SDFSC grantees for reference purposes only.
- Materials are not “approved” or required by ADP.
- Appropriateness of resources is contingent upon alignment with program services, and with proposed outcomes.
- Additional consultation is recommended before implementing any of these tools/strategies.

*Format modified.

Table of Contents

MEASURES

YUBA SUTTER
STRENGTHENING FAMILIES
PARENT SURVEY

Instructions: This survey is confidential. We are asking you to complete the following questions because it will tell us if this program has been worthwhile. No one other than our evaluators will see your responses.

Circle the response after each statement that shows how often you do each item

		A little of the time	Some of the time	A good bit of the time	Most of the time
1.	Wait to deal with problems with my child until I have cooled down.	A	B	C	D
2.	Say "I love you" to my child.	A	B	C	D
3.	Help my youth understand what the family and house rules are.	A	B	C	D
4.	Take time to do something fun together as a family.	A	B	C	D
5.	Let my youth know what the consequences are for breaking rules.	A	B	C	D
6.	Give hugs to my child.	A	B	C	D
7.	Attend parent-teacher conferences at school.	A	B	C	D
8.	Tell my youth when I am upset without blaming or criticizing.	A	B	C	D
9.	Spend special time one-on-one with my youth.	A	B	C	D
10.	Let my youth know the reason for the rules we have.	A	B	C	D
11.	Listen to my youth when he or she is upset.	A	B	C	D
12.	Have regular times for homework.	A	B	C	D
13.	Work together with my youth to solve problems that come up at home.	A	B	C	D
14.	Try to see things from my youth's point of view.	A	B	C	D
15.	Help my youth figure out how to solve problems at school or with friends.	A	B	C	D
16.	Give points and rewards when my child learns to follow a rule or do chores at home.	A	B	C	D
17.	I show my child love and respect.	A	B	C	D
18.	Give compliments and special rewards when my youth follows the rules.	A	B	C	D
19.	Follow through with consequences each time he or she breaks a rule.	A	B	C	D

20. Have you let your child know specifically what you expect regarding alcohol and drug use? Yes No

21. Children do better in school, in choosing the right friends, and in learning responsibility when their parents show love and have limits at the same time.

ρ True ρ False

22. If children have goals and dreams for their futures, they do better in school and are more likely to stay out of trouble.

ρ True ρ False

23. Children need to learn to listen and respect their parents.

ρ True ρ False

24. There are three parts to an "I statement". The first part is to tell the child how you feel, next describe the specific behavior or situation to the child, and finally tell the child what you would like them to do now or in the future.

ρ True ρ False

25. Encouragement and compliments work just as well as consequences and penalties when trying to teach you child to follow the rules.

ρ True ρ False

26. Even kids with lots of problems do what they're suppose to about a third of the time.

ρ True ρ False

27. Penalties and consequences are best delivered a few hours after the incident that caused the problem to allow you time to calm down.

ρ True ρ False

28. Parents need to learn how to really listen to their children to hear what they are saying.

ρ True ρ False

29. Studies show that kids who drink too much or use drugs are more likely to join gangs, get in trouble with the law and be involved in teen pregnancy.

ρ True ρ False

30. All families can use extra help and support at times of special need.

ρ True ρ False

FINALLY, PLEASE ANSWER THE FOLLOWING QUESTION REGARDING THE EFFECTIVENESS OF THE Strengthening Families program:

How prepared do you feel to use the skills you learned during Strengthening Families classes?

ρ I am very prepared to use what I've learned

ρ I am somewhat prepared to use what I've learned

ρ I do not feel that I am adequately prepared to use what I've learned

DO YOU HAVE ANY COMMENTS YOU WOULD LIKE TO ADD?

YUBA SUTTER
STRENGTHENING FAMILIES
YOUTH SURVEY

Instructions: This survey is confidential. We are asking you to complete the following questions before and after your participation in the program because it will tell us if this program has been worthwhile. No one other than our evaluators will see your responses.

1. How old are you?

   A) 10 years old or younger
   B) 11 years old
   C) 12 years old
   D) 13 years old
   E) 14 years old

2. **What is your gender?**

   A) Male B) Female

3. In what grade are you?

   A) 4th grade
   B) 5th grade
   C) 6th grade
   D) 7th grade
   E) 8th grade
   F) Other

Circle the response after each statement that shows how often you do each item

		A little of the time	Some of the time	A good bit of the time	Most of the time
4.	I know one step to take to reach one of my goals	A	B	C	D
5.	I do things to help me feel better when I am under stress	A	B	C	D
6.	I appreciate the things my parent(s)/caregiver(s) do for me.	A	B	C	D
7.	I use the Peer Pressure Steps (Ask questions, Name the Problem, etc.) when I'm pressured to get into trouble.	A	B	C	D
8.	We have family meetings to discuss plans, schedules, and rules.	A	B	C	D
9.	I know how to tell when I am under stress.	A	B	C	D
10.	I listen to my parent(s)/caregiver(s)' point of view.	A	B	C	D
11.	I understand the values and beliefs my family has.	A	B	C	D
12.	I know there are consequences when I don't follow a given rule.	A	B	C	D
13.	My parent(s)/caregiver(s) and I can sit down together to work on a problem without yelling or	A	B	C	D

getting mad.

14.	I know what my parent(s)/caregiver(s) think I should do about drugs and alcohol	A	B	C	D
15.	I know the things needed in a good friend.	A	B	C	D
16.	My parent(s)/caregiver(s) are calm when they discipline me.	A	B	C	D
17.	I feel truly loved and respected by my parent(s)/caregiver(s).	A	B	C	D

18. What are examples of things that could cause stress in your life? (Circle all that apply or F)

A) problems with siblings
B) worrying about not being liked
C) problems with friends
D) problems with parents
E) use of drugs and alcohol
F) None of the above

19. What are some ways you could tell if you're under stress? (Circle all that apply or E)

A) Symptoms in your body (headaches, stomach aches, sweaty palms, blushing)
B) Feelings or emotions (anger, frustration, fear, nervousness, sadness)
C) Changes in behavior (saying something mean, blowing up at someone)
D) Changes in the way you get along with others (wanting to be alone, thinking no one likes you)
E) None of the above

20. What are some ways healthy ways to help manage your stress? (Circle all that apply or F)

A) Scream and yell
B) Exercise
C) Hit the person that is causing your stress
D) Talk to others who would listen
E) Listen to music
F) None of the above

21. What are good examples of a "ground rule"? (Circle all that apply or F)

A) One person talks at a time
B) All people in the group must sit on the ground.
C) Respect other people's ideas
D) Keep your hands to yourself.
E) Confidentiality
F) None of the above

22. What are good examples of ways to resist someone who is pressuring you to do something wrong? (Circle all that apply)

A) Tell the person pressuring you that they are stupid.

B) Suggest another activity to do together.

C) Tell them what could happen to them if they are caught

D) Stay calm and cool.

E) Say "O.K" because everyone else is doing it.

F) Leave

G) None of the above

Please answer true or false to the following statements.		False	True
23.	**When a parent or caregiver asks their child to perform a chore, they are just being mean.**	F	T
24.	**Someone who lies makes a good friend.**	F	T
25.	**Drugs and alcohol often help youth to reach their goal.**	F	T
26.	**It is a good idea to follow rules.**	F	T
27.	**Drugs and alcohol change your brain so you can't tell the difference between reality and what's going on inside your head.**	F	T
28.	**It's hard to be a kid, but easy to be a parent/caregiver.**	F	T
29.	**It is important to talk calmly when communicating with others.**	F	T
30.	**Setting limits involves rules, consequences and communication.**	F	T

Courtesy of Santa Cruz County*

Friday Night Live/Club Live Partnership

Service to Science Survey – Spring 2009

Tell us what you think!

This survey asks questions about you, your feelings, and your thoughts. By completing this survey you will help us understand how members are learning from the FNL/CL program and how we can make the program better in the future. Sometimes youth worry about who will see these answers. There is no place for your name on this survey. Your answers will be kept private. Answering these questions is voluntary; you do not have to answer any question that makes you feel uncomfortable. Sometimes, youth worry about whether they have answered the questions correctly. This is not a test, so there are no right or wrong answers. Just be honest and respond as best you can. To help keep your answers private, please work by yourself. The survey should take you 15-20 minutes to complete. Please circle only one response for each statement.

What grade are you currently in? _____

Please check all programs that you have been involved with or are involved with now:

___ Club Live
___ Friday Night Live
___ Youth Technical Assistance Pool
___ Friday Night Live Youth Council
___ Youth Coalition Santa Cruz
___ Lock In
___ Club Live Youth Council
___ Media Project
___ Connection in Action Leadership Conference
___ First Night/Downtown Fury

How long have you participated in FNL/CL?

___ Less than a month
___ 1-3 months
___ 4-6 months
___ 7-9 months
___ 10-12 months
___ 1 year
___ 2 years
___ 3 + years
___ Other (describe)
_____

How many FNL/CL meetings have you attended this school year?

___ 1-3 ___ 4-6 ___ 6-9 ___ 9-11 ___ Other (describe)_____

What did you like to do the most in FNL/CL?

What kept you coming back to the meetings?

Section 1. About Your Skills

1. Please rank yourself based on where you are now on the skills listed. Circle only <u>one</u> answer for each question. Circle "I have not learned this yet" if you have not worked on this skill.	I'm great at this	I'm good at this	I'm okay at this	I'm not so good at this	I have not learned this yet
a. Setting goals.	1	2	3	4	5
b. Working together in a group setting.	1	2	3	4	5
c. Planning and carrying out a community project.	1	2	3	4	5
d. Being open-minded and inclusive towards different people and cultures.	1	2	3	4	5
e. Managing a budget.	1	2	3	4	5
f. Speaking in public/giving presentations.	1	2	3	4	5
g. Making decisions as part of a group.	1	2	3	4	5
h. Planning and organizing my own time.	1	2	3	4	5
i. Planning meetings, activities, and events with my group.	1	2	3	4	5
j. Handling and working out conflicts respectfully.	1	2	3	4	5
k. Assessing issues in my school or community.	1	2	3	4	5
l. Developing an action plan to address school or community issues.	1	2	3	4	5
m. Creating positive change in my school or community.	1	2	3	4	5
n. Listening to other people (active listening).	1	2	3	4	5
o. Effectively communicating my ideas through speech.	1	2	3	4	5
p. Problem solving.	1	2	3	4	5
q. Leading group meetings.	1	2	3	4	5
r. Taking care of problems without violence or fighting.	1	2	3	4	5
s. Taking care of problems without using alcohol, tobacco, or drugs.	1	2	3	4	5

2. Please circle the number that is closest to how you feel now.	*All of the* time	Most of the time	Some of the time	Never
a. I feel good about myself.	1	2	3	4
b. I feel I have control over things that happen to me.	1	2	3	4

c. I feel that I can make a difference.	1	2	3	4
d. I am good at learning new things.	1	2	3	4
e. I feel good about my future.	1	2	3	4
f. I am good at handling whatever comes my way.	1	2	3	4
g. I get along with other people my age.	1	2	3	4
h. I am good at making friends.	1	2	3	4

Section 2. About School

1. How would you describe your grades in school last year? Circle one.

Mostly A's | Mostly A's & B's | Mostly B's & C's | Mostly C's | Mostly C's & D's | Mostly D's | Mostly D's & F's | Mostly F's

2. Please circle the number that is closest to how you feel now.	All of the time	Most of the time	Some of the time	Never
a. I am interested in going to school.	1	2	3	4
b. I get along with other students.	1	2	3	4
c. I care about my school.	1	2	3	4
d. I feel a strong connection to my school.	1	2	3	4
e. I participate in activities at my school (other than Friday Night Live/Club Live).	1	2	3	4

Section 3: About Your Community

1. Please circle the number that is closest to how you feel now.	All of the time	Most of the time	Some of the time	Never
a. I am important to my community.	1	2	3	4
b. I feel a strong connection to my community.	1	2	3	4
c. I feel good about myself because I help others.	1	2	3	4
d. I feel that I have influence on what happens in my community.	1	2	3	4
e. I know how to make things better in my community.	1	2	3	4

2. Please circle the number that is closest to how you feel now.	All of the time	Most of the time	Some of the time	Never
a. I care about youth of other cultures,	1	2	3	4

races or ethnic groups.				
b. I have respect for youth of other cultures, races or ethnic groups.	1	2	3	4
c. I feel comfortable with youth of other cultures, races or ethnic groups.	1	2	3	4
d. I try not to judge people based on skin color.	1	2	3	4

Section 4: Feelings About Alcohol and Other Drugs

1. During the past 30 days, on how many days did you use…	0 days	1-2 days	3-9 days	10-19 days	20-30 days
a. cigarettes (frajos)?	1	2	3	4	5
b. smokeless tobacco (chew or snuff)?	1	2	3	4	5
c. at least one drink of alcohol?	1	2	3	4	5
d. five or more drinks of alcohol in a row, that is within a couple of hours?	1	2	3	4	5
e. marijuana (pot, weed, grass, hash, yeska)?	1	2	3	4	5
f. blunts (cigar or cigarette laced with marijuana)?	1	2	3	4	5
g. inhalants (things you sniff, huff, or breathe to get high)?	1	2	3	4	5
h. methamphetamine (meth, crank, crystal)?	1	2	3	4	5
i. heroin (chiva)?	1	2	3	4	5
j. any other drugs (such as ecstasy, cocaine, LSD, PCP, or pills not prescribed by a doctor)?	1	2	3	4	5

2. Please circle number that is closest to how you feel now.	All of them	Most of them	Some of them	None of them
a. How many of your closest friends have used marijuana during the last 30 days?	1	2	3	4
b. How many of your closest friends have been drunk in the last 30 days?	1	2	3	4
c. How many of your closest friends have used blunts (cigarettes laced with marijuana)?	1	2	3	4
d. How many of your closest friends have used a drug like meth, cocaine, or heroin during the past 30 days?	1	2	3	4

3. How wrong do you think it is…	Not wrong at all	A little bit wrong	Wrong	Very wrong
a. for someone your age to take one or two drinks of beer, wine or hard liquor per day?	1	2	3	4
b. for someone your age to smoke cigarettes?	1	2	3	4
c. for someone your age to smoke marijuana?	1	2	3	4

d. for someone your age to use drugs like meth, heroin or another illegal "hard" drug?	1	2	3	4
4. Please circle the number that is closest to how you feel now.	Strongly agree	Agree	Disagree	Strongly disagree
a. I know what would happen if a youth was caught driving under the influence of drugs or alcohol.	1	2	3	4
b. I know what would happen if a youth was sent to juvenile hall for possession of drugs.	1	2	3	4
c. I understand the difference between the school's laws and the community's laws when youth are caught in possession of drugs or alcohol.	1	2	3	4

5. Please circle the number that is closest to how you feel now.	Very easy	Somewhat easy	Somewhat difficult	Very difficult
a. How easy is it for you or someone else you know to get tobacco?	1	2	3	4
b. How easy is it for you or someone you know to get alcohol?	1	2	3	4
c. How easy is it for you or someone you know to get marijuana?	1	2	3	4

6. Please circle the number that is closest to how you feel now.	Approve	Wouldn't care	Disapprove	Greatly disapprove
a. How would your parents/guardian feel if you smoked cigarettes?	1	2	3	4
b. How would your parents/guardian feel if you used alcohol?	1	2	3	4
c. How would your parents/guardian feel if you smoked marijuana?	1	2	3	4

7. How old were you when you first tried alcohol, tobacco, or other drugs? Please do not include any time when you only had a sip or two from a drink.

_____ years old
_____ I've never tried alcohol, tobacco, or other drugs

8. If you have tried alcohol, tobacco, or other drugs, please write what you tried first _____

9. Binge drinking (i.e. dangerous drinking) means having _____ drinks in about 2 hours. I am not sure _____

10. How do you or others your age get alcohol? Check <u>all</u> that apply.

___ From home with parental knowledge
___ From home without parental knowledge
___ Older sisters, brothers, or relatives
___ From friends
___ Ask someone to purchase
___ Buy it ourselves from a store
___ Steal from store
___ Other (describe) _____

11. In your opinion, what drugs are the easiest to get right now?
12. Do you think you will attend CL or FNL next year? _____ Yes ____ Maybe _____ No
13. Please explain your answer.
14. Do you have any suggestions on how we can improve FNL/CL?
15. Write any other comments about this survey and/or your experience in FNL/CL.
Thank you!

Friday Night Live/Club Live
Service to Science Spring 2006 Member Survey

San Lorenzo Valley High School

	FIRST NAME	LAST NAME
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

SURVEY ADMISNISTRATOR: _____

SURVEY DATE: _____

Courtesy of Napa County*

Insight Survey 1

Student ID number or code _____

Section One

1.1 Are the following statements true or false?

True	False	
❑	❑	Marijuana causes brain changes similar to those from other drug use.
❑	❑	Marijuana causes an increased risk for lung cancer.
❑	❑	Marijuana is less harmful and addictive than tobacco.
❑	❑	Marijuana contains more cancer-causing chemicals than tobacco.
❑	❑	Students who smoke marijuana get higher grades than students who don't smoke marijuana.
❑	❑	Marijuana today is not as strong as it was twenty years ago.
❑	❑	Marijuana use can lead to drug dependency.

Check the correct answer:

1.2 A person who <u>needs</u> drugs to feel <u>normal</u> is

- ❑ Just experimenting.
- ❑ Looking for a mood swing.
- ❑ Controlling their amount of use.
- ❑ Dependent on alcohol, marijuana or other drugs.

1.3 Which of the following is a sign of drug dependency?

- ❑ Never using more than a person plans to.
- ❑ Continuing to use even after getting into trouble.
- ❑ Never using alone.
- ❑ Trying marijuana once at a party.

1.4 Which of the following does NOT put teens at higher risk for problems with alcohol, marijuana or other drugs?

- ❑ Getting low grades.
- ❑ Having an argument with a best friend.
- ❑ Having parents or other close relatives who abuse alcohol, marijuana or other drugs.
- ❑ Starting to use alcohol, marijuana or other drugs before age 13.

	Score
Section One	
Section Two	
Section Three	
Section Four	
Section Five	

Section Two

Check any one of the four boxes in each section:

2.1 Do you think drinking alcohol sounds exciting or boring?

Exciting	-	-	Boring
❑	❑	❑	❑

2.2 When you see your friends using marijuana, you think it looks:

Cool	-	-	Not cool
❑	❑	❑	❑

2.3 I am responsible for behaviors that affect my health.

Never	-	-	Always
❑	❑	❑	❑

2.4 How much do you think teenagers risk harming themselves, if they…

	No Risk	Slight Risk	Moderate Risk	Great Risk
Have one or two drinks nearly every day.	❑	❑	❑	❑
Drive after drinking.	❑	❑	❑	❑
Smoke marijuana every day.	❑	❑	❑	❑
Drive after smoking marijuana.	❑	❑	❑	❑
Take "meth" once or twice.	❑	❑	❑	❑

Section Three

3.1 How many days (if any) have you had alcoholic beverages to drink?

During the last month (30 days)? _____ (number of days)

3.2 How many days (if any) have you been drunk or very high from drinking alcoholic beverages?

During the last month (30 days)? _____ (number of days)

3.3 How old were you the first time you used alcohol (other than just a sip)?

_____ (age)

3.4 During the last month (30 days), on how many days did you have five or more drinks in a row?

_____ (number of days)

3.5 How old were you the first time you used marijuana?

_____ (age)

3.6 How many days (if any) have you used marijuana or hashish?

During the last month (30 days)? _____ (number of days)

3.7 Please write down how many days in the last month (30 days) you used any of the following drugs.

Crack/Cocaine _____ (number of days)

Stimulants/Amphetamines (uppers, ups, speed, bennies, dexies, pep pills, diet pills, meth or crystal meth _____ (number of days)

Tranquilizers (Librium, Valium or Miltown) _____ (number of days)

"Club Drugs" — "Ecstasy" (MDMA, MDA, MDEA) _____ (number of days)

Barbiturates (downs, downers, goof balls, yellows, reds, blues, rainbows) _____ (number of days)

Quaaludes (quads, ludes, soapers) _____ (number of days)

Sniffed glue or the contents of aerosol spray cans or inhaled any other gases or sprays in order to get high _____ (number of days)

"Date rape drugs," such Rohypnol and GHB _____ (number of days)

Hallucinogens (LSD, PCP, angel dust, mushrooms) _____ (number of days)

Steroids (not prescribed for you) _____ (number of days)

Ritalin (not prescribed for you) _____ (number of days)

Heroin (smack, horse, skag) _____ (number of days)

Section Four

4.1 How strongly do you agree or disagree with the following statements?

	Strongly Agree	Agree	Disagree	Strongly Disagre
I have a number of good qualities.	❑	❑	❑	❑
I do things as well as most other people.	❑	❑	❑	❑
On most days, I am satisfied with myself.	❑	❑	❑	❑
When I am an adult I will be sucessful.	❑	❑	❑	❑
I enjoy being in school.	❑	❑	❑	❑
I try to do my best in school.	❑	❑	❑	❑
I have to have things right away.	❑	❑	❑	❑
I often do things without thinking.	❑	❑	❑	❑

4.2 When you use alcohol, marijuana or other drugs, do you think your parents know?

- ❑ They never know when I have been using.
- ❑ They know about a few times.
- ❑ They know about half the time.
- ❑ They know most of the time.
- ❑ They always know when I have been using.

4.3 If your parents found out that you had been using alcohol, marijuana or other drugs, how upset do you think they would be?

- ❑ Not at all upset
- ❑ Somewhat upset
- ❑ Very upset

4.4 At my school, there is a teacher or other adult who...

	Strongly Agree	Agree	Disagree	Strongly Disagree
Is concerned when I'm not there.	❑	❑	❑	❑
Listens to me when I have something to say.	❑	❑	❑	❑
Gives me encouragement.	❑	❑	❑	❑
Tells me when I do a good job.	❑	❑	❑	❑
Believes that I can be successful.	❑	❑	❑	❑

4.5 How many of your closest friends use alcohol, marijuana or other drugs?

None	Some	Most	All
❑	❑	❑	❑

Section Five

In every section that applies to you, check only one answer.

Alcohol Use

- ❑ I do not drink alcohol.
- ❑ I drink, but my alcohol use is not a problem for me.
- ❑ I ought to cut down using alcohol.
- ❑ I ought to quit using alcohol.
- ❑ I've recently quit using alcohol.
- ❑ I've been alcohol-free for more than six months.
- ❑ Even though I quit using alcohol for a while, I started using again recently.

Marijuana Use

- ❑ I do not use marijuana.
- ❑ I use, but my marijuana use is not a problem for me.
- ❑ I ought to cut down using marijuana.
- ❑ I ought to quit using marijuana.
- ❑ I've recently quit using marijuana.
- ❑ I've been marijuana-free for more than six months.
- ❑ Even though I quit using marijuana for a while, I started using again recently.

Drug you use most often, other than alcohol or marijuana: _____

- ❑ I do not use any other drug.
- ❑ I use _____, but my drug use is not a problem for me.
- ❑ I ought to cut down using _____.
- ❑ I ought to quit using _____.
- ❑ I've recently quit using _____.
- ❑ I've been _____ -free for more than six months.
- ❑ Even though I quit using _____ for a while, I started using again recently.

Section Six

6.1 The following list describes some of the things you did or learned about in Insight. Which were the most valuable parts for you?

	Not Valuable	-	-	-	Very Valuable
Learning about alcohol, marijuana and other drug use.	❑	❑	❑	❑	❑
Hearing about other people's problems and what to do about them.	❑	❑	❑	❑	❑
Hearing what the facilitator(s) said about my alcohol, marijuana or other drug use.	❑	❑	❑	❑	❑
Hearing what others in the group said about my alcohol, marijuana or other drug use.	❑	❑	❑	❑	❑
Learning about how my feelings affect my alcohol, marijuana or other drug use.	❑	❑	❑	❑	❑
Learning about how I use defenses to ignore problems.	❑	❑	❑	❑	❑
Learning about the difference between experimenting and being addicted to alcohol, marijuana or other drugs.	❑	❑	❑	❑	❑
Learning about the risks for becoming addicted and how they apply to me.	❑	❑	❑	❑	❑
Learning ways to have fun and socialize without using alcohol, marijuana or other drugs.	❑	❑	❑	❑	❑

6.2 How strongly do you agree or disagree with the following statements?

	Completely Agree	-	-	-	Completely Disagree
I needed a class like Insight at this time.	❑	❑	❑	❑	❑
I will go to my Insight facilitator if I have problems in the future.	❑	❑	❑	❑	❑
If a friend were having trouble with alcohol, marijuana or other drugs, I'd recommend him/her to Insight.	❑	❑	❑	❑	❑

6.3 In what specific ways did Insight help you?

6.4 What suggestions do you have for making Insight better?

6.5 What parting words do you have regarding your experience in Insight?

Courtesy of Mendocino County

Project SUCCESS Prevention Knowledge Assessment **POST-TEST**

What Did You Learn?

Please complete this brief survey to help us understand what you have learned about the effects of alcohol and drugs during this class.

For each statement, CIRCLE "T" or "F."

		True or False?	
1.	One shot of liquor has more alcohol than a can of beer.	T	F
2.	The effects of marijuana wear off in a few hours.	T	F
3.	Drinking alcohol is more dangerous for teens than for adults.	T	F
4.	Alcohol makes people feel happy, so it can't be a depressant.	T	F
5.	Most middle school students have smoked marijuana in the past month.	T	F
6.	A person must get drunk or take drugs every day to be called an alcoholic or chemically dependent (addicted).	T	F
7.	If a student talks to the WAFER/Project SUCCESS teacher about his or her parent's drinking or drug use, the teacher must call the parents.	T	F
8.	Alcoholism and drug addiction are diseases.	T	F
9.	Most alcoholic/chemically dependent people have jobs and live with their families.	T	F
10.	Family members can get the chemically dependent person to stop using if they use the right approach.	T	F

11. What did you like best about the class?

12. What would you like to learn more about?

13. What changes have you made in your life because of what you learned in the class?

WAFER EVALUATION: 7TH GRADE PREVENTION KNOWLEDGE POST-TEST (V20080309)

WAFER Courtesy of Mendocino County

Knowledge, Attitude, and Behavior (KAB) **POST**-Survey

For each question, check the column that best reflects your experience or opinion.

1. **HOW LONG** have you been participating in the WAFER Project? _____ months

2. **DURING THE PAST 30 days**, on how many days did you use…

	0 DAYS	1-2 DAYS	3-5 DAYS	6-9 DAYS	10-19 DAYS	20-31 DAYS
Cigarettes?						
At least one drink of **alcohol**?						
Five or more drinks of alcohol within a couple of hours?						
Marijuana?						
Methamphetamine (meth, speed, crystal, crank)?						
Prescription pain pills to get high (Oxycontin, Vicodin)?						
Inhalants?						

3. How much do you think people risk harming themselves if they use the following substances **REGULARLY**?

	NO RISK	SLIGHT RISK	MODERATE RISK	GREAT RISK
Cigarettes? *(1 pack or more per day)*				
Alcohol? *(1 or 2 drinks nearly every day)*				
Marijuana? *(more than 1 time/week)*				
Prescription pain pills to get high (Oxycontin, Vicodin)?				
Inhalants?				

4. Do you think it is OK for people your age to do the following things?

	NEVER OK	SOMETIMES OK	DEFINITELY OK
Drink **alcohol** regularly?			
Smoke any **cigarettes?**			
Smoke any **marijuana?**			
Use **prescription pain pills to get high** (Oxycontin, Vicodin)?			
Use **Inhalants**?			

5. About what percent of students in your school do you think regularly do the following things (in other words, how many in a group of 100 students)?

	PERCENT (%) OF STUDENTS										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Drink **alcohol** at least once a week?											
Binge drink (5 or more drinks within a couple of hours?											
Smoke **marijuana** at least once a week?											
Use **prescription pain pills to get high**?											
Use **Inhalants**?											

	True	A little true	True	True
Who really cares about me.				
Who tells me when I do a good job.				
Who expects me to do my best.				
Whom I trust.				

7. How strongly do you agree or disagree with the following statements about your school?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I feel like I am part of this school.					
Teachers here treat students fairly.					
I feel safe in my school.					
I feel close to people at school.					
At my school, I learn accurate information about the effects of drugs and alcohol.					

8. How would you describe what you heave learned about the AMOUNT of alcohol and marijuana that are used by other students at your school?

	ALCOHOL	MARIJUANA
On the whole, students use MORE than I had thought.		
On the whole, students use LESS than I had thought.		
On the whole, students use about THE SAME AMOUNT that I had thought.		

9. How much have you learned about the EFFECTS of drugs and alcohol through this project?

☐ A lot ☐ A little ☐ Nothing

10. What is your opinion of the project overall?

☐ Disappointing ☐ It was OK ☐ Very Helpful

11. Did you participate in out-of-school time activities with the program?

☐ Yes ☐ No

12. What did you like most about the project?

13. What suggestions would you make to improve the project?

THANK YOU FOR COMPLETING THIS SURVEY!

WAFER Parent Survey

Courtesy of Mendocino County

Please answer these questions about your child's participation in the substance abuse prevention services offered by AODP through the your child's school. The survey is anonymous.

1. ***WHY*** *was your child referred to the substance abuse treatment program?*

2. ***WHAT SUBSTANCES*** *has your child been involved with?*

	NO	YES
Cigarettes?	☐	☐
Alcohol?	☐	☐
Inhalants (huffing glue, paint, deodorant, etc.)?	☐	☐
Marijuana?	☐	☐
Methamphetamine (meth, speed, crystal, crank)?	☐	☐
Cocaine?	☐	☐
Prescription drugs (oxycontin, vicodin, cough suppressant)?	☐	☐
Something else? _____	☐	☐

3. *If your child drinks alcohol, does he or she* ***binge drink*** *(5 or more drinks in a couple of hours)?*

☐ YES ☐ NO ☐ Child does not drink alcohol ☐ Don't know

4. ***HAVE YOU DISCUSSED*** *the prevention program with your child? Please explain your answer—what did you discuss, and how did it go?*

5. ***HOW*** *has participation in the prevention program affected your child?*

6. ***HOW HELPFUL*** *would you say the following program components were for you and/or your child…*

	VERY useful	Somewhat useful	NOT useful	Don't Know
Individual support from the counselor	☐	☐	☐	☐
Group sessions	☐	☐	☐	☐
Parent workshops and/or support	☐	☐	☐	☐
After school activities	☐	☐	☐	☐

13. ***HOW HAVE YOU BEEN INVOLVED*** *in your child's prevention program?*

14. Overall, how would you rate the prevention program?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

THANK YOU FOR COMPLETING THIS SURVEY.

WAFER EVALUATION: PARENT SURVEY (V200808016)

WAG's Healthy Cooking Class What Did You Learn?

Courtesy of Mendocino County*

Please take a look at this rubric and rate your participation in the Cooking Class by giving yourself points in the last column. As you can see, the higher your score, the more involved you have been in the Cooking Class. When you've finished the rubric, please answer the questions on the next page (or maybe on the back of this page, if these were copied by someone with a good environmental conscience).

COMPONENT	THE BEST	PRETTY GOOD	FAIR	NOT GOOD AT ALL	POINTS
	3	2	1	0	
1. Attendance	**Regular Participant:** I came to cooking class almost every time that it happened.	**Pretty Regular Participant:** I came to most cooking class sessions – I only missed when I was sick or had some other really good excuse.	**Not So Regular Participant:** I came to some cooking classes, but only if I didn't have anything better to do.	**Invisible Participant:** I don't remember coming to any cooking classes.	
2. Activities	**Full Participation:** I had turns planning meals, choosing recipes, making shopping lists, shopping, doing prep work, cooking, serving, and cleaning up!	**Quite a Bit of Participation:** I didn't help with everything, but I helped with everything I could.	**Not so Involved:** I mostly just came to eat.	**Invisible Participant:** Where is the cooking class again?	
3. Using what I've learned about cooking	**Making the Most of What I've Learned:** I've cooked the recipes at home for my family, and also brought home the ideas about healthy foods and family mealtimes. I've been changing how I make food choices at school, and helped my family with the shopping. I've even been using some of the meal-planning skills to organize my schoolwork!	**I'm Thinking About Using New Foods, But It's Hard:** I tried cooking some of the foods at home, and I've tried to make better food choices for myself.	**I'm Not Really Into Cooking:** I took home some leftovers, but I haven't really made any changes in my eating habits.	**Invisible Participant:** When will dinner be ready?	
4. Making the most of the chance to learn new things	**It's Helping My Grades!** The cooking class gave me a chance to work on a lot of academic skills (*e.g., math, reading, and writing)* when we were planning meals, shopping, measuring – you get the idea.	**Maybe I'm Learning By Osmosis:** I haven't really thought about the academic skills, but maybe I'm learning without know it.	**My Learning Style Is Different:** I like to learn by watching and listening, not by reading and writing.	**Invisible Participant:** Can I have seconds?	
5. Building my resiliency…	**I Am Empowered:** The cooking class gave me a chance to learn personal development skills. (*Please circle anything that applies to you: communication, tolerance, having fun without drugs or alcohol, making new friends, focusing and staying on-task, decision-making, developing friendships with adults…)*	**Making New Friends Was Cool:** The most important thing for me was just getting to know people better.	**Hanging Out Was Fun:** I liked hanging out at WAG, but I didn't really think about it in terms of personal development.	**Invisible Participant:** I liked how everyone stayed on-task and got my dinner cooked.	

WAFER EVALUATION: COOKING CLASS SELF-ASSESSMENT RUBRIC (v20080216)

6. What did you like best about the Cooking Class?
7. Is there anything you'd like to change about the Cooking Class?
8. What changes have you made in your life (eating habits, maybe?) because of the class. (If you haven't made any changes, just say NONE.)
9. Are you in any Project SUCCESS Groups? Which one(s)? (If you don't know what these are, ask John.)
10. What would you normally be doing after school if you weren't coming to the cooking class?

Courtesy of San Luis Obispo County

Student Survey on Alcohol, Tobacco and Other Drugs

Please take a few minutes to answer this survey. Please answer honestly. If a question makes you feel uncomfortable, you don't have to answer it. If you don't understand a question, ask one of the survey volunteers. ***PLEASE COMPLETE BOTH SIDES!***

For each statement, please fill in the circle that best fits your opinion:

How much do you think people risk harming themselves (physically or in other ways) if they. . .	***No Risk***	***Slight Risk***	***Moderate Risk***	***Great Risk***	***Can't say, drug not familiar***
1. Smoke one or more packs of cigarettes per day	①	②	③	④	⑤
2. Try marijuana once or twice	①	②	③	④	⑤
3. Smoke marijuana regularly	①	②	③	④	⑤
4. Take one or two drinks of an alcoholic beverage nearly every day	①	②	③	④	⑤
5. Have five or more alcoholic drinks once or twice each weekend	①	②	③	④	⑤
6. Use club drugs (such as Ecstasy, GHB, Rohypnol) occasionally	①	②	③	④	⑤
7. Use meth or "speed" occasionally	①	②	③	④	⑤

-- Please answer some questions about your school, neighborhood, and home--

For each statement below, <u>please circle</u> the most accurate answer.						
8. What is the language you use most often at home?	English		Spanish		Other	
9. Where are you living now?	On a farm		In the country, not on a farm		In a city, town, or suburb	
10. Putting them all together, what were your grades like last year?	***Mostly… >***	F's	D's	C's	B's	A's
11. In my school, students have lots of chances to help decide things like class activities and rules.	***Pick One >***		NO!	No	Yes	YES!
12. There are a lot of chances for students in my school to get involved in sports, clubs, and other school activities outside of class.	***Pick One >***		NO!	No	Yes	YES!
13. If you wanted to get some beer, wine, or hard liquor (for example, vodka, whiskey or gin), how easy would it be for you to get some?	***Pick One >***		Very Hard	Sort of Hard	Sort of Easy	Very Easy
14. If you wanted to get some marijuana, how easy would it be for you to get some?	***Pick One >***		Very Hard	Sort of Hard	Sort of Easy	Very Easy
15. About how many adults have you known personally who in the past year have gotten drunk or high?	***Pick One >***	None	1 adult	2 adults	3-4 adults	5 or more adults
16. Has anyone in your family ever had a severe alcohol or drug problem?	***Pick One >***		YES		NO	
17. Think of your four best friends (the friends you feel closest to), in the past (12 months), how many of your best friends have drank alcohol when their	***Pick One >***	None	1	2	3	4

parents didn't know about it?						
18. Think of your four best friends (the friends you feel closest to), in the past (12 months), how many of your best friends have used marijuana, or other illegal drugs?	***Pick One >***	None	1	2	3	4
19. How wrong do your parents feel it would be for you to drink beer, wine, or hard liquor (for example vodka, whiskey, or gin) regularly (at least once or twice a month)?	***Pick One >***		Very Wrong	Wrong	A little bit wrong	Not wrong at all
20. How wrong do your parents feel it would be for you to smoke marijuana?	***Pick One >***		Very Wrong	Wrong	A little bit wrong	Not wrong at all
21. My family has clear rules about alcohol and drug use.	***Pick One >***		NO!	No	Yes	YES!
22. If I had a personal problem, I could ask my mom or dad for help.	***Pick One >***		NO!	No	Yes	YES!
23. People in my family have serious arguments.	***Pick One >***		NO!	No	Yes	YES!
24. When I am not at home, one of my parents knows where I am and whom I am with.	***Pick One >***		NO!	No	Yes	YES!

For each statement below, please mark the box that shows <u>how many times</u> you did this activity during the past 30 days.

25. How frequently have you smoked cigarettes during the past 30 days.

☐ Not at all ☐ Less than one per day ☐ About one-half pack per day

☐ About one pack per day ☐ 1 to 5 cigarettes per day ☐ More than one pack per day

26. On how many occasions during the past 30 days (if any) have you used marijuana (grass, pot) or hashish (hash, hash oil)?

☐0 occasions ☐1-2 occasions ☐3-5 occasions ☐ 6-9 occasions ☐10-19 occasions ☐20 or more occasions

27. On how many occasions during the past 30 days have you had alcoholic beverages to drink (more than just a few sips)? (Note: Alcoholic beverages include beer, wine, wine coolers, and liquor.)

☐0 occasions ☐1-2 occasions ☐3-5 occasions ☐ 6-9 occasions ☐10-19 occasions ☐20 or more occasions

28. On how many occasions during the past 30 days (if any) have you been drunk or very high from drinking alcoholic beverages?

☐0 occasions ☐1-2 occasions ☐3-5 occasions ☐ 6-9 occasions ☐10-19 occasions ☐20 or more occasions

29. On how many occasions during the past 30 days (if any) have you taken methamphetamine in any form (“crank”, “speed”)?

☐0 occasions ☐1-2 occasions ☐3-5 occasions ☐ 6-9 occasions ☐10-19 occasions ☐20 or more occasions

30. On how many occasions during the past 30 days (if any) have you used club drugs such as “Ecstasy,” GHB, or Rohypnol?

☐0 occasions ☐1-2 occasions ☐3-5 occasions ☐ 6-9 occasions ☐10-19 occasions ☐20 or more occasions

31. How honest were you in filling out this survey?	***Circle One >***	I was very honest	I was honest pretty much of the time	I was honest some of the time	I was honest once in a while	I was not honest at all

32. What's your gender?: Male Female

33. What is your grade?: 6 7 8 9 10 11 12

34. What is your age? _____

35. Which of the following best describes you? ☐ White ☐ Hispanic/Latino ☐ Arab American
☐ Black / African American ☐ American Indian ☐ Asian
☐ Native Hawaiian / Other Pacific Islander

36. Are you a member of Friday Night Live (high school) or Club Live (middle school) (please circle)? YES NO

37. How many brothers and sisters, including stepbrothers & stepsisters, do you have? _____

38. Please indicate which family members currently reside in the house you MOSTLY live:
☐Mother ☐Father ☐Brother/Sister ☐ Grandmother ☐Grandfather ☐Stepmother ☐Stepfather
☐Stepbrother/stepsister ☐Foster father ☐ Foster mother ☐Foster brother/foster sister ☐Other

39. During the LAST FOUR WEEKS, how many whole days of school have you missed because of illness?
Pick one:
☐None ☐ 1 day ☐ 2 days ☐ 3 days ☐ 4-5 days ☐ 6-10 days ☐11 or more days

40. During the LAST FOUR WEEKS, how many whole days of school have you missed because you skipped or "cut"?
☐None ☐ 1 day ☐ 2 days ☐ 3 days ☐ 4-5 days ☐ 6-10 days ☐11 or more days

41. During the LAST FOUR WEEKS, how many whole days of school have you missed for other reasons?
☐None ☐ 1 day ☐ 2 days ☐ 3 days ☐ 4-5 days ☐ 6-10 days ☐11 or more days

42. Now thinking back over the past year in school, how often did you enjoy being in school?
☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Almost Always

THANK YOU!

Courtesy of Shasta County

P. O. Box 493777
Redding, CA 96049
(530)241-5958

A T O D Survey

Have you ever used or tried…	…during your life (ever)?		…in the last 30 days?		How old were you the first time you tried this drug?	
(Mark an X or √ for each question)	No	Yes	No	Yes	Never tried	Age
One full drink of alcohol (such as a can of beer, glass of wine, wine cooler, or shot of liquor)						
Five or more drinks of alcohol in a row, that is, within a couple of hours						
Cigarettes, cigars, cigarillos, or pipes						
Smokeless tobacco (dip, chew or snuff such as Redman, Skoal, or Beechnut)						
Marijuana (pot, weed, grass, hash, or bud)						
Methamphetamines (meth, speed, crystal, crank, ice, bennies, black beauties)						
Prescription painkillers not prescribed by a doctor (Vicodin, OxyContin, Percodan)						
Other prescription medicines not prescribed by a doctor						
Other illegal drug (such as heroin, cocaine, Ecstasy, PCP, downers, barbs)						

What other drugs have you used? _____

On a scale of 1 to 5, how harmful do you think it is to use each of the following drugs? *(Circle the correct answer)*	Not Harmful		Somewhat Harmful		Very Harmful
One full drink of alcohol (such as a can of beer, glass of wine, wine cooler, or shot of liquor)	1	2	3	4	5
Five or more drinks of alcohol in a row, that is, within a couple of hours	1	2	3	4	5
Cigarettes, cigars, cigarillos, or pipes	1	2	3	4	5
Smokeless tobacco (dip, chew or snuff such as Redman, Skoal, or Beechnut)	1	2	3	4	5
Marijuana (pot, weed, grass, hash, or bud)	1	2	3	4	5
Methamphetamines (meth, speed, crystal, crank, ice, bennies, black beauties)	1	2	3	4	5
Prescription painkillers not prescribed by a doctor (Vicodin, OxyContin, Percodan)	1	2	3	4	5

Other prescription medicines not prescribed by a doctor	1	2	3	4	5
Other illegal drug (such as heroin, cocaine, Ecstasy, PCP, downers, barbs)	1	2	3	4	5

FOSTER Interest Inventory

P. O. Box 493777 -- Redding, CA 96049
Phone (530) 241-5958 FAX (530 247-0915

What do you like to do in your free time? _____
_____
_____
_____
_____
_____
_____
_____

We would like to know in what activities you would like to participate. What sort of activities would you like to try if you have the chance?

We have only listed a few examples. Feel free to add your own ideas.

Team sports

- ☐ Baseball
- ☐ Basketball
- ☐ Football
- ☐ Soccer
- ☐ Volleyball
- ☐ Other_____

Individual sports

- ☐ Archery
- ☐ Bicycling
- ☐ Fishing
- ☐ Hiking
- ☐ Martial Arts *(examples: Karate, Judo)*
- ☐ Other_____

Leadership opportunities

- ☐ Boy Scouts/Girl Scouts
- ☐ Leadership Conferences
- ☐ Mentoring *(Friday Night Live, Plus One)*
- ☐ Student Government
- ☐ Volunteering *(examples: Turtle Bay, YMCA)*
- ☐ Other_____

The Arts

- ☐ Art classes *(examples: ceramics, music)*
- ☐ Dance
- ☐ Drama
- ☐ Riverfront Playhouse
- ☐ Video/music editing
- ☐ Other_____

School groups

- ☐ College Connection
- ☐ Peer counseling
- ☐ Debate team
- ☐ Job Shadowing
- ☐ Vocational Training
- ☐ Other_____

Other activities

- ☐ Astronomy Club
- ☐ Field trips *(Turtle Bay, Camping, Six Flags)*
- ☐ Fitness Center/Gyms
- ☐ Job Development classes/training
- ☐ JROTC
- ☐ Sierra Club
- ☐ Summer Camps
- ☐ Other_____

Courtesy of Shasta County
FOSTER Grant Program
DAP Referral to HIP

Date _____

Name _____ **Age** _____ **Gender** _____

Foster Parent/Caregiver _____

Phone # _____ **Unique Identifier** _____

_____ completed his/her initial interview on

_____ and is ready for you to call and schedule the DAP pre-assessment.

Items completed at the initial interview were:

	Circle one	
ATOD pre-survey	Yes	No
Parental Permission	Yes	No
Interest Inventory	Yes	No
Other _____		

Please let me know when you will administer the DAP.

Cindy Diezsi
Program Manager
FOSTER Grant
Shasta County Chemical People, Inc.
P.O. Box 493777
Redding, CA 96049
(530) 241-5958
(530) 247-0915
diezsiduo@charter.net
www.chemicalpeople.org

Courtesy of San Luis Obispo County

Appendix Item #3: SAFE Referral Form – Pre/Post

Dare To Be You Attendance Roster and Class Schedule 2004-2005

Counselor _____ School _____

Student Name	WEEK 1 D2BU Topic _____ Date:	WEEK 2 D2BUTopic _____ Date:	WEEK 3 D2BU Topic _____ Date:	WEEK 4 D2BU Topic _____ Date:	WEEK 5 D2BU Topic _____ Date:	WEEK 6 D2BU Topic _____ Date:	WEEK 7 D2BU Topic _____ Date:	WEEK 8 D2BU Topic _____ Date:
Notes								

Student Name	Referral Form/Pre-test	COA Indicators (please note)	Post-test	SAFE Documentation	NOTES

COA Indicators: Please mark the following numbers based on your observations and intervention.

1. Anxiety/Depression 2. Low Self-Esteem 3. Self-report of parental alcohol/drug abuse
4. Emotional outbursts (crying, etc.) 5. Fear of going to school, other fears 6. Isolation/lack of friends
7. Report of Nightmares 8. Poor academic performance 9. Other (please indicate)

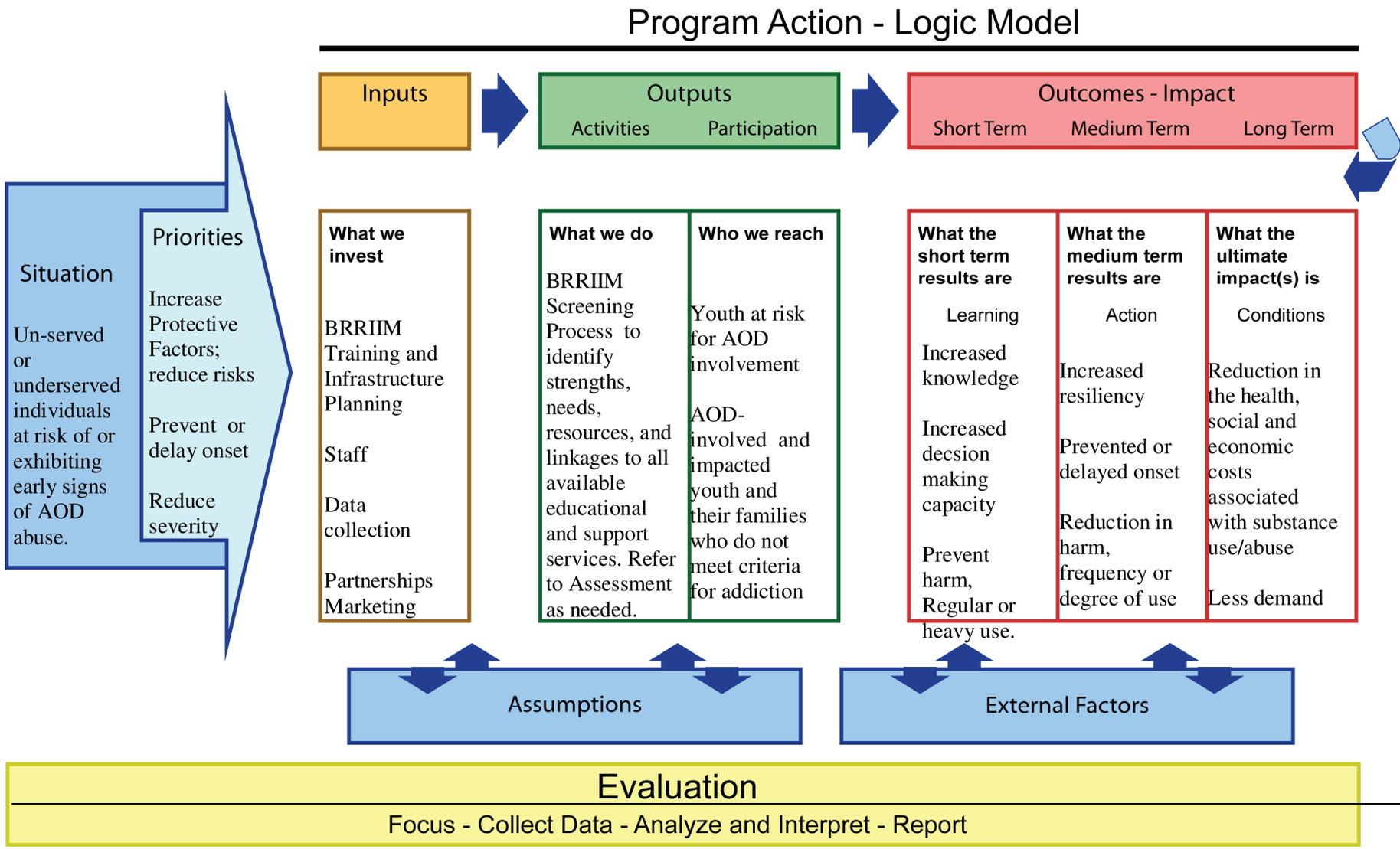
LOGIC MODELS

Courtesy of Riverside County

Jim Rothblatt and Jan Ryan Redleaf Resources Consulting and Training

BRIEF RISK REDUCTION INTERVIEW AND INTERVENTION MODEL (BRRIIM)

Indicated Prevention Planning – Implementation – Evaluation

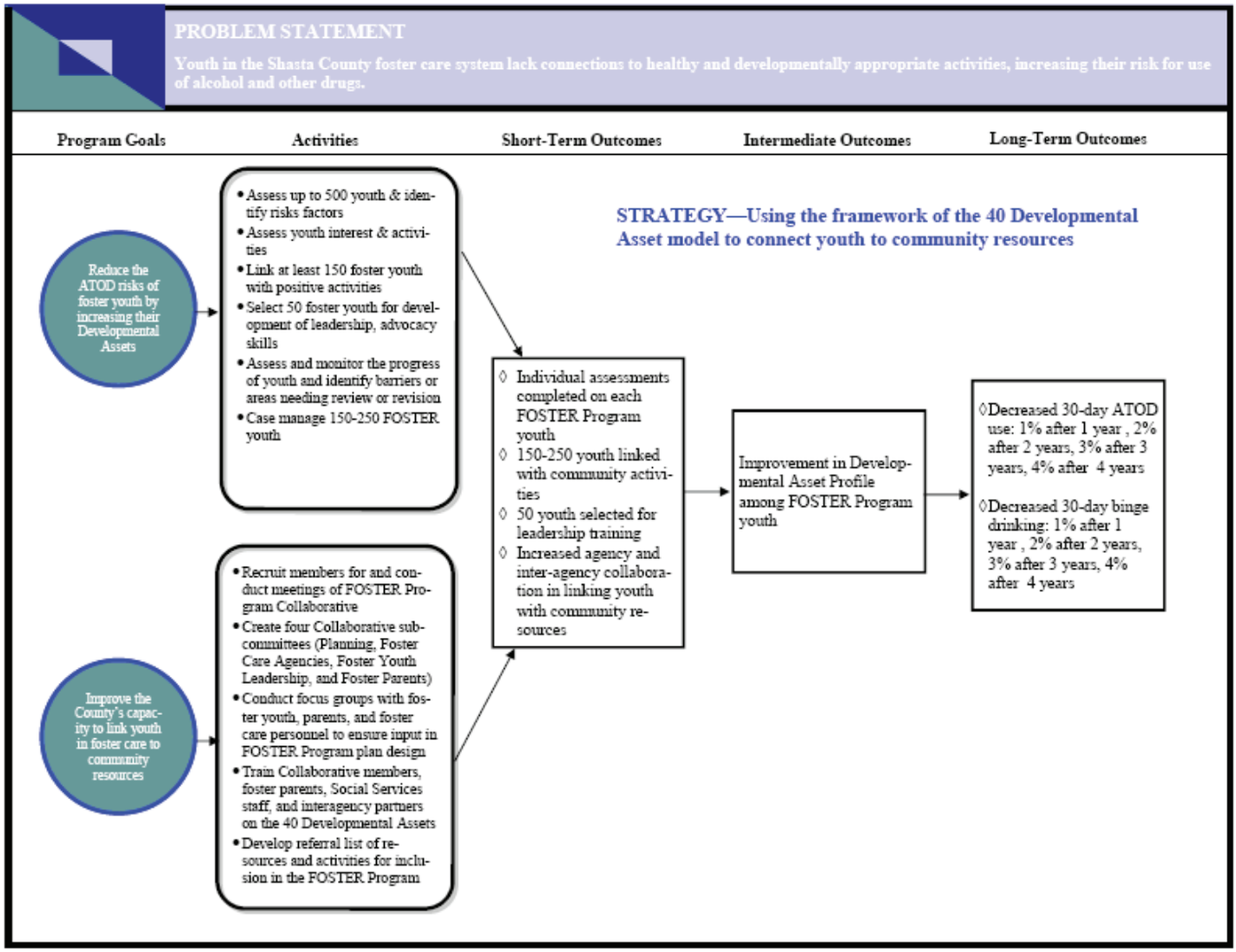


Logic Model

Identified Problem or Need (supported by data)	CONTRIBUTING FACTORS
Too many youth in St. Helena and Calistoga engage in high risk alcohol and drug use.	1. Lack of coordinated effort to prevent and intervene with students using alcohol and drugs 2. "Rite of passage" mentality that fails to recognize the risks associated with youth alcohol and drug use 3. Social norms favorable to alcohol use 4. Fragmented service delivery system that fails to proactively recognize, refer and follow up with students experiencing barriers to learning

GOAL (or Aim)	RESOURCES (What do we have to help meet our goal?)	STRATEGIES (What methods will we use?)	EXPECTED OUTCOMES (What do we think will happen as a result of our efforts?)			MEASUREMENT INDICATORS (Specifically, how will we know what happened?)
			SHORT- TERM (Year 1)	INTERMEDIATE (Years 2-4)	LONG-TERM (Year 5)	
Reduce the number of St. Helena and Calistoga students engaged in high risk alcohol and drug use.	Full support for school-based programs by the Boards of Trustees and administrators of CJUSD and SHUSD. Framework for Student Assistance Programs in place at both CJSHS and SHHS. Prevention and intervention programs	***Expand Student Assistance Programs:*** Provide a mechanism to refer and track students Market services to students, parents and community. Improve identification and screening Build school and community awareness of the problem of underage drinking and	Increase in number of students being connected to school and community based services. Increase in number of students referred for AOD screening. Formalization of referral systems and case management practices, including screening and follow-up School policies	***Students who participate in SAP will:*** Report decrease in alcohol, drug and tobacco use.	***Students who participate in SAP will report:*** Increased perception of risk. Reduction in alcohol and drug use in past 30 days. Reduction in alcohol and drug use frequency. Reduction in early onset of alcohol and drug use.	***For students who participate in SAP*** 65% of students will report moderate or great risk in binge drinking. 35% less students will report use of illegal substances in the last 30 days. 35% of students will report a reduction in alcohol and drug use frequency.

GOAL (or Aim)	RESOURCES (What do we have to help meet our goal?)	STRATEGIES (What methods will we use?)	EXPECTED OUTCOMES (What do we think will happen as a result of our efforts?)			MEASUREMENT INDICATORS (Specifically, how will we know what happened?)
			SHORT- TERM (Year 1)	INTERMEDIATE (Years 2-4)	LONG-TERM (Year 5)	
	at both school sites. Strong partnerships with community-based organizations to provide a broad range of services, including parenting education.	drug use Provide AOD screening, Brief Intervention and curriculum-based services. Link with community-based environmental prevention efforts	regarding AOD use are adopted, strengthened and enforced.	Decrease in suspension and disciplinary action rates pre/post participation. Improve school attendance pre/post participation.	Improvement in average reported grade point averages pre/post participation.	20% of students will improve their grade point averages 60% of students will incur no further disciplinary suspensions due to alcohol and drug violations 66% of students will improve their attendance
				Increase in number of students being connected to school and community based services.	Increase in number of students being connected to school and community based services.	80% of SAP students are referred to Wolfe Center for AOD screening. 85% of students referred to SAP are linked to a program or services.
				School-wide: Better understanding of prevention and intervention services among students, parents, school staff and community organizations.	***School-wide:*** School staff will be more aware of student support services and the impact of substance abuse on academics.	25% increase in number of teachers making referrals to the program. Key informant interviews will indicate better understanding of prevention and intervention services.
				Improvement in school connectedness.	Increases in developmental assets and school connectedness.	10% increase in developmental assets and school connectedness (CHKS)


PROBLEM STATEMENT
Youth in the Shasta County foster care system lack connections to healthy and developmentally appropriate activities, increasing their risk for use of alcohol and other drugs.
Program Goals
Activities
Short-Term Outcomes
Intermediate Outcomes
Long-Term Outcomes
STRATEGY—Using the framework of the 40 Developmental Asset model to connect youth to community resources
Reduce the ATOD risks of foster youth by increasing their Developmental Assets
• Assess up to 500 youth & identify risks factors
• Assess youth interest & activities
• Link at least 150 foster youth with positive activities
• Select 50 foster youth for development of leadership, advocacy skills
• Assess and monitor the progress of youth and identify barriers or areas needing review or revision
• Case manage 150-250 FOSTER youth
Improve the County's capacity to link youth in foster care to community resources
• Recruit members for and conduct meetings of FOSTER Program Collaborative
• Create four Collaborative subcommittees (Planning, Foster Care Agencies, Foster Youth Leadership, and Foster Parents)
• Conduct focus groups with foster youth, parents, and foster care personnel to ensure input in FOSTER Program plan design
• Train Collaborative members, foster parents, Social Services staff, and interagency partners on the 40 Developmental Assets
• Develop referral list of resources and activities for inclusion in the FOSTER Program
◊ Individual assessments completed on each FOSTER Program youth
◊ 150-250 youth linked with community activities
◊ 50 youth selected for leadership training
◊ Increased agency and inter-agency collaboration in linking youth with community resources
Improvement in Developmental Asset Profile among FOSTER Program youth
◊Decreased 30-day ATOD use: 1% after 1 year , 2% after 2 years, 3% after 3 years, 4% after 4 years
◊Decreased 30-day binge drinking: 1% after 1 year , 2% after 2 years, 3% after 3 years, 4% after 4 years

EVALUATION PLANS

County: NAPA

Project Name: NAPA COUNTY STUDENT ASSISTANCE PROGRAM

OBJECTIVE/ACTIVITY TO BE MEASURED	Reduce high-risk alcohol and drug use
MEASUREMENT INDICATORS How will we know if things have changed?	Increased number of students who have abstained from using alcohol and other drugs or reduced the severity of their substance use.
SUCCESS CRITERIA How much must things change for the program to be considered a success?	65% of program participants will report increased perceived harm regarding the risks associated with binge drinking. 35% decrease in number of program participants who report use of alcohol or drugs in the last 30 days. 35% of program participants will report a reduction in alcohol and drug use frequency.
METHOD OF MEASUREMENT Data collection tools.	Pre/Post Surveys
DATA SOURCES Where will you get your data?	Student Pre/Post Surveys
REPORTING How will you analyze your data? How often will data analysis occur?	Data will be analyzed by the Project Evaluator using appropriate statistical analysis tools. Data will be analyzed two times per year to determine progress towards outcomes and identify strategies for course correction.
DISSEMINATION How will information from the evaluation be provided as feedback and used to improve the program?	Evaluation reports will be reviewed with the SAP Core Teams to determine extent to which outcomes were achieved and to explore strategies for program improvement.

OBJECTIVE/ACTIVITY TO BE MEASURED	Improved academic achievement of SAP-referred students
MEASUREMENT INDICATORS How will we know if things have changed?	% of SAP-referred students who improve their grade point averages % of SAP student who incur no further disciplinary suspensions % of SAP-referred students who improve their attendance
SUCCESS CRITERIA How much must things change for the program to be considered a success?	20% of 6^{th}-10^{th} grade program participants will improve their grade point average 12-18 months following entry into SAP. 60% of program participants will incur no further suspensions or disciplinary actions due to alcohol and drug violations from

	semester prior to entry into SAP compared to 12-18 months following entry into SAP. 66% of program participants will improve their attendance from semester prior to entry into SAP compared to 12-18 months following entry into SAP. 25 % of 11th and 12th grade program participants who have credit deficiencies at program entry will report an increase in credit accumulation the full semester following program entry..
METHOD OF MEASUREMENT Data collection tools.	Flag program participants in district student information system.
DATA SOURCES Where will you get your data?	Student information system data flagged for program participants.
REPORTING How will you analyze your data? How often will data analysis occur?	Data will be analyzed by the Project Evaluator using appropriate statistical analysis tools. Data will be analyzed two times per year to determine progress towards outcomes and identify strategies for course correction.
DISSEMINATION How will information from the evaluation be provided as feedback and used to improve the program?	Evaluation reports will be reviewed with the SAP Core Teams to determine extent to which outcomes were achieved and to explore strategies for program improvement.

OBJECTIVE/ACTIVITY TO BE MEASURED	Better understanding of prevention and intervention services among school staff, students, parents and community members
MEASUREMENT INDICATORS How will we know if things have changed?	School staff will be more aware of student support services, utilize the service, and understand the impact of substance abuse on academics. Increase in developmental assets and school connectedness .
SUCCESS CRITERIA How much must things change for the program to be considered a success?	A majority of teaching staff will have referred students to SAP at the end of the five year funding period. Decrease in the number of students reporting low assets on Resiliency Module. Increase in staff satisfaction and improvements in school climate (Staff Survey)
METHOD OF MEASUREMENT Data collection tools.	Referral tracking form CHKS Resiliency Module CHKS Staff Survey

DATA SOURCES Where will you get your data?	SAP referral tracking forms CHKS Resiliency Module CHKS Staff Survey
REPORTING How will you analyze your data? How often will data analysis occur?	Data will be analyzed by the Project Evaluator using appropriate statistical analysis tools. Data will be analyzed once a year to determine progress towards outcomes and identify strategies for course correction.
DISSEMINATION How will information from the evaluation be provided as feedback and used to improve the program?	Evaluation reports will be reviewed with the SAP Core Teams to determine extent to which outcomes were achieved and to explore strategies for program improvement.

OBJECTIVE/ACTIVITY TO BE MEASURED	Formalization and implementation of referral systems and case management practices, including screening and follow-up.
MEASUREMENT INDICATORS How will we know if things have changed?	Increase in number of students being connected to school and community based services. Increase in number of students referred for AOD screening.
SUCCESS CRITERIA How much must things change for the program to be considered a success?	85% of students referred to SAP are linked to a program or services. .
METHOD OF MEASUREMENT Data collection tools.	Student information system.
DATA SOURCES Where will you get your data?	SAP referral and service tracking forms.
REPORTING How will you analyze your data? How often will data analysis occur?	Data will be analyzed by the Project Evaluator using appropriate statistical analysis tools. Data will be analyzed two times per year to determine progress towards outcomes and identify strategies for course correction.
DISSEMINATION How will information from the evaluation be provided as feedback and used to improve the program?	Evaluation reports will be reviewed with the SAP Core Teams to determine extent to which outcomes were achieved and to explore strategies for program improvement.

EVALUATION REPORTS

Courtesy of: San Luis Obispo County
EXCERPTED FROM: SDFSC Round 1 Evaluation Report

Excerpt begins mid-report:

Risk and Protective Factors

The most anticipated outcomes, amongst DAS staff and community stakeholders, are those demonstrating improvements in risk and protective factors. This SDFSC project was clear in its mission to address those perceptions, attitudes, and behaviors which both lead youth towards the negative consequences of substance use; and those which support young people in avoiding the risks altogether. FNL programs across the State have developed tools for measuring the impact of the program on youth participation, governance, and civic engagement. DAS saw this project as an opportunity to also monitor and document the impact programming had on youth's knowledge and beliefs about AOD; their resilience in avoiding AOD; and their actual alcohol and drug use.

Using three main tools; the California Healthy Kids Survey; the FNL Youth Participation Survey; and the SLO SDFSC Survey, DAS was able to measure the general population of youth being targeted (via randomized survey methods in CHKS, and the first round of SLO SDFSC Surveys), as well as those youth participating in FNL programs. As demonstrated earlier (Tables XX and XX), risk levels were assessed using these same tools to assure programming was appropriately targeting youth with elevated risk.

As part of the efforts to track progress, DAS also sought to measure indicators which aligned with the National Outcome Monitoring System (NOMS), and the Government Performance and Results Act (GPRA). These indicators included:

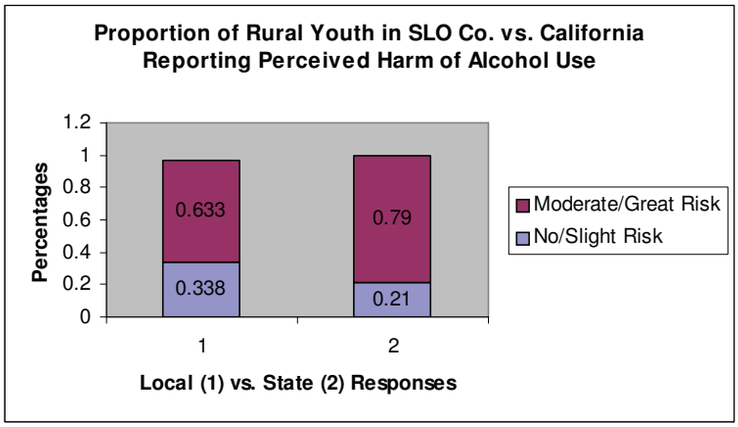
- Past 30-day use of AOD
- Perceived Harm of AOD
- Perception of Approval/Disapproval

The data collected indicates that the expansion of Friday Night Live Programs into the rural communities of San Luis Obispo County has had a positive impact on reducing risk and elevating protective factors. The following outcome results demonstrate significant improvements in the stated objectives.

Favorable Attitudes to Drug Use /Perceived Harm of AOD

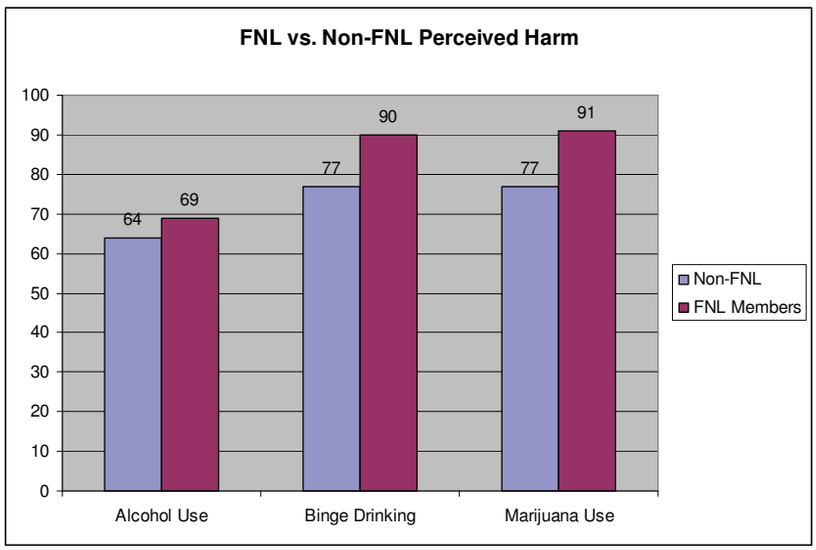
Perceived harm of alcohol and marijuana is an important measure in SLO County since in recent years the number of local youth who perceive alcohol and marijuana to be less harmful has grown while across the State that figure amongst youth has decreased. In the rural communities this trend has been more pronounced. In the first year of using the SLO SDFSC Survey in targeted rural schools, perceived harm of alcohol was significantly less amongst these youth.

Proportion of Rural Youth in SLO Co. vs. California Reporting Perceived Harm of Selected ATOD Use		
	SLO Co. Rural – Frequent Use of Alcohol (SLO SDFSC Survey 2004)	State youth – Frequent Use of Alcohol (CSS, 2004)
No/Slight Risk	.338	.210
Moderate/Great Risk	.633	.790



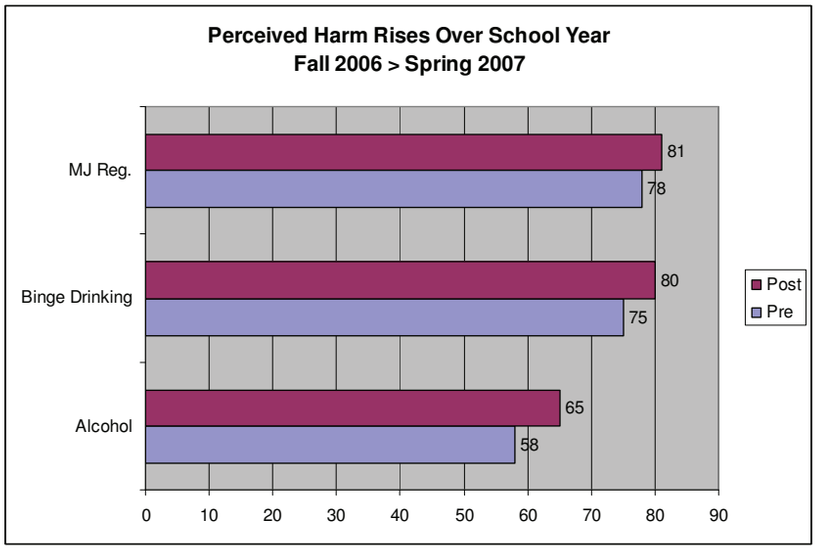
The results for marijuana were similar. In the most recent CHKS, however, there was some improvement. In San Miguel middle school youth reporting regular use of alcohol to be harmful increased from 56% in 2003 to 69% in 2005, while those viewing regular use of marijuana as harmful increased from 67% to 88%. This trend was also evident in Shandon 9th graders and Nipomo High School youth. However, each of these gains were still lower than the county averages per grade group.

Among FNL members the perceived harm of AOD is significantly higher. In a pre-post study using the same sample of youth in this past year, rural FNL youth demonstrated higher levels of perceived harm than non-FNL students.



2006-2007 SLO SDFSC Survey, 7th-12th grade youth, N = 213

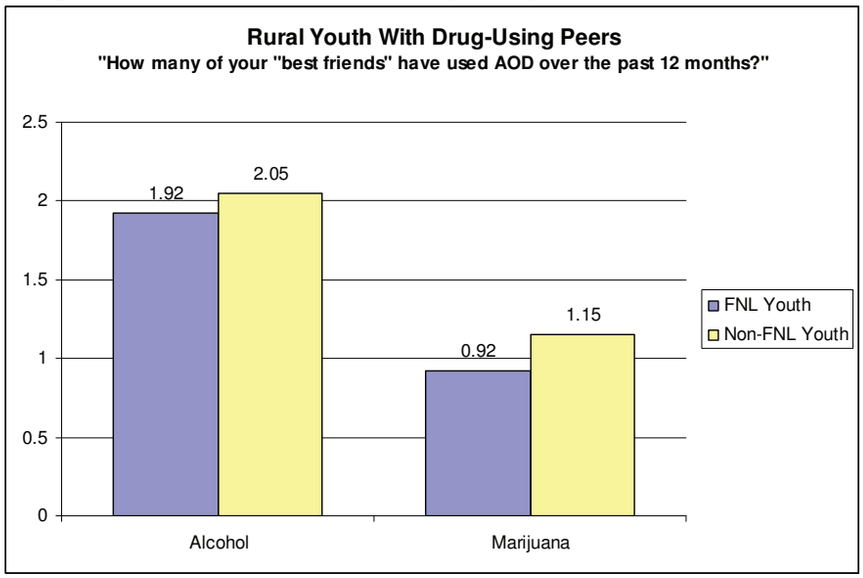
This pre-post examination also demonstrated that FNL presence on the rural campuses has had an impact on raising the perception of harm amongst the most commonly available and used drugs amongst local youth, alcohol and marijuana.



2006-2007 SLO SDFSC Survey, 7th-12th grade youth, N = 213

Association with Drug-Using Peers

Peer relationships are an important aspect of positive youth development, and the FNL program offers youth many opportunities to build meaningful relationships with peers in substance-free environments. Active FNL participants (75%) report that they have opportunities to get to know young people "different from themselves" and 87% report having the ability, through FNL, to do things with youth their age. Resilience skills are built, with 89% of youth reporting they are better at working in groups because of their active FNL participation.



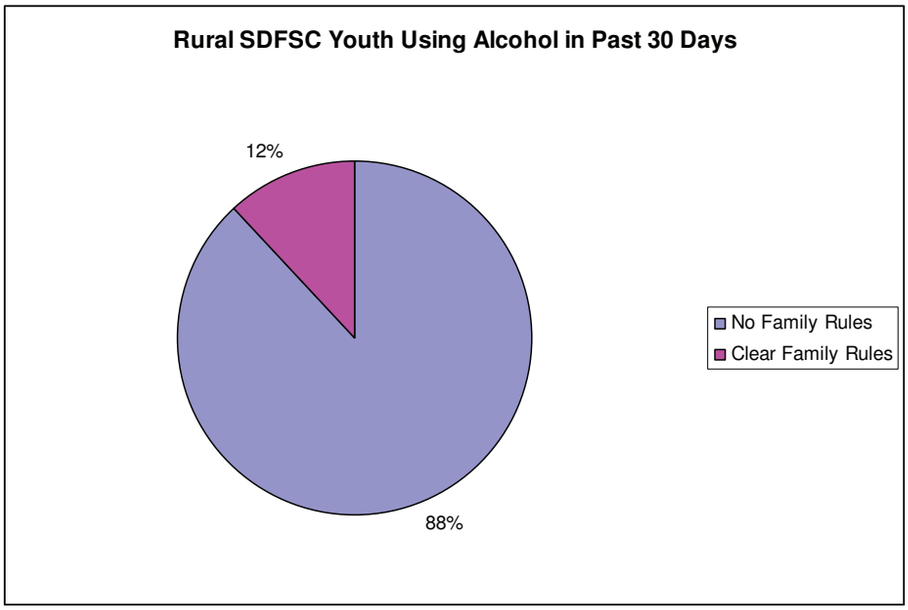
2006-2007 SLO SDFSC Survey, 7th-12th grade youth, N = 107

Using the pre-post method to determine if resilience skills built in FNL make a difference over time, the project demonstrates a positive relationship between those youth in FNL and their reduction of drug-using peers. FNL youth reduce their association with drug-using peers by an average of 31% over the course of the school year.

Family Drug Behavior/ Perception of Approval or Disapproval

To measure impacts on family AOD behavior far more complex examinations would be required than what was employed in this SDFSC project. However, surveys did indicate interesting correlations. For instance, 72% of youth in rural SDFSC sites reported, on average during the Fall pre-test period, knowing at least two adults who had used AOD to get drunk or high. This figure actually increased to 76% in the post-test period in the following Spring. However, for FNL youth this percentage actually decreased from 76% in Fall to 44% in the Spring. This may be attributable to these youth having better understandings of AOD use symptoms, a better grasp of realities versus perceptions as discussed in Chapter events, or information shared with FNL Youth is being processed at home.

Family rules are important factors in determining if youth are more inclined to be involved with AOD. In the SLO SDFSC Survey those youth with "clear rules about alcohol and drug use" in their families reported less AOD use than their peers without those guidelines.



2006-2007 SLO SDFSC Survey, 7th-12th grade youth, N = 175

FNL participants also report higher levels of family rules, and the figure increases during the school year. In the 2006-2007 survey, while 83% of non-FNL youth reported clear rules at home regarding AOD, 92% of FNL Youth did the same. That number grew to 94% by the end of the school year. These figures indicate a successful aspect of FNL programming is in its contact with parents through forums and trainings which outline effective parenting techniques.

Peer disapproval of substance use is measured bi-annually in the CHKS process. The rural youth in this project have typically reported lower peer disapproval than the rest of the County for substances including alcohol, tobacco, and marijuana. In this project the rate of parental disapproval was measured to both indicate risk, and to monitor whether programming was building youth and family capacity. Parental disapproval of alcohol use was slightly higher amongst FNL youth (76% of non-FNL reported their parents would consider it wrong to drink regularly, while 80% of FNL youth said the same). However, there was no difference between the groups when measuring parental disapproval of marijuana use, with both groups reporting 92% of the parents would disapprove.

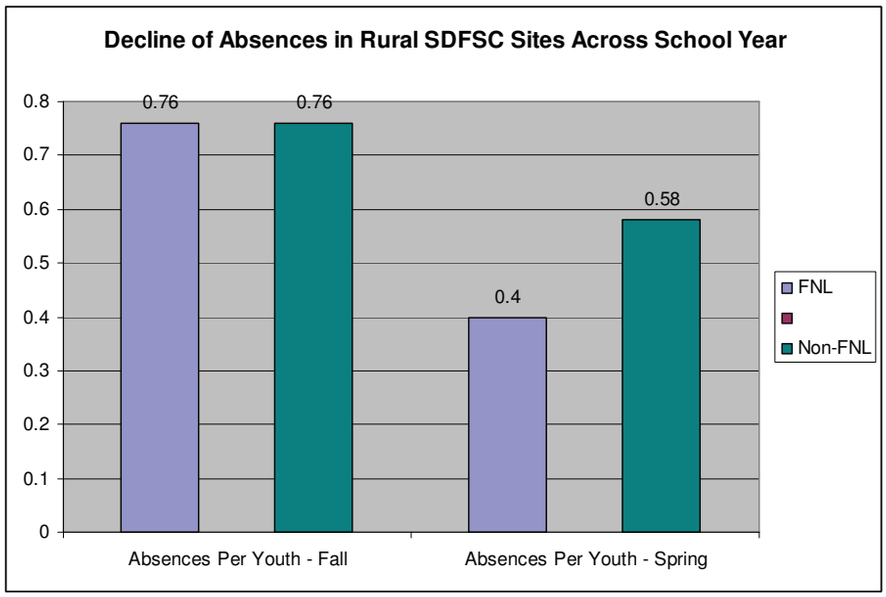
Lack of Bonding/Commitment to School

In measuring school outcomes, the project enlisted both survey responses from middle and high school youth, along with school faculty reports for elementary school youth in Years 2-4. The FNL Kids student outcomes for the 03-06 school years were conducted by surveying school faculty (primarily the counselors and FNL Advisors) to determine participant increases, decreases, and stabilizations of grades, attendance, and disciplinary referrals. The results indicate that:

- 92% of participants either maintained or increased grade performances.
- 100% of participants maintained good attendance, with 8% increasing, and 0 % decreasing.
- 91% of participants either maintained low disciplinary referrals, with 28% decreasing negative behavior referrals, and only 7% increasing.

The SLO SDFSC and FNL Student Participation surveys yielded results for middle and high school youth reporting their perceptions of school connectedness. For instance, 89% of FNL Youth in Fall reported feeling students in their school had "lots of chances to help decide things like class activities and rules." Only 62% of non-FNL youth reported the same. This figure increased during the school year to 95% of FNL youth reporting this level of meaningful participation, while the figure for non-FNL youth remained at 62%. This is an important outcome for FNL programs which seek to increase youth governance and voice in planning and implementing healthy activities.

Another indicator of improved school connectedness is in the reduction of absences among youth. The following chart demonstrates the average number of days missed amongst non-FNL youth versus the active FNL population in middle and high school. As is demonstrated here, one risk indicator which school personnel are trained to use when referring youth to FNL for participation is that of absenteeism. FNL has been successful in engaging youth in a way which encourages school bonding and places responsibilities on youth to be in attendance in order to participate in positive activities. As is clear from the following chart, the FNL youth miss significantly less days of school, as the school year progresses.



2006-2007 SLO SDFSC Survey, 7th-12th grade youth, N = 214

Courtesy of: San Luis Obispo County
EXCERPTED FROM: D2BU Evaluation Report 2007-2008

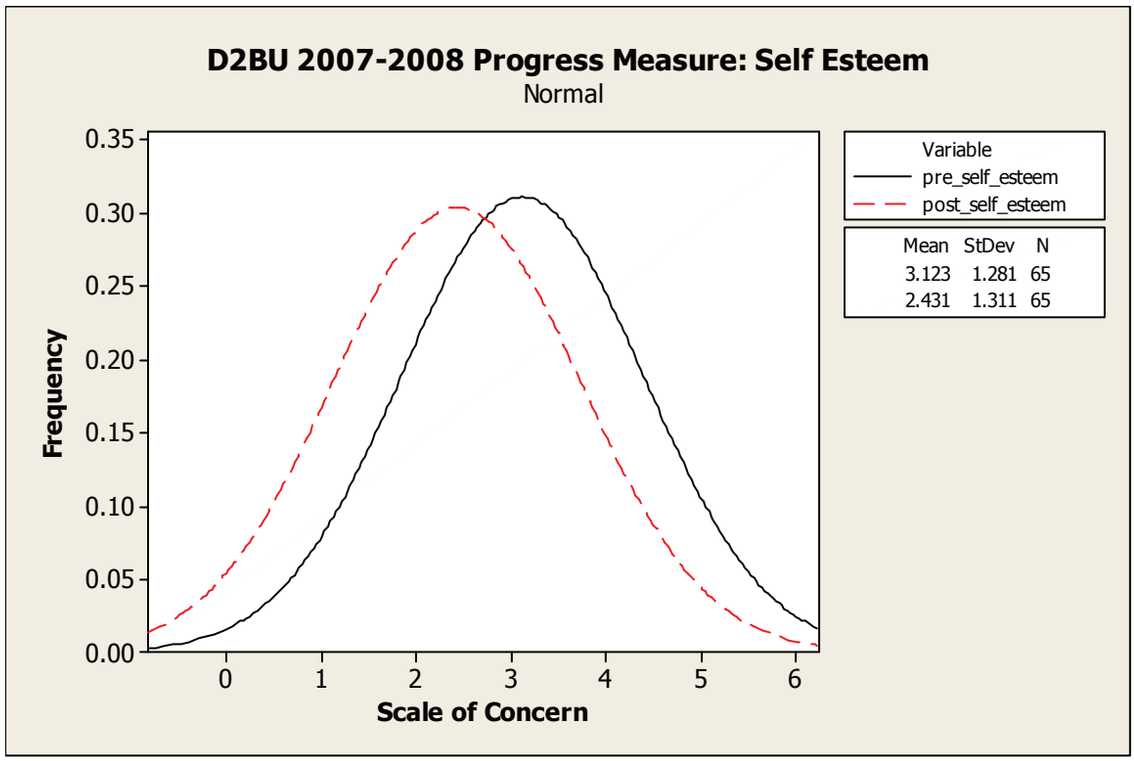
Appendix Item #1: D2BU Evaluation Report 2007-2008

Individual Pre and Post Risk Measures

Each referral form is used to conduct a pre-test measurement of child behavior and issues. The child's primary teacher or counselor completes these forms. The pre-post asks staff to assess the concern over a child's behavior/attitude using a scale of 0 = no concern to 5 = severe concern. The same staff person upon completion of the program completes these referral forms.

Mean total scores:

Variable	N*	Mean	StDev		N*	Mean	StDev
pre_self_esteem	65	3.123	1.281	post_self_esteem	65	2.431	1.311
pre_agressive	65	2.200	1.787	post_agressive	65	1.523	1.724
pre_peer_relation	65	3.077	1.493	post_peer_relation	65	2.415	1.580
pre_attendance	65	0.815	1.457	post_attendance	65	0.585	1.171
pre_withdrawn	65	1.862	1.657	post_withdrawn	65	1.323	1.371
pre_self_control	65	2.800	1.651	post_self_control	65	2.477	1.640



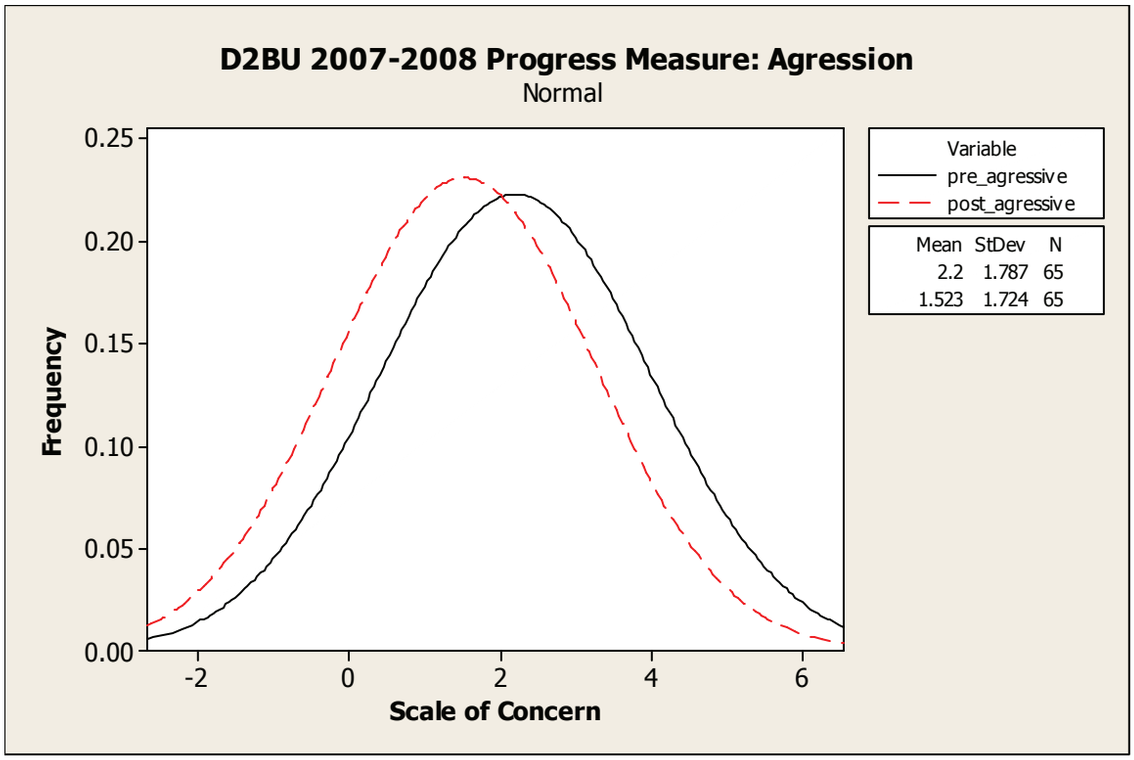
A.

pre_self_esteem 65 3.123 1.281 0.159
post_self_esteem 65 2.431 1.311 0.163
Difference 65 0.692 1.045 0.130
95% CI for mean difference: (0.433, 0.951)
T-Test of mean difference = 0 (vs not = 0): T-Value = 5.34 P-Value = 0.000

There was a 22% drop in the mean pre-post scores for concern over self-esteem. There is strong evidence to conclude that the reduction in concern was not due to randomness. There was a 33% drop in the number of youth rated as high concern (4,5) for self-esteem after participation in D2BU.

pre_self_esteem	Count	Percent	post_self_esteem	Count	Percent
0	3	4.62	0	7	10.77
1	5	7.69	1	8	12.31
2	10	15.38	2	14	21.54
3	16	24.62	3	26	40.00
4	25	38.46	4	6	9.23
5	6	9.23	5	4	6.15
N=	65		N=	65	

B.



	N	Mean	StDev	SE Mean
pre_agressive	65	2.200	1.787	0.222
post_agressive	65	1.523	1.724	0.214
Difference	65	0.677	1.062	0.132

95% CI for mean difference: (0.414, 0.940)
T-Test of mean difference = 0 (vs not = 0): T-Value = 5.14 P-Value = 0.000

There was a 30% drop in the mean pre-post scores for concern over aggressive behavior. There is strong evidence to conclude that the reduction in concern was not due to randomness. There was a 11% drop in the number of youth rated as high concern (4,5) for aggressive behavior after participation in D2BU.

pre_agressive	Count	Percent	post_agressive	Count	Percent
0	17	26.15	0	29	44.62
1	12	18.46	1	10	15.38

2	4	6.15	2	6	9.23
3	12	18.46	3	7	10.77
4	13	20.00	4	9	13.85
5	7	10.77	5	4	6.15
N=	65		N=	65	

Courtesy of: Napa County
EXCERPTED FROM: SDFSC 2008 Annual Report - Project Year One

Excerpts are from 2 different sections of the report:

II Target Population

A. Describe your strategies for targeting and recruiting your selected target population (High Rate Users/Binge Drinking; Children/Youth in Foster Care; Children/Youth of Substance-Abusing Parents/Guardians/Caregivers in Treatment)? *Describe any screening or recruitment tools that are utilized as well as any barriers to recruitment.*

SAP promotional information is available widely through the campuses in both communities. Teachers, administrators, students, and parents can refer youth for services. Students who are involved in disciplinary action are evaluated to SAP services and when drugs and alcohol are involved also referred to the Wolfe Center for screening and assessment. The programs are both experiencing a healthy volume of referrals and are facing the challenge of meeting all of the demands of their role as coordinator.

A. For each core component list the number of participants that have been recruited and the demographic characteristics of the participants (i.e., age, gender, and ethnicity). *Describe any changes to your target population from your initial proposal.*

The data presented below covers Year One which straddled two state fiscal years. The data is duplicative (not unique student contacts) since we did not set up our Cal OMS data entry for unique contacts. For Year Two we have changed the manner in which Cal OMS data is captured so we are able to calculate total contacts as well as unique student and parent contacts.

Service Component	Actual Implementation	Ethnicity	Age	Gender
Student Assistance Program Coordination - Calistoga	1930 contacts	White, Not Hispanic: 584 Asian American:10 Hispanic/Latino:1263 African American: 4 Multiracial:67	Under 5: 6 5-11: 14 12-14: 655 15-17: 510 26-44: 218 45-64: 144	Male: 884 Female: 1046

		Other: 2	Over 65: 2	
Student Assistance Program Coordination –St. Helena	556 contacts	White, Not Hispanic: 301 Hispanic/Latino:193 African American: 1 Multiracial:55 Hawaiian/Pacific: 6	5-11: 3 12-14: 144 15-17: 320 18-20: 8 26-44: 25 45-64: 56	Male: 280 Female: 274 Other: 2
AOD Screening	(08-09)94	White, Not Hispanic: 36 Hispanic/Latino:54 African American:2 Multiracial:2 Talk to Dolores about 07-08 data	5-11: 2 12-14: 60 15-17: 32	Male: 32 Female: 62
Brief Intervention	08-09	Multiracial: 2	15-17:2	Males:2
Project Toward No Drug Abuse and Helping Teens Overcome Alcohol, Marijuana and Other Drug Problems	08-09	Hispanic/Latino: 6	12-14: 5 15-17: 1	Male: 2 Female: 4

C. How are youth retention rates being tracked within each service component? To what extent are you tracking overlap in youth participation across the core program components?

We plan to track retention rates by keeping track of students' start and exit dates for each service, as well as number of contacts.

Excerpt 2:

V Lessons Learned

A. Describe what you have learned based on the results and outcomes you reported in Section IV and what, if any, programmatic or organizational changes you feel should be made to the project as a result of this new knowledge.

Through the initial implementation of the Student Assistance Program grant we have identified a number of programmatic and organizational issues that need to be addressed:

St. Helena

Bilingual staff to assist SAP Coordinator in working with limited English speaking families;

Administrative infrastructure to support program expansion including fund development;

Calistoga

Space to provide services

Calistoga and St. Helena

Clerical support to meet data and evaluation demands;

Funding to purchase student support services from providers;

Intern assistance to co-facilitate groups and assist with service delivery

OTHER RESOURCES

FOSTER Grant Referral Form

Contact – Cindy Diezsi, Program Manager
phone - 241-5958 fax - 247-0915
e-mail - diezsiduo@charter.net

Partners For A Drug-Free Community
THE CHEMICAL PEOPLE

(PLEASE PRINT) Date of Referral _____

Name of Shasta County Youth _____DOB _____

Name of current Caregiver/Placement provider _____

Home Address_____ City _____

Phone # _____ E-mail _____

Placement type: Relative _____ Non-related caretaker_____
County Foster Home_____ Foster Family Agency_____ Group Home_____

Name of Referring Party/Agency:
_____Signature_____

Phone # _____ E-mail _____

Name of Social Worker/Case Manager _____

Phone # _____ E-mail _____

Does this child have special needs? _____Yes (please explain) _____ No
_____
_____
_____

Court Services designation (please circle) FR PP Ward

Known Interests or Activities the youth might like or benefit from:
_____
_____
_____

How many other children in the family? _____Foster _____Biological

Please fax or e-mail completed form to Cindy Diezsi, Program Manager, FOSTER Grant

FAX 247-0915 E-mail diezsiduo@charter.net

Dear Parent or Foster Parent,

Your foster child has been selected to participate in the Foster Outreach Strengthened Through Empowerment and Resources (FOSTER) Program. This program is funded through the Safe and Drug Free Schools and Communities grant as part of the No Child Left Behind Act of 2001 and administered by Shasta County Chemical People.

Data will be collected on each foster youth electing to participate in the FOSTER Program. Data collected will include, but not be limited to, the following: school attendance, referrals, and grades, Developmental Asset Profile, law enforcement records, alcohol, tobacco, and other drug use surveys and an interest inventory. The data will be used to evaluate the FOSTER Program grant and make an overall determination of whether participation in the program increased Developmental Assets and positive outcomes among youth.

All information collected on your foster child will be kept confidential. The data will be maintained in a password-protected electronic database. Any paper records will be kept in a locked location and shredded when the evaluation is completed. The final results of this evaluation will not be shared on an individual child basis with any person or agency. All data will be reported on an aggregate basis only (not by individual) and shared internally in the Shasta County Health and Human Services Agency, with the Shasta County Chemical People, Health Improvement Partnership, and Youth Violence Prevention Council, and forwarded to the California Department of Alcohol and Drug Programs.

In the event that your foster child is matched with an activity, you agree to indemnify the Shasta County Chemical People and its staff or agents, release them from any and all claims and liability, and claim judgment and/or expenses that may incur arising out of your foster child's participation in this program.

You understand that your foster child's participation in this program, as with any program, contains certain dangers and risk of injury; that there will be both indoor and outdoor activities. You further understand that other participants may pose a danger to your foster child as there may be physical activities. You voluntarily accept all risks involved with your foster child's participation in the FOSTER grant program.

You recognize that Shasta County Chemical People and its agents are in no way liable or responsible for transportation to and from FOSTER activities.

You grant full permission to Shasta County Chemical People and its staff to use any audio or video recording or photographs of your foster child from all activities while participating in FOSTER activities without receiving any money in return.

I, _____, parent or caregiver of _____,
(please print) (please print)
give permission for my foster child to fully participate in the FOSTER Program. In addition, I authorize the collection of data on my foster child, as detailed above in this permission form, to evaluate the success of the FOSTER Program. This authorization gives all agencies and partners in the FOSTER Program permission to release data as needed to the evaluator for the FOSTER Program grant. I understand that all data will be kept confidential and I will not be provided with any data collected as part of my child's participation in the FOSTER Program. If I have any questions about the data being collected, I may contact Cindy Diezsi at Shasta County Chemical People at (530) 241-5958.

_____ _____
(signature) (date)

Partners For A Drug-Free Community
THE CHEMICAL PEOPLE

Partners For A Drug-Free Community
THE CHEMICAL PEOPLE

P. O. Box 493777
Redding, CA 96049
(530)241-5958

Talking points about data collection for FOSTER Program grant – for social workers or case managers only (Do not distribute to foster family)

- Evaluation is a required activity to receive the more than $1.2 million in grant funding, so data collection is vital to the success of that evaluation and future funding opportunities for foster kids
- Need a pre and post measurement of the level of Developmental Assets and risk taking behaviors
    - Will collect data from the child on 30-day alcohol, tobacco, and other drug use
    - Will administer survey to child to measure Developmental Asset level
    - Will collect data from Social Services/Social Worker on law enforcement problems and recidivism
    - Will collect data from Shasta County Office of Education on grades, school attendance, & school disciplinary records
    - Will track participation in the FOSTER Program
- The data collected on the child & other children will be analyzed to determine whether participation in the FOSTER Program increased assets and decreased risk taking behaviors
- Data is confidential and will not be reported to anyone other than the County evaluator with the child's name
- Reports will only include aggregated data and will not identify any child by name or in any way that a child can be identified
- Any reports will be shared within the Shasta County HHSA and with the FOSTER grant partners – Chemical People, Health Improvement Partnership, and Youth Violence Prevention Council, and forwarded to California Department of Alcohol and Drug Programs
- Parents will not be provided with data collected on their child
- Some youth will be asked to participate in meetings for the purpose of obtaining feedback and advice about the FOSTER program
- Youth may be asked to share orally or in written narrative form the impact of the grant and services provided
- Inform youth and adult that a representative of HIP will be contacting them about scheduling a time to complete the Developmental Asset Survey (DAP)

SHASTA COUNTY CHEMICAL PEOPLE - PARTNERS FOR A DRUG-FREE COMMUNITY

SAFE AND DRUG FREE SCHOOL AND COMMUNITIES PROGRAM

SAMPLE DATA Report

Asset Development

Event Date	Location	Event Title	Time	Males	Females	Asian	African American	Hispanic	Native American	Caucasian	Pacific Islander	Under 5	6-9	10-12	13-15	16-18	19-25	26-54	Over55
10/20/2008	Shasta College	Asset Development for Social Workers	180	7	12	2	1	4	1	11	0	0	0	0	0	2	10	5	2

Summary for 'Program' = Asset Development (1 detail record)

Sum	Males	Females	Asian	African American	Hispanic	Native American	Caucasian	Pacific Islander	Under 5	6 - 9	10-12	13-15	16-18	19-25	26-54	Over 55 Over 55
	7	12	2	1	4	1	11	0	0	0	0	0	2	10	5	2

Drug Education Class

Event Date	Location	Event Title	Time	Males	Females	Asian	African American	Hispanic	Native American	Caucasian	Pacific Islander	Under 5	6-9	10-12	13-15	16-18	19-25	26-54	Over55
10/7/2008	Juvenile Hall	Session #6	90	6	2	0	0	1	0	7	0	0	0	0	4	3	0	1	0
10/14/2008	Juvenile Hall	Session #7	90	6	2	0	0	0	0	8	0	0	0	0	4	3	0	0	1
10/21/2008	Juvenile Hall	Session #8	90	5	2	0	0	1	0	6	0	0	0	0	4	2	0	1	0
10/28/2008	Juvenile Hall	Session #9	90	6	2	0	0	1	0	7	0	0	0	0	4	3	0	1	0
11/4/2008	Juvenile Hall	Session #10	90	5	2	0	0	1	0	6	0	0	0	0	3	3	0	1	0
11/5/2008	Juvenile Hall	Session #1	90	5	1	0	0	2	0	4	0	0	0	0	1	4	0	1	0
11/9/2008	Juvenile Hall	Session #2	90	5	2	0	0	2	0	5	0	0	0	0	3	3	0	1	0
11/16/2008	Juvenile Hall	Session #3	90	4	3	0	0	1	0	6	0	0	0	0	2	4	0	0	1
11/24/2008	Juvenile Hall	Session #4	90	3	1	0	0	3	0	1	0	0	0	1	0	2	0	1	0

Summary for 'Program' = Drug Education Class (9 detail records)

	Males	Females	Asian	African American	Hispanic	Native American	Caucasian	Pacific Islander	Under 5	6 - 9	10-12	13-15	16-18	19-25	26-54	Over 55
Sum	45	17	0	0	12	0	50	0	0	0	1	25				

The Seven challenges program
Youth surveys

Applied Survey Research / County of Santa Cruz Alcohol and Drug Program

Informed Consent Form

The Santa Cruz County Alcohol and Drug Program is surveying youth, like yourself, who participate in The Seven Challenges Program both before (pre survey) and after (post survey) participation in the program in order to understand participants' attitudes and experiences with alcohol and other drugs. You will be asked questions about a variety of topics, including your thoughts and behavior related to alcohol, tobacco, and other drugs, and your view of the consequences of drinking and using drugs, and in the post survey, you will also be asked about your thoughts about The Seven Challenges Program. The survey will take about 15 minutes to complete. The survey is being conducted by Applied Survey Research, a local research firm, and is funded by the State of California Alcohol and Drug Program.

This is not a test, so there are no right or wrong answers. In this survey you will be asked some personal questions; however, you do not need to answer any questions that you don't want to. If you agree to participate in the survey, you can still stop the survey at any time. If you choose to stop taking the survey, please put it into the envelope provided to you, seal the envelope, and write "STOP" on the envelope.

All of your answers to the survey questions are completely confidential. Please do **not** write your name on the survey. Because you will be asked to complete this survey at the beginning and end of the program so we can see how you have changed over the program, we ask you to include your birth date, the first two initials of your first name, and the first three initials of your last name. This is only so that the research firm can match your two surveys to look for changes. The person who handed you this survey will not see your answers. All reports using this information will be summaries of the information and no one can be identified.

If you choose to complete the survey, please sign below and return the consent form to the staff person who handed it to you. All consent forms will be kept separate from the surveys. You will then be handed the survey. When you are finished with the survey, please put the survey into the envelope that was provided, and then seal the envelope. The staff person will collect only sealed envelopes.

If you have any questions, please call the researcher in charge of this project: Tracy Keenan at 831-728-1356 extension 22. If you would like someone to talk to about drugs or alcohol please visit our website at www.recoverywave.com for a list of resources or call 831-454-HELP or (4357).

I have read and understood the above information, and I voluntarily consent to participate in this project.

_____ _____

Signature **Date**

The Seven Challenges Program Survey
Intent for Non-Participation Form
2008-09 School Year

What is the purpose of the survey?
The purpose of The Seven Challenges Program surveys is to assess how well the program is working. A primary goal of the program is to reduce the use of alcohol, tobacco and other drugs by participants and other young people. The pre and post surveys ask students questions on a variety of topics, including their thoughts and behavior related to alcohol, tobacco, and other drugs, their view of the consequences of drinking and using drugs, and their thoughts about The Seven Challenges Program.

How does participating in the evaluation work?

Your child will fill out a survey at the beginning of the program and again at the end of the program, in order to see if there have been changes in their attitudes toward and use of alcohol, tobacco, and other drugs. The post survey will also include questions so that your child can provide feedback on their experiences in the program. It will take about 15 minutes to complete each survey. These surveys are completely voluntary, and your child's answers will be kept confidential.

Are there benefits associated with participation in the evaluation?
There are some benefits to your child's participation in the evaluation process. These include the opportunity for your child to provide feedback that can lead to program improvements for them and future program participants.

Is participation voluntary?

1. Yes, participation in the surveys is completely voluntary.
2. Your child may withdraw their participation at any time without loss of program benefits.
3. Your child may skip any question that he/she does not wish to answer.

Questions About Participating in the Surveys
If you have questions, please feel free to contact:

Tracy Keenan
Applied Survey Research
PO Box 1927
Watsonville, CA 95077
(831)-728-1356 Ext. 22

I have reviewed the information above and choose **NOT** to have my child participate in the surveys.

⇨SIGN ONLY IF YOU DO **NOT** WISH YOUR CHILD TO BE INVOLVED IN THE SURVEYS⇦

_____ _____
Parent/Guardian Signature Parent/Guardian Name (Please Print Name)

_____
Date

Courtesy of Santa Cruz County

Friday Night Live/Club Live Service to Science Survey – Spring 2007

Survey Administration Procedures

Purpose

This survey will help us measure how well FNL/CL helps young people. It includes questions about member's feelings and perceptions about a range of topics. It also has questions related to youth views of their school, their community, and ATOD use.

It is important that staff administering the survey follow specific procedures to ensure the confidentiality of member's answers and to encourage members to complete the survey thoughtfully and honestly. Youths must work by themselves on this survey.

Procedures

1. Assemble youth in a quiet and private environment to take the survey. Make sure youths have space between them so they have privacy as they fill out the survey. If possible, provide drinks and snacks.

2. **Clearly PRINT the youth names** on the Sign-In sheet provided in your survey envelope. After all youth are signed in, distribute the surveys (make sure the survey number on the envelope corresponds to the Sign-In sheet number next to each youth name.)

3. Explain the purpose of the survey and the key topics it will cover and the response categories that will be used. (Here is an introduction to use.)

-This survey will help us understand how members think and feel about some different topics that are important to youth. It will also help us understand how well FNL/CL helps young people.

-The survey includes questions about your feelings and perceptions about things such as life skills, school, friends, and the community. It also has questions related to your views about alcohol and drugs. Answering the questions is voluntary; and you do not have to answer any question that makes you uncomfortable. It is important that you know that we don't ask for your name and that your name will never be used. All of your answers will be strictly confidential, so please answer as honestly as you can.

-The survey will take about 15 to 20 minutes to complete. It is important that you circle only one answer for each question. Please raise your hand if you need more information or don't understand a question.

If youth notice that they are receiving numbered envelopes that correlate with the sign-in sheet, please tell them the following:

- You are correct; the sign-in sheet does correlate to the survey envelope you have received. This is because we have members take this survey at the beginning of the year and at the end so we can see if members feelings, perceptions, views or life skills have changed at all. In order to track changes the evaluators assign each survey a code number, by assigning each member a code number at the beginning they can compare that member's fall survey with their spring survey to see if there were any changes. Only the data entry person will open the envelope and be able to see the sign in sheet with your name and your specific survey. As they will be inputting about 500 surveys they only use the sign in sheet to match surveys not to identify the survey taker.

Be sure to seal your envelope.

4. Hand out the survey and envelope and review the response categories and how to mark their answers. Tell them to seal the confidential envelope after they have put their survey inside and return it to the staff person. Be sure that youth work by themselves.

5. **PLEASE OBSERVE STRICT CONFIDENTIALITY PROCEDURES AND ASSURE YOUTH THAT THEIR SURVEYS WILL NEVER BE SEEN BY ANY STAFF AND TO FILL IT OUT AS HONESTLY AS THEY CAN.**

6. *Take notes on the back of this sheet re: questions that tend to be unclear to youth and any other issues or concerns that come up as you administer the survey. This will help as we make revisions*. Return your notes to your supervisor.

Thanks for your assistance!!

The Seven Challenges

Year: 2 Quarter: ___Oct-Dec. __Jan-Mar __Apr.-June __ July-Sept.

Site: __ Harbor __ Santa Cruz __Soquel __ COE ___ Other: _____

Completed by: _____

☐ 1) # suspensions this Quarter

☐ 2) # Referrals

Asst. Principal		Counselor	
Self		SAP	
Counselor		Parent	
Other			

☐ 3) # Initial Contacts

Students

Date	Number

☐ 4) # Initial Contacts

Parents/Guardians

Date	Number

The Seven Challenges

☐ 5) # Screenings/Assesments

CRAFFT	OTHER

☐ 6) # Seven Challenges Referrals

☐ 7) # Other Referrals

Prevention		Academic		
Treatment		Alt. Ed.		
Counseling		Basic Needs		I.e. food/ shelter
Medical		Other		Please list type: _____

☐ 8) #'s The Seven Challenges Groups

Date	Number Attended

Date	Number Attended

Date	Number Atten

☐ 9) # Follow Up Contacts

☐ 10) # Follow Up Contacts

The Seven Challenges

Students

Date	Number

Parents/Guardians

Date	Number

☐ **11) Type of Follow Up Resources Provided**

Students

#'s	Type
	Youth Services
	Counseling
	Treatment
	12 Step Program
	Social Services
	Academic
	Other (identify) _____
	Other (identify) _____

Parents

#'s	Type
	Parent Class
	Counseling
	Treatment
	12 Step Prog.
	Social Services
	Academic
	Other (identify) _____
	Other (identify) _____

☐ **12) # of Students Tranferring**

Comprehensive School	
Alternative School	
Private School	
Independent Study	
Left School	
Other	

Identify: _____

Santa Cruz City Schools

Office of Student Services

Student/Family Contract: Tobacco and Substance

School: _____ Date of incident: _____

Student Name: _____ Grade: _____ Gender: _____

Person Referring _____ Contact Phone #_____

SUBSTANCE OF CONCERN

_____ Tobacco ____Alcohol ____ Other Drug : _____

___ Youth Services Consent Signed ___ Student/Family Contract Signed ___ Youth Survey Opt Out Form
(Only if parent declines participation)

Parent Notification Date:_____

Student Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date:_____

INTERVENTION

TO BE COMPLETED BY STUDENT SUPPORT SERVICES STAFF

____The Seven Challenges ____Youth Services DMC ____ SAP ____ CRAFFT/Screening

____ Athletics/Extracurricular Contact ____ Special Ed ____ Parent Education

Other:_____

____ Follow-up with student:_____

Dates/hours attended ____/_____ ____/_____ ___/_____ ____/_____ ____/_____

____ Contract Completed ____ Contract Not Completed

Action Taken_____

_____ Date: _____
Signature to authorize student's completion of program

STUDENT ASSISTANCE PROGRAM MANUAL

A Project Information, Data Collection, and Data Entry Guide

NAPA COUNTY HEALTH AND HUMAN SERVICES

November 2008

A Safe and Drug-free Schools and Communities Grant Project
Funded by California Department of Alcohol and Drug Programs

COMPREHENSIVE STUDENT ASSISTANCE PROGRAM

MISSION STATEMENT

The Student Assistance Program will provide a systematic process to identify, refer, access, educate and support students who exhibit behaviors that interfere with the learning process and healthy development.

PURPOSE

The purpose of the SAP is to improve the quality of education and the school environment, and to provide assistance to students who may be experiencing physical, safety, social, medical, familial, or alcohol, tobacco, and other drug-use issues.

SAP GOALS AND OBJECTIVES

GOAL 1- Reduce high-risk alcohol and drug use

Objectives

1. 65% of program participants will report increased perceived harm regarding the risks associated with binge drinking.

2. 35% of program participants will report a reduction in use of alcohol or drugs in the last 30 days.

3. 35% of program participants will report a reduction in alcohol and drug use frequency.

GOAL 2- Improve academic achievement among SAP-referred students

Objectives

1. 20% of 6th-10th grade program participants will improve their grade point average 12-18 months following entry into SAP.

2. 60% of program participants will incur no further suspensions or disciplinary actions from semester prior to entry into SAP compared to 12-18 months following entry into SAP.

3. 66% of program participants will improve their attendance from semester prior to entry into SAP compared to 12-18 months following entry into SAP.

4. 25 % of 11th and 12th grade program participants who have credit deficiencies at program entry will report an increase in credit accumulation the full semester following program entry.

GOAL 3- Promote a better understanding of prevention and intervention services among school staff, students, parents, and community members.

Objectives

1. Teaching staff will have referred students to SAP at the end of the five year funding period.

2. Decrease in the number of students reporting low assets on Resiliency Module of CHKS survey.

3. Increase in staff satisfaction and improvements in school climate on Staff CHKS Survey.

GOAL 4- Formalization of referral systems and case management practices, including screening and follow-up.

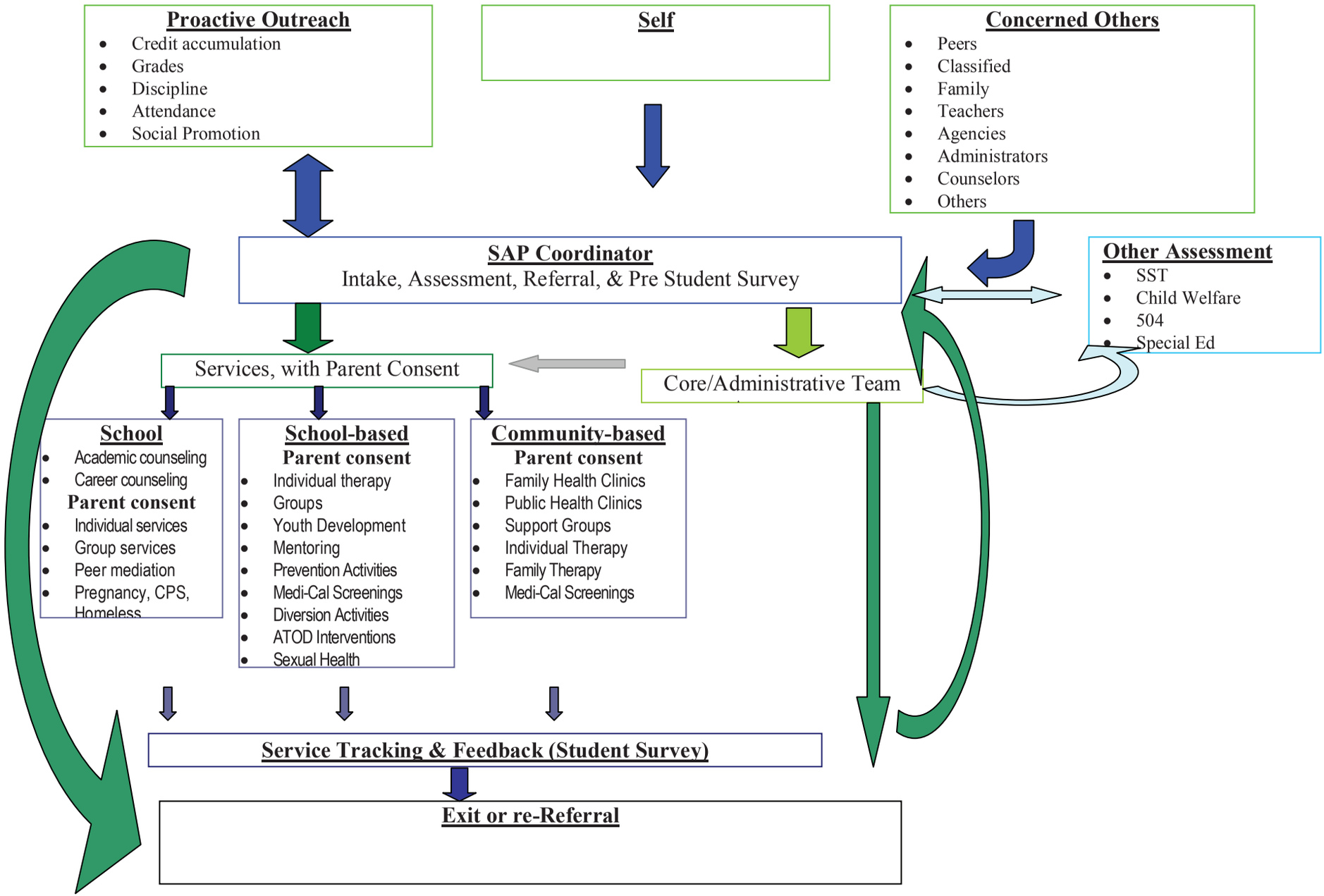
Objectives

1. 85% of students referred to SAP will be linked to a program or services.

SAP SITE COORDINATOR ASSIGNMENTS

- Coordinate the Student Assistance Program (SAP) on campus
- Coordinate site staff development on conflict resolution, violence prevention, and alcohol, tobacco, and other drug prevention/intervention, etc.
- Coordinate support groups, individual counseling, and/or connect students to other service providers
- Coordinate the collection of all evaluation data
- Participate in the SAP Team Meetings with other Site Coordinators, to review program progress and make recommendations for improvements

SAP FLOWCHART



INTRODUCTION TO DATA COLLECTION

The basic principles for SAP teams to consider when reviewing and redesigning the information gathering process are:

- It is the right and the responsibility of the school district to continuously monitor the behavior of its students in order to provide a safe learning environment and to protect their health, safety, and welfare.
- The parental perspective on what may be contributing to their child's behavior and performance at school is essential to the SAP process and parental input should be sought as early as possible.
- The collection of information from school staff and its retention and maintenance have implications for a school's records policies and procedures. These should be reviewed as outlined in the Family Educational Rights and Privacy Act (FERPA), California State Board of Education Regulations on Pupil Records, the Protection of Pupil Rights (PPRA), and the Health Insurance Portability and Accountability Act (HIPAA).
- Assisting the student and his/her family in overcoming the barriers to learning is the primary objective of SAP. This parameter should be used in determining the appropriateness of any **observable** information that is collected in the school setting and the accompanying information collection forms.
- Information may be shared with other staff and others within the school district that have a **legitimate educational interest,** but dissemination of the information to other school districts or outside agencies must comply with the parental consent requirements outlined in FERPA.
- Remember, the following rules for data collection should apply: use observable behaviors and be cautious of the use of statements requiring judgment; eliminate hearsay and innuendos.
- Keep in mind that parents have the right to review all individual forms collected in this process, including the forms completed by teachers and staff. Because SAP records are student records, the maintenance of these forms is governed by school district policy and applicable laws.

DATA COLLECTION OVERVIEW

1. SAP CONFIDENTIAL REFERRAL FORM—complete <u>before</u> each student's assessment
Site staff, administrators, parents and other concerned persons will utilize this form when they wish to make a referral to the SAP program office.

2. SAP STUDENT INTERVENTION PLAN—complete <u>at the time</u> a meeting the confidential referral is reviewed
This form will be utilized as the "minutes" or history of the planning process and/or screening meeting, and the plan of action developed for the student. This form also includes student consent for SAP services.

3. SAP PARENT PERMISSION FORM—attempt to obtain after the SAP Coordinator's preliminary assessment and <u>before services</u> are provided to encourage parent participation
However, services will not be denied to any student who does not obtain parental consent. The parent permission form may be kept in the case file.

4. SAP CONSENT TO SHARE INFORMATION FORM—complete after the SAP Coordinator's preliminary assessment and <u>before services</u> are provided
Both the client and parent complete this form. The consent form may be kept in the case file.

5. SAP SERVICE TRACKING—complete <u>at the time of service</u> provision
Each service provider will track every time the service is provided and give data to the SAP Coordinator. The data will be retained in the school student information system, reviewed by the SAP Coordinator, and reframed to share as feedback with the referring party, Site Core Team, and program evaluators (with no names and a unique identifier).

6. SAP STUDENT SURVEY—complete a pre-test at the time a student enters the program, and a post-test at the end of the program, or the end of the school year
Students participating in alcohol and/or drug services will complete a student survey at intake (pretest) and at the exit of services (posttest).

HOW STUDENTS ARE REFERRED

SAP CONFIDENTIAL REFERRAL FORM—complete before each student's assessment
Site staff, administrators, parents and other concerned persons will utilize this form when they wish to make a referral to the SAP program office.

Who can refer and how? Referrals can be received from students, including self referrals, teachers, principal or vice principals, counselors, classified staff, nurses, School Resource Officers, coaches, other schools, district level staff, agencies, SART, peer leaders, parents, and/or campus supervisors. **All referrals** will need to be completed by **generating the Referral Form** to begin the SAP process. Paper copies of the initial referral form will be available in the SAP office.

What happens after referrals are made? The SAP Coordinator will review the referral and make the determination of the next steps, including **attempting to obtain parent permission** for services, and (as needed) a formal referral to the Site Core Team to collectively generate a recommendation for services.

Who is on the Site Core Team? The Site Core Team composition may vary by site, by rotation, and by selection. A typical team can consist of: the nurse, school psychologist, counselor, speech therapist, social worker, some teachers, a vice principal, academic advisor, community liaison, service providers, a representative from Child Welfare Services and/or Health and Human Services, and parent/guardians. The child may also be invited to attend.

How often does the Site Core Team meet? The SAP Coordinator will determine the meeting schedule, but typically the meetings will be held **every other week**, either during lunch or before or after school. Meeting length will be determined by the number of referrals to be reviewed, but typically each case will be reviewed for a period of 15-30 minutes in duration.

HOW STUDENTS ACCESS SERVICES

SAP STUDENT INTERVENTION PLAN—complete at the time a meeting is held to review the confidential referral
This form will be utilized as the "minutes" or history of the planning process and/or screening meeting, and the plan of action developed for the student. This form also includes student consent for SAP services.

When and by whom is the screening accomplished? The SAP Coordinator or Support Staff member will record the date of the preliminary individual assessment done by the SAP Coordinator, and also the date and attendance of Site Core Team members (selected as stated above) at the meetings; all members in attendance will sign the recommendation form.

How are program referrals made? The team will review program options available to assist the student, and will select the one(s) that they believe will be most helpful in creating a successful outcome for the student. For campus-based services, the SAP Coordinator or Support Staff member will contact the site lead responsible for the planned prevention/intervention activity and confirm availability for the student to participate. For services to be provided by an outside agency, the Coordinator or Support Staff member will contact the outside agency staff member and make initial service arrangements.

How will students be notified about service plans? The SAP Coordinator or Support Staff member or service provider will arrange the time, day, and place for the meetings and will contact the student and give him/her the participation details.

Where do services occur? Most services will occur on campus; however, if necessary, some referrals will be sent outside to partnering agencies to provide school or community-based services that are better able to support the student.

HOW PARENTS ARE INFORMED

SAP PARENT PERMISSION FORM—attempt to obtain parental permission after the SAP Coordinator's preliminary assessment and before services are provided to encourage parent participation. Services will not be denied to any student who does not obtain parental consent.

SAP CONSENT TO SHARE INFORMATION FORM—must be completed by the student to authorize the sharing of SAP information among agencies and/or persons. This form must be completed by the parent to authorize the sharing of school records.

The parent permission form and consent to share information form may both be kept in the case file.

How are parents initially informed? After the initial screening by the SAP Coordinator, the SAP Coordinator will attempt to contact parents and get at least a verbal consent for the student to enter the SAP program. In some cases, parents will be requested to attend the team assessment meeting. Then a letter will also be given to the parents or guardians, requesting written permission for their son/daughter to participate. The SAP office will provide the letter if the services are to be given by school/SAP personnel. The outside service provider will generate the letter for school-based or community-based services. As stated above, effort will be made to obtain parent permission but students will be provided to all students that consent to receive services. However, parent permission must be obtained if students will receive services during class time.

How will they receive further information? (To be determined) At semester intervals, or at the end of the services, an additional message (letter or email) will be sent to parent(s) to share levels of attendance in program activities, and to request an additional meeting, if deemed necessary.

HOW SERVICES TO STUDENTS ARE TRACKED

SAP SERVICE TRACKING FORM—complete at the time of service provision
Each service provider will track every time the service is provided and give data to the SAP Coordinator. The data will be retained in the school student information system, reviewed by the SAP Coordinator, and reframed to share as feedback with the referring party, Site Core Team, and program evaluators (with no names and a unique identifier).

What types of services are accessed though the SAP? An array of services will be reviewed and one or more chosen by the SAP Coordinator and Site Core Team to meet student needs.

Who records participation in various activities? The designated program leader or service provider will be in charge of tracking student attendance and/or participation in activities. This person will need to **send participation records to the SAP Coordinator on a monthly basis**. The SAP Coordinator will then enter the information into the student information system.

HOW STUDENT PROGRESS IS ASSESSED

SAP STUDENT SURVEY— complete a pre-test at the time a student enters the program, and a post-test at the end of the program, or the end of the school year
Students participating in alcohol and/or drug services will complete a student survey at intake (pretest) and at the exit of services (posttest).

Alcohol and/or drug services providers will administer the student survey at the pretest and posttest, which assesses drug and alcohol use, as well as attitudes and feelings surrounding drugs and alcohol.

How will student survey be handled confidentially? At the time the student is given the measure to complete, they will also be given an envelope to put their responses in and to seal. When the student returns the envelope, the person monitoring the session will record the seven digit **district identification number** on the outside of the envelope and mail it to DUERR Evaluation Resources for processing at 55 Hanover Lane, Chico, CA 95973. Preferably, a set of several envelopes will be sent at once to save on postage.

What other information will be monitored? In addition, grades, attendance, CST scores, credit attainment, etc., will be monitored for students participating in the SAP program at the end of each semester. Through administration of the California Healthy Kids Survey other information regarding safety, violence, gang involvement, levels of substance use, perceived levels of meaningful participation at school, and other mental health-related general student population indicators will also be monitored and reported.

STUDENT ASSISTANCE PROGRAM

REFERRAL FORM

I am concerned about the following student/friend/self _____ Grade _____

CONCERNS (Please specify in comments section)

- ❑ Academic
- ❑ Attendance
- ❑ Peer Conflict
- ❑ Disruptive Behavior
- ❑ Loss / Separation / Grief
- ❑ Gang Affiliation
- ❑ Substance Use / Abuse
- ❑ Social Involvement & Support
- ❑ Hygiene
- ❑ Health
- ❑ Vision/Hearing
- ❑ Dental
- ❑ Home Environment
- ❑ Other Relational Conflict
- ❑ Other:

Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____

You are:

- ❑ Self
- ❑ Peer
- ❑ Parent
- ❑ Teacher
- ❑ Staff
- ❑ Administration
- ❑ Counselor
- ❑ Other:

Does this student know he or she is being referred to the *Student Assistance Program*? o Yes o No

Person referring: _____ Date: _____
erson referring: _____ Date: _____

PLEASE RETURN THIS FORM TO THE *STUDENT ASSISTANCE PROGRAM* BOX

PARENTAL CONSENT FOR REFERRAL

o **By Phone** o **In Person: Signature** _____ **Date:** _____

Permanent District Identification Number: __ __ __ __ __ __

STUDENT ASSISTANCE PROGRAM

STUDENT INTERVENTION PLAN (SIP)

Name of Student being Referred: _____ Date: _____

Referred by: _____ Relationship to Student: o Self o Teacher o Peer o Staff o Parent o Admin o Counselor o Other: _____

Date of Parent Notification: _____

Parent Comments:

Reason for Referral:

- ❑ Academic
- ❑ Attendance
- ❑ Peer Conflict
- ❑ Disruptive Behavior
- ❑ Loss / Separation / Grief
- ❑ Gang Affiliation
- ❑ Substance Use / Abuse
- ❑ Social Involvement & Support
- ❑ Hygiene
- ❑ Health
- ❑ Vision/Hearing
- ❑ Dental
- ❑ Home Environment
- ❑ Other Relational Conflict
- ❑ Other: _____

Please Explain:

What's Going Right:

Comments:

Intervention Strategies:

See Back of Page

Follow-up Recommendations:

Recommendation made by: o Parent o Student o Admin o Agency Rep. o SAP Staff

INTERVENTION STRATEGIES

Service Type	**Service Plan Status** Check all that apply 1	2	3	4	5	**Person/Agency Responsible**	Referral Date	Check-in Date	Completion Date
Housing:	o	o	o	o	o	_____	/ /	/ /	/ /
Child Care:	o	o	o	o	o	_____	/ /	/ /	/ /
Vocational:	o	o	o	o	o	_____	/ /	/ /	/ /
Employment:	o	o	o	o	o	_____	/ /	/ /	/ /
Basic Needs:	o	o	o	o	o	_____	/ /	/ /	/ /
Transport:	o	o	o	o	o	_____	/ /	/ /	/ /
AODT:	o	o	o	o	o	_____	/ /	/ /	/ /
Legal:	o	o	o	o	o	_____	/ /	/ /	/ /
Mental Health:	o	o	o	o	o	_____	/ /	/ /	/ /
Phys. Health:	o	o	o	o	o	_____	/ /	/ /	/ /
Family/Social:	o	o	o	o	o	_____	/ /	/ /	/ /
Life Skills:	o	o	o	o	o	_____	/ /	/ /	/ /
Other_____:	o	o	o	o	o	_____	/ /	/ /	/ /
Other_____:	o	o	o	o	o	_____	/ /	/ /	/ /

Please list any other Service Type(s):

_____

Service Plan Status Definitions (from 1-5 Scale seen above)
1 = Not a Need
2 = Client Refused Service
3 = Service not Available
4 = In Service, but with other Case Manager
5 = Will Begin Service

I give my consent to receive SAP services.

Client Signature_____ Date_____

CALISTOGA JOINT UNIFIED SCHOOL DISTRICT

STUDENT ASSISTANCE PROGRAM

Dear Parent/Guardian:

Your child has been referred for additional support services. Students referred receive an initial assessment and, if appropriate, are invited to participate in individual or group counseling facilitated by a trained and experienced adult. The goal of these services is to help students identify ways to address problems constructively and identify positive, achievable goals that are appropriate for their age and developmental level.

Individual and group counseling meetings occur weekly during lunch or one period. Students will be excused for a class absence and are expected to make up any work missed. All counseling is confidential. In the event of any life threatening information is disclosed, it will be reported to appropriate authorities and to parents/guardians.

In order for your student to participate in individual or group counseling, we must have parent/guardian consent. Please feel free to contact Juan Hernandez, Student Assistance Program Coordinator, at 942-6278 with any questions or concerns.

PERMISSION FOR STUDENT ASSISTANCE PROGRAM SERVICES

I give permission for my son/daughter to participate in Student Assistance Program service at Calistoga JR/SR High School.

_____ _____

Parent/Guardian signature Date

_____

Parent/Guardian name (printed)

_____

Student name

You will be contacted regarding the service your child is recommended to receive and invited to participate in the process.

Please return this consent form to the school office or Student Assistance Program Coordinator

Calistoga
STUDENT ASSISTANCE PROGRAM
RELEASE OF INFORMATION FORM

I, _____, hereby authorize the Calistoga Student Assistance Program to share and receive information obtained in the course of my assessment, screening, and diagnosis and/or treatment services as needed with the following agencies and/or persons:

CALISTOGA

School-based Services

- ❑ Calistoga JR/SR High School
- ❑ 8th Period: After School Tutoring
- ❑ Academic Counseling
- ❑ Aldea Family Services: MHS Interns
- ❑ Career Counseling
- ❑ Migrant Ed.
- ❑ Parenting Classes
- ❑ Parents CAN
- ❑ Safe Schools Ambassadors: Anne Williams
- ❑ Wolfe Center (AOD): Group/Individual
- ❑ Other _____

Community-based Services

- ❑ Aldea Children and Family services
- ❑ Big Brothers Big Sisters
- ❑ Boys and Girls Club
- ❑ Calistoga Affordable Housing
- ❑ Calistoga Family Center
- ❑ Clinic Ole: Medical, Dental, Vision
- ❑ Community Action Napa Valley
- ❑ Community Resources for Children
- ❑ Cope Family Center
- ❑ Family Services of Napa Valley
- ❑ Healthy Moms and Babies
- ❑ Legal Aid of Napa Valley
- ❑ MHS: Kathleen Herrea
- ❑ Napa County Health and Human Services
- ❑ Napa County office of Ed.: After School Programs
- ❑ Napa Emergency Women's Services
- ❑ Plaza Communitara (Community Plaza)
- ❑ Progress Foundation
- ❑ Other _____

The person who has signed this consent form can revoke this authorization in writing at any time; otherwise this release will remain in effect for the duration of the undersigned person's involvement with the Calistoga Student Assistance Program.

Client Signature_____ Date_____

Parent's Signature_____ Date_____

Witness Signature_____ Date_____

Programa Asistencial de la Escuela
La forma de liberacion de informacion

Yo, _____, afirmo por la presente, que autorizo al Programa Asistencial de la Escuela de Calistoga de compartir y recibir información obtenida en el curso de mi evaluación, diagnostico, y/o servicios de tratamiento como sean necesarios con:

CALISTOGA

Servicios educa-despreciables

- ❑ Calistoga JR/SR High School
- ❑ 8th Period: After School Tutoring
- ❑ Academic Counseling
- ❑ Aldea Family Services: MHS Interns
- ❑ Career Counseling
- ❑ Migrant Ed.
- ❑ Parenting Classes
- ❑ Parents CAN
- ❑ Safe Schools Ambassadors: Anne Williams
- ❑ Wolfe Center (AOD): Group/Individual
- ❑ Other _____

Servicios de comunidad-basó

- ❑ Aldea Children and Family services
- ❑ Big Brothers Big Sisters
- ❑ Boys and Girls Club
- ❑ Calistoga Affordable Housing
- ❑ Calistoga Family Center
- ❑ Clinic Ole: Medical, Dental, Vision
- ❑ Community Action Napa Valley
- ❑ Community Resources for Children
- ❑ Cope Family Center
- ❑ Family Services of Napa Valley
- ❑ Healthy Moms and Babies
- ❑ Legal Aid of Napa Valley
- ❑ MHS: Kathleen Herrea
- ❑ Napa County Health and Human Services
- ❑ Napa County office of Ed.: After School Programs
- ❑ Napa Emergency Women's Services
- ❑ Plaza Communitara (Community Plaza)
- ❑ Progress Foundation
- ❑ Other _____

La persona quien a firmado esta forma se consentimiento puede revocar o suspender esta autorización por escrito a cualquier hora, de no ser así, este consentimiento permanecerá en efecto por el tiempo que la persona abajo firmante continué en participación con Programa Asistencial de la Escuela de Napa County.

Firma del Cliente_____Fecha_____

Firma del Cliente_____ Fecha_____

Firma del Cliente_____ Fecha_____

UNDERSTANDING CONFIDENTIALITY AND MINOR CONSENT IN CALIFORNIA

UNDERSTANDING CONFIDENTIALITY AND MINOR CONSENT IN CALIFORNIA

An Adolescent Provider Toolkit

Illustrations by Jordan Zioni, 17

HOW TO OBTAIN A COPY OF THIS TOOLKIT

This toolkit can be downloaded from the following websites:
Adolescent Health Working Group - www.ahwg.net
San Francisco Health Plan – www.sfhp.org

Additional copies of the Toolkit may be requested via mail, telephone, fax or e-mail from:
Adolescent Health Working Group
323 Geary Street, Suite 418
San Francisco, CA 94102
Telephone: (415) 576-1170 x312
Fax: (415) 576-1286
E-mail: info@ahwg.net

ADOLESCENT HEALTH WORKING GROUP

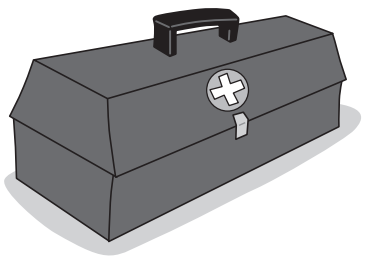
The Adolescent Health Working Group (AHWG) was formed in 1996 when adolescent health providers, administrators, and youth advocates in San Francisco became concerned about Medicaid managed care's impact on young people's access to youth-sensitive, comprehensive health care. Today, the mission of the AHWG is to significantly advance the health and well-being of San Francisco's youth by applying the collective wisdom, resources, and energy of individuals and agencies that care for and support young people. The AHWG's activities include conducting community research, public policy advocacy, and training activities. Members of the collaborative include representatives of youth development agencies; public and private primary care, behavioral health clinics and programs; academic institutions; health plans; schools; social service and advocacy organizations; youth and parents.

SAN FRANCISCO HEALTH PLAN

San Francisco Health Plan (SFHP) is a licensed community health plan providing affordable health coverage to low and moderate-income families residing in San Francisco. SFHP was designed for and by the residents it serves, many of whom would not be able to otherwise obtain health care for themselves or their families. Through SFHP, members have access to a full spectrum of medical services, including preventive care, hospitalization, prescription drugs, family planning, and substance abuse programs. SFHP's mission is to provide superior, affordable health care that emphasizes prevention and promotes healthy living, with the goal of improving the quality of life for the people of San Francisco.

SUGGESTED CITATION

M. Simmons, J. Shalwitz, S. Pollock (2002). *Understanding Confidentiality and Minor Consent in California: An Adolescent Provider Toolkit*. San Francisco, CA: Adolescent Health Working Group, San Francisco Health Plan.



San Francisco Health Plan
San Francisco, CA

Adolescent Health Working Group
San Francisco, CA

Dear Colleagues:

We are pleased to present you with *Understanding Confidentiality and Minor Consent in California: An Adolescent Provider Toolkit.* This is one chapter of a larger project, The Adolescent Provider Toolkit, made possible through the generous support of The California Endowment and our close collaboration with the San Francisco Health Plan (SFHP). The Toolkit contains resources to help health care providers better meet the needs of adolescent patients.

Adolescents list concerns about confidentiality as the number one reason they might forgo medical care. A young person is more likely to disclose sensitive information if he or she is provided with confidential services and has time alone with the provider. However, providers indicate that they are mystified and confused by the various confidentiality and minor consent laws and about their reporting responsibilities. This toolkit, compiled by a multi-disciplinary group of lawyers, health care providers, and youth advocates, strives to clarify these issues.

Designed for busy providers, the Toolkit includes materials that you are free to copy and distribute to your adolescent patients and their families or to hang in waiting and exam rooms. In addition, we will soon have a link to an online confidentiality training on our website, which you will be able to access without charge.

We would like to thank The California Family Health Council and the California Adolescent Health Collaborative for their assistance with the printing and distribution of this resource.

If you have questions regarding the Toolkit or its accompanying trainings and resources, please call the Adolescent Health Working Group at (415) 576-1170.

Regards,

Marlo Simmons, MPH, Program Coordinator
Adolescent Health Working Group

Janet Shalwitz, MD, Director
Adolescent Health Working Group

Karen Smith, MD, Medical Director
San Francisco Health Plan

ACKNOWLEDGEMENTS

The Adolescent Health Working Group gratefully acknowledges The California Endowment for generously supporting the production of this toolkit.

THE ADOLESCENT PROVIDER TOOLKIT ADVISORY COUNCIL

We would like to extend our sincerest thanks to members of the Toolkit Advisory Council for their time, energy, dedication and unwavering commitment to the health of adolescents.

Valerie Brown, MSW– New Generation Health Center
Amanda Goldberg – San Francisco Unified School District
Eric Hernandez, RD – Child Health and Disability Project
David Knopf, MSW MPH – UCSF Division of Adolescent Medicine
Nancy Lewis, FNP – Huckleberry's Cole Street Clinic, SFDPH
Caroline Miranda, LCSW – New Generation Health Center
Erica Monasterio, FNP – UCSF Division of Adolescent Medicine
Payal Patel – SFGH Child and Adolescent Services, Department of Psychiatry
Patricia Peretz – Jewish Vocational Services
Michelle Persha, MPH – San Francisco Health Plan
Naomi Schapiro, PNP – Valencia Health Services
Anita Shankar, MPH – Health Initiatives For Youth
Karen Smith, MD – San Francisco Health Plan
Lisa Stone - SFGH Child and Adolescent Services, Department of Psychiatry
Kelly Wong, MD – Pediatrician, Private Practice

We would also like to thank the following individuals and organizations for contributions of their experience, ideas, and tools.

Tanene Allison – Adolescent Health Working Group
Renee Cheney-Cohen – Child Health and Disability Prevention Program
Natalie Combs
Abigail English, JD- Center for Adolescent Health and the Law
Rebecca Gudeman, JD, MPA – National Center for Youth Law
Mary Isham, RN
Dan Leonard – San Francisco HealthCorps
Yoshiko Ogino
Elizabeth Ozer, PhD – UCSF Division of Adolescent Medicine
Jordon Zioni – Illustrations

MODULE **ONE:**

Confidentiality

TABLE OF CONTENTS

* Please copy and distribute these handouts to teens and their caregivers. Spanish and Chinese versions are available online at www.ahwg.net or www.sfhp.net or by calling 415-576-1170.

CALIFORNIA MINOR CONSENT LAWS

Who Can Consent For What Services And Providers' Obligations

MINORS OF ANY AGE MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
PREGNANCY	"A minor may consent to medical care related to the prevention or treatment of pregnancy," except sterilization. (Cal. Family Code § 6925)	The health care provider is not permitted to inform a parent or legal guardian. (Cal. Health & Safety Code §§ 123110(a) and 123115(a))
CONTRACEPTION	A minor may receive birth control without parental consent. (Cal. Family Code § 6925)	The health care provider is not permitted to inform a parent or legal guardian. (Cal. Health & Safety Code §§ 123110(a) and 123115(a))
ABORTION	A minor may consent to an abortion without parental consent and without court permission. (American Academy of Pediatrics v. Lungren 16 Cal.4th 307 (1997))	The health care provider is not permitted to inform a parent or legal guardian. (Cal. Health & Safety Code §§ 123110(a) and 123115(a))
EMERGENCY MEDICAL SERVICES* *An emergency is "a situation . . . requiring immediate services for alleviation of severe pain or immediate diagnosis of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death" (Cal. Code Bus. & Prof. 2397 (c)(2)).	A minor who has a condition or injury which is considered an emergency but whose parent or guardian is unavailable to give consent is permitted to give consent for medical services. (Cal. Business and Professions Code § 2397)	The health care provider shall inform the minor's parent or guardian.
SEXUAL ASSAULT AND RAPE SERVICES **Rape requires the act on non-consensual sexual intercourse. **For the purposes of minor consent alone, sexual assault includes acts of rape, oral copulation, sodomy, and other violent crimes of a sexual nature.	A minor who may have been sexually assaulted or raped may consent to medical care related to the diagnosis, treatment and the collection of medical evidence. (Cal. Family Code § 6928)	The health care provider must attempt to contact the minor's parent/guardian and must note the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the rape or assault. (Note: This provision does not apply if the minor is over 12 and treated for rape. See "Rape" below.)
SKELETAL X-RAY TO DIAGNOSE CHILD ABUSE OR NEGLECT* * The provider does not need the minor's or her parent's consent to perform a procedure under this section.	"A physician and surgeon or dentist or their agents . . . may take skeletal X-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of." (Cal Penal Code § 11171)	Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported pursuant to this law in any court proceeding.

NATIONAL CENTER FOR YOUTH LAW, www.youthlaw.org, revised: April 2002

(Continued on next page)

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
OUTPATIENT MENTAL HEALTH SERVICES* * This section does not authorize a minor to receive convulsive therapy, psychosurgery or psychotropic drugs without the consent of a parent or guardian.	"A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if both of the following requirements are satisfied: (1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services. (2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse." (Cal. Family Code § 6924)	MENTAL HEALTH TREATMENT: The health care provider is required to involve a parent or guardian unless the health care provider decides that involvement is inappropriate. This decision must be documented in the minor's record. SHELTER: Although minor may consent to service, the shelter must use its best efforts based on information provided by the minor to notify parent/guardian of shelter services. **(Note: California law gives health care providers the right to refuse access to records anytime the health care provider determines that access to the patient records requested by the [parent/guardian] would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being. The decision of the health care provider as to whether or not a minor's records are available for inspection under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith. (Cal. Health & Safety Code § 123115(a)(2))**
DIAGNOSIS AND/OR TREATMENT FOR INFECTIOUS, CONTAGIOUS COMMUNICABLE DISEASE, AND SEXUALLY TRANSMITTED DISEASES.	"A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer, or is a related sexually transmitted disease, as may be determined by the State Director of Health Services."(Cal. Family Code § 6926) A minor must be at least 12 years of age to request testing or treatment for sexually transmitted diseases (including HIV/AIDS). (Cal. Family Code § 6926)	The health care provider is not permitted to inform a parent or legal guardian without minor's consent. The provider can only share the minor's medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a) and 123115(a))

(Continued on next page)

MINORS 12 YEARS OF AGE AND OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
AIDS/HIV TESTING AND TREATMENT	A minor 12 and older is competent to give written consent for an HIV test. (Cal. Health and Safety Code § 121020)	The health care provider is not permitted to inform a parent or legal guardian without minor's consent. The provider can only share the minor's medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a) and 123115(a))
DRUG AND ALCOHOL ABUSE TREATMENT	"A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem."(Cal. Family Code §6929(b)) However, "this section does not authorize a minor to receive replacement narcotic abuse treatment . . . without the consent of the minor's parent or guardian." (Cal. Family Code § 6929(e))	Any program regulated or directly or indirectly funded by the federal government MAY NOT reveal any information to parents without the minor's written consent. Programs include those licensed under a federal agency, registered with Medicare, those receiving federal funds of any kind, or those allowed to receive tax deductible donations from the IRS or with tax exempt status. For all other programs, "the treatment plan of a minor authorized by this section shall include the involvement of the minor's parent or guardian, if appropriate, as determined by the professional person or treatment facility treating the minor. The professional person providing medical care or counseling to a minor shall state in the minor's treatment record whether and when the professional person attempted to contact the minor's parent or guardian, and whether the attempt to contact the parent or guardian was successful or unsuccessful, or the reason why, in the opinion of the professional person, it would not be appropriate to contact the minor's parent or guardian." (Cal. Family Code § 6929(c)) **(Note: California law gives health care providers the right to refuse access to records anytime the health care provider determines that access to the patient records requested by the [parent/ guardian] would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being. The decision of the health care provider as to whether or not a minor's records are available for inspection under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith. (Cal. Health & Safety Code § 123115(a)(2))**

NATIONAL CENTER FOR YOUTH LAW, www.youthlaw.org, revised: April 2002

(Continued on next page)

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
RAPE	"A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape." (Cal. Family Code 6927)	The health care provider is not permitted to inform a parent or legal guardian without minor's consent. The provider can only share the minor's medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a) and 123115(a))
MINORS MUST BE 15 YEARS OF AGE OR OLDER	**LAW**	**CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER**
GENERAL MEDICAL CARE	"A minor may consent to the minor's medical care or dental care if all of the following conditions are satisfied: (1) The minor is 15 years of age or older. (2) The minor is living separate and apart from the minor's parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence. (3) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income." (Cal. Fam. Code § 6922(a))	"A physician and surgeon or dentist MAY, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian." (Cal. Fam. Code § 6922(c))
MINOR MUST BE EMANCIPATED (GENERALLY 14 YEARS OF AGE OR OLDER) A minor is emancipated if: • She/he has entered into a valid marriage, whether or not the marriage has been dissolved; • She/he is on active duty with the armed forces; or • She/he has received a declaration of emancipation from a court. (Cal. Family Code §§7002, 7050(e))	**LAW**	**CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER**
GENERAL MEDICAL CARE	An emancipated minor may consent to medical, dental and psychiatric care. (Ca. Family Code § 7050(e)).	The health care provider is not permitted to inform a parent or legal guardian without minor's consent. The provider can only share the minor's medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a) and 123115(a))

NATIONAL CENTER FOR YOUTH LAW, www.youthlaw.org, revised: April 2002

WHEN AM I MANDATED TO REPORT THE SEXUAL ACTIVITY OF MINORS TO CHILDREN'S PROTECTIVE SERVICES OR POLICE IN CALIFORNIA?

? If a minor has consensual sexual intercourse with an older partner, is a report mandated?

AGE OF PARTNER ►	12	13	14	15	16	17	18	19	20	21	21+
AGE OF PATIENT ▼											
11	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
12	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
14	Y	Y	N	N	N	N	N	N	N	Y	Y
15	Y	Y	N	N	N	N	N	N	N	Y	Y
16	Y	Y	N	N	N	N	N	N	N	N	N
17	Y	Y	N	N	N	N	N	N	N	N	N
18	Y	Y	N	N	N	N	N	N	N	N	N

Note: Providers have no legal obligation to ask about partner's age.

? What other sexual activity must be reported by a mandated reporter?

Mandated reporters must report sexual intercourse or other sexual activity with a minor which is coerced, exploitative, or based on intimidation, regardless of claimed consent by the minor.

Additionally, mandated reporters must report other sexual activity (lewd and lascivious acts) when a minor is 14 or 15 and the partner is more than 10 years older, or when a minor is under 14 and the partner is over 14, regardless of claimed consent by the minor.

* This worksheet is not intended to be a complete review of all California child abuse reporting laws.

Adapted by David Knopf, LCSW, from: *An Analysis of Assembly Bill 327: New California Child Abuse Reporting Requirements for Family Planning Providers*, by Catherine Teare and Abigail English, National Center for Youth Law. (May 1998) Available at http://www.youthlaw.org/AB327.pdf.

CONFIDENTIALITY AND MINOR CONSENT Q&A

Q: What are the services a minor can consent to?

A: See Chart A-1 "CALIFORNIA MINOR CONSENT LAWS: Who can consent for what services and providers' obligations."

Q: If a minor cannot give consent to health care, who (besides a parent) can give it for them?

A:

Adult Caretaker:	With letter from parent, or with caregiver consent affidavit
Guardian:	With court order granting guardianship
Court:	Minors 16 and over whose parents are unavailable
Juvenile court:	Minor who is a dependent of court
Foster Parent:	Only with dependency court permission
Emergency:	Consent not required in an emergency

Q: How far should I go when trying to reach a parent?

A: When parental consent is necessary in order to provide a service, the provider must obtain that consent. If the provider is unable to reach a parent and believes that treatment must be provided immediately, the provider should proceed if the youth's medical condition qualifies as an emergency. The provider should clearly document his/her actions and decisions and rationale for treatment or interventions.

Q: Can consent be given verbally?

A: California statutes do not specifically require that consent be written. Often, for routine uncomplicated care, providers feel comfortable with verbal consent. In these cases, it is clear that the person giving consent understands the risks and consequences of the procedure and that the verbal communication is documented in the medical record. If the treatment is more complicated, the provider may want a signed consent form to be sure that the person providing consent is providing "informed consent" and understands the ramifications of the procedures performed. Health care providers should establish an office policy to provide all staff guidance.

Q: If parents give consent to treatment, does that give them the right to look over medical records?

A: The general rule is that parents have a right to see medical records if the parents consented to the treatment.

HOWEVER, California law gives health care providers the right to refuse access to records anytime the health care provider determines that access to the patient records would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical or psychological well-being. (Cal. Health and Safety Code § 123115(a)(2)).

The health care provider is not liable for denying access to records under this provision if the decision to deny access was made in good faith.

Q: When the youth has the right to confidential care, what do I do if I'm uncomfortable NOT telling parents?

A: If a minor has the legal right to confidential care, a provider must abide by that right or risk liability or other legal sanction. There are a few minor consent statutes that grant the health provider the right to decide whether contacting a parent is appropriate or necessary even over the minor's objection. One example is the minor consent drug treatment statute. See the Chart A-1 confidentiality column for statutes that allow providers to share with parents over the minor's objection. In those cases and no others, a provider can rely on their professional judgment to decide whether to share information with parents.

Providers are not legally obligated to provide services to which they are morally or ethically opposed. In such circumstances, the provider should refer the adolescent to another provider, clinic, or program who can better meet the teen's health care needs.

CONFIDENTIALITY AND MINOR CONSENT Q&A

Q: What if the minor does not SEEM competent to make his or her own decisions? (low IQ, drug use, adult influence)

A: A patient is competent if the patient (1) understands the nature and consequence of his/her medical condition and the proposed treatment and (2) can communicate his/her decision.

Providers can make their own assessment of a patient's competency and do not need a judicial ruling or psychiatric diagnosis in order to find a patient incompetent. When assessing whether the patient understands the nature and consequences of his/her medical condition (and can communicate his/her decision) take into account the following:

(1) Always start with the presumption that a patient is competent.

(2) Minority age alone is not a sufficient basis for determining if someone is incompetent. The law specifically deems minors capable of providing consent in certain medical situations.

(3) Physical or mental disorders alone are not a sufficient basis for finding incompetency.

(4) The nature and consequence of the medical condition must be explained in terms a minor would understand.

(5) Believing that the patient is making an unwise or "wrong" medical decision is not a sufficient basis for finding the patient incompetent.

(6) Competency is situation specific. A minor deemed incompetent in one situation may not be considered incompetent in all situations.

Q: How can we provide confidential care when the patient's health plan sends Explanation of Benefits (EOBS), bills, or surveys home after a visit?

A: If you know that a health plan will automatically send out materials to your patient you can do the following:

(1) Become a Family PACT provider and bill for services through this program.

(2) Urge your patient to sign-up for the MediCal Minor Consent program and bill for services through this program.

(3) Refer your patients to Family PACT or MediCal Minor Consent providers. See Chart A-7, "Financing Tips for Providing Confidential Teen Services"

(5) Contact the patient's health plan and let them know your concerns.

Q: I know that minors over 12 can consent to their own mental health care when they are mature enough to participate in the service and the minor would present "a danger or serious physical or mental harm to self or others without the mental health treatment." But, what is "serious harm?"

A: There is no statute or regulation that defines the term "serious harm". The interpretation of this term is left to the discretion and professional judgment of the provider. We recommend that you develop guidelines for your staff to ensure consistency in your office/clinic/agency. The San Francisco Department of Public Health (SFDPH) policy uses the Global Assessment of Functioning (GAF) scale to assess psychological and social functioning. According to SFDPH, a score of <60 indicates symptoms and level of functioning that satisfies the definition of "serious danger of physical or mental health harm." (Lubosky, L. "Clinicians' Judgments of Mental Health," Archives of General Psychiatry, 7: 407-417, 1962)

MANDATED REPORTING Q&A

Q: Who is a Mandated Reporter?

A: There is a list of 33 mandated reporters, but those pertaining to adolescent health services are:
1) Physicians 2) Surgeons 3) Psychiatrists 4) Psychologists 5) Psychological Assistants 6) Mental Health and Counseling Professionals 7) Dentists 8) Dental Hygienists 9) Registered Dental Assistants 10) Residents 11) Interns 12) Podiatrists 13) Chiropractors 14) Licensed Nurses 15) Optometrists 16) Marriage, Family and Child Counselors, Interns and Trainees 17) State and County Public Health Employees 18) Clinical Social Workers 19) EMT's and Paramedics 20) Pharmacists

Q: Why and when am I required to make a report?

A: The California Child Abuse and Neglect Reporting Act created a set of state statutes that establish the whys, whens and wheres of reporting child abuse in California.

"Mandated reporters" are required to make a child abuse report anytime, in the scope of performing their professional duties, they discover facts that lead them to know or reasonably suspect a child is a victim of abuse.

Reasonable suspicion of abuse occurs when "it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse or neglect."

The Act requires professionals to use their training and experience to evaluate the situation; however, "nothing in the Act requires professionals such as health practitioners to obtain information they would not ordinarily obtain in the course of providing care or treatment. Thus, the duty to report must be premised on information obtained by the health practitioner in the ordinary course of providing care and treatment according to standards prevailing in the medical profession." (People v. Stockton Pregnancy Control Medical Clinic, 203 Cal.App.3d 225, 239-240, 1988)

The pregnancy of a minor in and of itself does not constitute a basis for a reasonable suspicion of sexual abuse. A child who is not receiving medical treatment for religious reasons shall not be considered neglected for that reason alone.

Q: What about the right of patient confidentiality?

A: Child Abuse reporting is one of the few exceptions to patient confidentiality. Reporters do not need the minor or parent's consent to share the otherwise confidential information necessary to make a report. The Child Abuse Reporting Act specifically exempts reporters from any liability if they make a good faith report of abuse.

Q: When does a mandated reporter have to report sexual activity?

A: See Chart A-2 " When am I Mandated To Report The Sexual Activity of Minors to Children's Protective Services or Police in California?"

MANDATED REPORTING Q&A

Q: How do I make a report?

A:
1. First, call the Department of Social Services immediately (in San Francisco, 415-558-2650). If you are unsure whether you need to report, call this number for more information. If the young person lives outside of San Francisco, call the county where he or she lives. If the place of residence and place of abuse are not the same, you must report in both counties. Let the reporter know this information at the beginning of your report.
2. You must file a written report (DOJ form SS 8572) within 36 hours of the verbal report. See an example of the report form on the back of this page.

Q: What will I report?

A:
1. Your name, although this is kept confidential except in certain, limited, situations.
2. The child's name
3. The present location of the child
4. The nature and extent of the injury
5. Any other information, including that which led you to suspect child abuse, requested by the child protective agency
6. If the child does not feel safe returning to the place of abuse or if he or she is in immediate danger, report this information as well.

Q: What happens to the reports?

A:
1. The report will be investigated either by the local law enforcement agency or by the child protective services agency.
2. The report will be assessed as to whether there is a need for immediate action.
3. High risk factors will be considered to determine whether immediate face-to-face contact is required (ex. Direct interviews with anyone who might provide more information on the situation.)
4. The report will be determined to be either
   a. Unfounded (false, inherently improbable, to involve accidental injury, or not to constitute child abuse)
   b. Substantiated (constitutes child abuse or neglect)
   c. Inconclusive (not unfounded, but the findings are inconclusive and there is insufficient evidence to determine whether child abuse or neglect has occurred)

Q: What happens if the report is not unfounded?

A:
1. It will be forwarded to the Child Abuse Central Index and investigation will continue.
2. The child may be taken into protective custody.
3. The case can be officially opened and regular in-home supervision and a number of services are provided.

Q: Will I be told about the status of the report?

A: The Child Protective Agency is required to provide mandated reporters with feedback about the report and investigation. It might be necessary to be proactive in this situation by calling the Department of Social Services.

Q: Is there a statute of limitations?

A: No. If an individual under 18 years old tells you about abuse, even if it occurred when he or she was a young child, you must report it. Other agencies will decide whether the case should be pursued.

SUSPECTED CHILD ABUSE REPORT

To Be Completed by Reporting Party
Pursuant to Penal Code Section 11166

A. CASE IDENTIFICATION — *TO BE COMPLETED BY INVESTIGATING CPA*
VICTIM NAME: _____
REPORT NO./CASE NAME: _____
DATE OF REPORT: _____

B. REPORTING PARTY
NAME/TITLE
ADDRESS
PHONE ( ) | DATE OF REPORT | SIGNATURE

C. REPORT SENT TO
☐ POLICE DEPARTMENT ☐ SHERIFF'S OFFICE ☐ COUNTY WELFARE ☐ COUNTY PROBATION
AGENCY | ADDRESS
OFFICIAL CONTACTED | PHONE ( ) | DATE/TIME

D. INVOLVED PARTIES
VICTIM
NAME (LAST, FIRST, MIDDLE) | ADDRESS | BIRTHDATE | SEX | RACE
PRESENT LOCATION OF CHILD | PHONE ( )
SIBLINGS
NAME | BIRTHDATE | SEX | BIRTHDATE | SEX | RACE
1.
2.
3.
PARENTS
NAME (LAST, FIRST, MIDDLE) | BIRTHDATE | SEX | RACE
ADDRESS | ADDRESS
HOME PHONE ( ) | HOME PHONE ( ) | BUSINESS PHONE ( )

E. INCIDENT INFORMATION
IF NECESSARY, ATTACH EXTRA SHEET OR OTHER FORM AND CHECK THIS BOX. ☐
1. DATE/TIME OF INCIDENT | PLACE OF INCIDENT | *(CHECK ONE)* ☐ OCCURRED ☐ OBSERVED
IF CHILD WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:
☐ FAMILY DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ SMALL FAMILY HOME ☐ GROUP HOME OR INSTITUTION
2. TYPE OF ABUSE: *(CHECK ONE OR MORE)* ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ASSAULT ☐ NEGLECT ☐ OTHER
3. NARRATIVE DESCRIPTION:
4. SUMMARIZE WHAT THE ABUSED CHILD OR PERSON ACCOMPANYING THE CHILD SAID HAPPENED:
5. EXPLAIN KNOWN HISTORY OF SIMILAR INCIDENT(S) FOR THIS CHILD:

THIS IS AN EXAMPLE ONLY
OBTAIN COPIES FROM THE DEPARTMENT OF SOCIAL SERVICES

SS 8572 (Rev. 1/93)

INSTRUCTIONS AND DISTRIBUTION ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). A CPA is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS-8583 if (1) an active investigation has been conducted and (2) the incident is **not** unfounded.

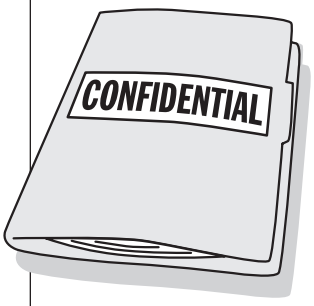
Police or Sheriff-WHITE Copy; County Welfare or Probation-BLUE Copy; District Attorney-GREEN Copy; Reporting Party-YELLOW Copy

Sources:
The Office of the Attorney General, Child Abuse Prevention Handbook, http://caag.state.ca.us/cvpc/main_pub_videos.html
Health Initiatives for Youth, Adolescent Provider's Guide, 1998.
San Francisco Child Abuse Council, A Training Curriculum for Mandated Reporters on the California Child Abuse Reporting Law, 1995.

IS YOUR OFFICE CONFIDENTIALITY CONSCIOUS?

Adolescents tend to underutilize existing health care resources. ***The issue of confidentiality has been identified by both providers and youth as a significant access barrier to health care.*** To support the promotion of adolescent care, please take a few moments to assess your office in determining whether it is confidentiality conscious. Creating a safe environment for teenagers to discuss issues concerning their health will facilitate the best possible care and counseling to respond to their needs.

- ☐ Do you have an office policy about confidential issues pertaining to youth and their families?
- ☐ Is it the usual practice in your clinic to allow adolescents and parents to talk separately with the health care providers about their concerns?
- ☐ Do you educate your members and staff regarding the California laws that specifically pertain to adolescents and their right to receive care without their parent or guardian's consent? (Please see "Summary of Legal Consent Requirements for Medical Treatment of Minors", included in this packet.)
- ☐ Does the atmosphere (pictures, wallpapers, etc.) create a safe and comfortable environment for teens to discuss private concerns regarding their health?
- ☐ Do you display and/or offer educational materials on confidentiality to adolescent patients and/or parents?
- ☐ Are you and your staff careful not to discuss patient information in open environments (elevators, hallways or waiting rooms)?
- ☐ When collecting an adolescent patient's medical history or discussing anything sensitive, do you make sure all doors are closed?
- ☐ Do you ask if your adolescent patient feels comfortable receiving messages or mail from you using the contact information they provide?
- ☐ At the beginning of the appointment, do you explain the parameters of confidentiality between you, your patients, and his/her parents?
- ☐ Do you discuss situations in which you may need to breach confidentiality?



TIPS FOR PROTECTING YOUTH CONFIDENTIALITY

While adolescent confidentiality laws provide us with formal (although often confusing) guidelines for ensuring confidentiality of our teen patients, it is frequently the small stuff that can seriously compromise an adolescent patient's confidence in his/her provider. The following is a list of tips – some obvious, some not – for preserving patient privacy and minimizing embarrassment in a clinic setting.

1. **Do not discuss patient information in elevators, hallways, or waiting rooms.**

   If an adolescent patient overhears this conversation, he or she may assume that you will also discuss his or her case in an open environment.

2. **Do not collect an adolescent patient's medical history or reason for visit in an open area.**

   It will be difficult for a teenager to discuss his or her personal issues honestly if s/he thinks other people will overhear.

3. **When an adolescent patient gives you a contact phone number, make sure that you can leave messages.**

   If you cannot, ask for an alternative number at which you can leave messages if necessary.

4. **Likewise, do not send mail (such as appointment reminders and bills) home unless you have discussed whether or not the patient feels comfortable receiving mail from you at his or her home.**

   If he or she does not wish to receive mail at home, try to work out an arrangement whereby mail is picked up at the clinic. TIP: Some clinics have check boxes on charting forms indicating a teen's preference regarding mail and phone calls. Other clinics clarify what kind of message might be ok to leave at a teen's contact number (e.g. "Tina" called).

5. **When discussing anything sensitive, such as sexual history, weight, or substance use, make sure all doors are closed.**

   A patient in the waiting room may overhear a discussion and thus be more reluctant to share information when he or she sees the health care provider.

6. **Think about how your clinic administers paperwork to patients.**

   Are you asking clients to fill out forms such that other people might be able to read their answers? Give out a clipboard with the forms; also make sure that there is enough room in which to complete forms with some degree of privacy.

7. **Make sure that any clinic literature your clinic or practice distributes is small enough to fit into a purse or wallet.**

   Asking a teenager to leave with bright, large brochures on a sensitive subject, such as gonorrhea, will cause more embarrassment than anything else. These types of materials should be offered to teens in private.

8. **At the beginning of the appointment, make it clear that a provider is required to maintain patient confidentiality, except under very specific circumstances.**

   Periodically remind the patient that anything s/he says about sex, drugs, and feelings will not leave the room.

PERFORMING AN ATRAUMATIC "PARENTECTOMY"

Or, how do I provide adolescent-sensitive services when a parent or caregiver is present?

Attempting to provide confidential services can cause great discomfort for youth, parents, and providers if it is not handled in a sensitive manner. The following are recommendations that can facilitate a smooth transition from the parent-accompanied visit to the confidential adolescent visit.

ROADMAP

- Lay out the course of the visit…

  ***for example**, "We will spend some time talking together about Joseph's health history and any concerns that you or he might have, and then I will also spend some time alone with Joseph. At the end of the visit, we will all meet together again to clarify any tests, treatments or follow-up plans."*

- Explain your office/clinic policy regarding adolescent visits.

  ***Review** your policy verbally early in the interaction with the youth and parent.*

  ***Acknowledge** that the youth is a minor and therefore has specific legal rights related to consent and confidentiality.*

  ***Introduce** the concept of fostering adolescent self-responsibility and self-reliance.*

  ***Reinforce** that this policy applies to all adolescents in your practice or clinic (in other words, this is not specific to YOUR child).*

- Validate the parental role in their child's health and well-being.
- Elicit any specific questions or concerns from the parent.
- Direct questions and discussion to the youth while attending to and validating parental input.

REMOVE

- Invite the parents to have a seat in the waiting area, assuring them that you will call them prior to closing the visit

REVISIT

- Once the parent is out of the room, revisit issues of consent and confidentiality with the youth, including situations when confidentiality has to be breached (suicidality, abuse, etc.).
- Revisit areas of parental concern with the youth and obtain the youth's perspective.
- Conduct the psycho-social interview and physical exam (ascertain whether youth desires parent's presence during PE and accommodate youth's preference).
- Clarify what information from the psycho-social interview and PE the youth is comfortable sharing with parent.

REUNITE

- Invite the parent back to close the visit with both parent and youth.

TIPS...

- A young person is more likely to disclose sensitive information to a health care provider if the youth is provided with confidential services, and has time alone with the provider to discuss his/her issues.

- Remember that even when the chief complaint is acne or an earache, there may be an underlying issues on the part of the adolescent (such as the need for a pregnancy test or contraception), which will only surface when provided confidential services.

EXTRA NOTES:

Additional ways to explain your policy regarding confidentiality:

- A letter to all new adolescent patients and their parents, and all parents and patients on the youth's 11th or 12th birthday explaining your policy. This will help families to come prepared for the adolescent and the provider to spend some time alone.
- Posters in the waiting area explaining adolescent consent and confidentiality and your policy as it relates to the law can also help lay groundwork that the provider will be spending time alone with the youth.

FINANCING SENSITIVE SERVICES: A GUIDE FOR ADOLESCENT HEALTH CARE PROVIDERS

Payment for sensitive services (i.e. STD testing and treatment, pregnancy tests, substance use counseling) can pose an enormous barrier to youth seeking confidential health care. Young people may not have enough money to pay for the services that they need. Often, they are also worried that if they access a free or low cost program such as Family PACT or Medi-Cal, their confidentiality will be compromised. It is thus important to understand the laws and policies governing the ways in which young people can access free or low cost sensitive services.

California State has two programs that reimburse confidential health services for youth: Medi-Cal Minor Consent and Family PACT (Planning, Access, Care, and Treatment). Below you will find information on how to become a provider in each of these programs, how to determine youth eligibility, and how to receive payment for services rendered.

	MEDI-CAL MINOR CONSENT	FAMILY PACT
SERVICES COVERED	• Pregnancy and pregnancy-related services, including abortion • Family planning (birth control), including emergency contraception • Drug and alcohol counseling and treatment • Sexually transmitted diseases testing and treatment • Sexual assault treatment	• Pregnancy testing, counseling, and referral • Family planning (birth control), including emergency contraception • Sexually transmitted diseases testing and treatment • Education and counseling about reproductive health • HIV testing and counseling • Referrals for other services
CLIENT ELIGIBILITY (Age)	12 up to 21	Up to 35 years old.
CLIENT ELIGIBILITY (Income)	Any income	Up to 200% of poverty level
CLIENT ELIGIBILITY (Citizenship)	Client must be a California resident	Client must be a California resident.
INFORMATION REQUESTED FROM CLIENT	First name, phone number, address to which confidential mail can be sent; Social Security Number is NOT requested.	No papers required.

(Continued on next page)

	MEDI-CAL MINOR CONSENT	FAMILY PACT
CLIENT CO-PAY	None	Voluntary $5. Client will not be turned away if s/he does not pay.
HOW A YOUNG PERSON CAN UTILIZE THIS PROGRAM	Call or visit your county Social Services office. A list of local Social Services is available at www.dhs.ca.gov/mcs/medi-calhome/countylisting1.htm	Client must visit a Family PACT provider, who will enroll the youth in the program. Services can be accessed immediately.
FOR MORE INFORMATION	Contact the Medi-Cal provider support center.	Contact the California Office of Family Planning at (916) 654-0357.
HOW CAN A CLINIC BECOME A PROVIDER	Provider must be a Medi-Cal provider. Call EDS at 1-800-541-5555 or visit http://files.medi-cal.ca.gov/pubsdoco/Pubsframe.asp?/hURL=/pubsdoco/prov_enroll.asp to download provider application forms.	Call the Family PACT Hotline at 1-800-257-6900 or visit FPACT Provider Support Services at http://www.dhs.cahwnet.gov/pcfh/ofp/FamPACT/ Providers must attend a one-day orientation program.

KEY DIFFERENCES BETWEEN MEDI-CAL MINOR CONSENT AND FAMILY PACT:

1. While both programs cover pregnancy testing, Family PACT does not cover abortion or care once one is pregnant. Medi-Cal Minor Consent does.
2. Family PACT covers individuals up to age 35; Medi-Cal Minor Consent up to age 21.
3. Clients must enroll in Family PACT at an FPACT provider's office. With Medi-Cal Minor Consent, however, clients enroll with an eligibility worker.
4. For Family PACT, eligible clients are activated for one year following application; for Medi-Cal Minor Consent, clients must renew eligibility every 30 days.

TIPS FOR TEENS

*The Truth About **CONFIDENTIALITY...***

Confidentiality means privacy. It means that when you, as a young person from 12 to 17 years old, talk with your health care provider about certain issues like sex, drugs, and feelings, he or she will not tell your parents or guardians what you talk about unless you give your permission.

What should I talk to the doctor or nurse about?

You can talk to your doctor or nurse about ANYTHING! Fill your doctor or nurse in if you…

- think you might be **pregnant**.
- need **birth control**.
- think you have a **sexually transmitted disease** (STD).
- need information about **alcohol, tobacco, or other drug use**.
- want to talk about **personal, school, family issues, or feelings about sex and sexuality.**

What will my doctor or nurse tell my parents?

According to the laws of the State of California, your doctor or nurse cannot tell your parents or guardians anything about your exam if you're seen for any ***confidential*** services. These include care for problems or concerns in the areas of sexuality, mental health and substance abuse. You, as a young person, ***can consent*** for care on your own in these areas. You need your parent or guardian's consent for other health services such as physicals and care for colds, flu, and injuries.

HOWEVER…

Some things cannot remain confidential. Your health care provider will need to contact someone else to help if you say…

- you are being **abused, physically and/or sexually**.
- you are going to **hurt yourself or someone else**.
- you are under 16 and **having sex with someone 21 years or older**.
- you are under 14 and **having sex with someone 14 years or older**.

Even though you don't have to ask your parents, it's a good idea to talk with them or another adult you trust about the medical care you need. We want you to be safe. If you have any questions about confidentiality, please ask us!

A LETTER FROM YOUR TEEN'S HEALTH CARE PROVIDER

Dear Parent or Guardian,

Now that your son or daughter is a teenager, there are some things I would like to share with you that are important to provide the best care. Your son or daughter's body is changing, and so are his or her feelings. There are many health risks during the teenage years that we try to prevent, such as accidents, violence, unprotected sex, alcohol and drug use, and stress.

Some areas of teen health that we may talk about during the appointment are:

- Diet, exercise, and body image
- Fighting, danger, and violence
- Sexuality and sexual behavior
- Safety and driving
- Smoking, drugs, and alcohol
- Working/Jobs
- Depression and stress
- Peer pressure and school
- Dating and relationships
- Family life

It is good to stay close to your child. It is also important for you to allow them some time alone to talk about their health and changes in their bodies and lives. This will help your teenager make good decisions. I encourage teenagers to share information about their health with their parents or guardians. However, there will be some things that your teenager would rather talk about with a doctor, nurse, or counselor. California law allows teenagers to receive some health care services on their own. Health care providers have to keep those services CONFIDENTIAL. "Confidential" means I will only share this information if a teenager says it's alright. I will also share this information if someone is in danger.

I can contact you about most of the services your child receives. However, if your teenager receives the following services, I cannot give you information about these visits without permission from your son or daughter:

- The prevention or treatment of pregnancy or sexually transmitted diseases (STDs) and other
  contagious diseases
- The diagnosis and treatment of sexual and physical abuse
- Care and counseling for drug or alcohol problems

I ask that you support these rules and help your teen learn to care for their own health needs. I look forward to providing ongoing medical care for your child. I will be happy to talk to you about the questions or concerns you may have about this letter and your child's health.

CAREGIVER'S AUTHORIZATION AFFIDAVIT

Use of this affidavit is authorized by Part 1.5 (commencing with section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1 - 4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5 - 8 is additionally required to authorize any other medical care. Print clearly.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: _____ .

2. Minor's birth date: _____ .

3. My name (adult giving authorization): _____ .

4. My home address: _____

_____

_____

5. ( ) I am a grandparent, aunt, uncle, or other qualified relative of the minor (see back page of this form for a definition of "qualified relative").

6. Check one or both (for example, if one parent was advised and the other cannot be located):

( ) I have advised the parent (s) or other person (s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.

( ) I am unable to contact the parent (s) or other person (s) having legal custody of the minor at this time, to notify them of my intended authorization.

7. My date of birth: _____

8. My California's drivers license or identification card number:_____

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: _____ Signed:_____

(Notices on following page)

Notices:

1. This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the Caregiver has legal custody of the minor.

2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.

3. This affidavit is not valid for more than one year after the date on which it is executed.

Additional Information:

To Caregivers:

1. "Qualified relative," for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

2. The law may require you, if you are not a relative or a currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions please contact your local Department of Social Services.

3. If the minor stops living with you, you are required to notify any school, health care provider, or heath care service plan to which you have given this affidavit.

4. If you do not have the information requested in item 8 (California driver's license or I.D.), provide another form of identification such as your social security number or Medi-Cal number.

To School Officials:

1. Section 48204 of the Education Code provides that this affidavit constitutes a sufficient basis for a determination of residency of the minor, without the requirement of a guardianship or other custody order, unless the school district determines from actual facts that the minor is not living with the Caregiver.

2. The school district may require additional reasonable evidence that the Caregiver lives at the address provided in item 4.

To Health Care Providers and Health Service Plans:

1. No person who acts in good faith reliance upon a Caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit, is subject to criminal liability or action, for such reliance if the applicable portions of the form are completed.

2. This affidavit does not confer dependency for health care coverage purposes.

Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine

Position

The Society for Adolescent Medicine Reaffirms Its Previous Position that Private and Confidential Health Services Are Essential for Adolescents.

In order to implement this policy, the Society for Adolescent Medicine recommends the following:

- Health providers should inform adolescent patients and their parents, if available, about the requirements of confidentiality, including a full explanation of what confidential care entails and the conditions under which confidentiality might be breached.
- Health providers must remain flexible when delivering confidential care to adolescents. Blind adherence to absolute confidentiality, or absence of confidentiality (in deference to parental wishes), is neither desirable nor required by ethics or law.
- Health providers should develop a disclosure plan for those adolescents who are deemed not to have capacity to give informed consent or for whom disclosure of information to responsible adults becomes necessary which involves adolescent wishes about the manner in which information is shared.
- Confidentiality considerations regarding record keeping are necessary. Health providers must consider the manner in which written and electronic medical records might be available to parties in ways that verbal communication are not, and in ways that would be objectionable to adolescent patients.
- Expanded efforts are needed to increase the education of health professionals regarding the laws and regulations in their jurisdiction relating to confidentiality and informed consent for adolescents. In addition, specific training is needed to increase providers' skills in effectively and appropriately incorporating confidentiality into clinical practice.
- Further research is necessary to evaluate the process of maintaining confidentiality. These investigations should include studies of the attitudes of adolescents related to confidentiality, specific influences of gender and race/ethnicity, provider and parental attitudes about confidentiality, and the approaches necessary to allow professional practices to optionally meet ethical and legal requirements.

Background

There is a growing need for education of health professionals regarding ethical and legal aspects of consent and confidentiality. Adolescents are engaging in a variety of health risk behaviors that should be known to their health providers (1,2). In addition, the protection of confidentiality within and beyond the health care setting is becoming more precarious owing to health care reform, computerization of health records, and changes in health care administration (3). Results of studies indicate a lack of consensus among practicing health providers about confidentiality when treating adolescent patients (4-7). A recent survey of primary care physicians in California indicates that physicians do not consistently discuss confidentiality with their adolescent patients and do not distinguish between unconditional and conditional confidentiality (7). Although minors' rights to confidential medical care have expanded over the past 25 years, these legal prerogatives undergo ongoing modification. Many states have passed mandatory parental consent and notification laws, especially related to the termination of pregnancy. As laws change, it becomes more difficult for health professionals to maintain familiarity with current laws determining when adolescents may consent for confidential medical care. It is unclear if providers understand these existing laws and policies regarding minor's consent and confidentiality (8),(9).

This article defines necessary terms and concepts, address reasons for confidentiality in adolescent health care, reviews legal guidelines, and provides suggestions for implementation.

Definitions

Confidentiality in a health care setting is defined as an agreement between patient and provider that information discussed during or after the encounter will not be shared with other parties without the explicit permission of the patient. It is best classified as a rule of biomedical ethics that derives from the moral principle of autonomy and accompanies other rules like promise-keeping, truthfulness and privacy (10).

Privacy means freedom from unsanctioned intrusion. In a health care setting it involves psychological, social and physical components in addition to confidentiality (11).

Informed consent describes the process during which the patient learns the risks and benefits of alternative approaches to management and freely authorizes a course of action proposed by the clinician. Informed consent has both ethical and legal derivations. Although usually bound together in clinical encounters, confidentiality and consent are different. Confidentiality can occur during an encounter whether or not specific informed consent for a treatment or intervention is given. For example, contraceptive options may be confidentially discussed before informed consent is given for any specific choice.

Under specific legal circumstances, adolescents may receive

confidential care and may give informed consent for recommended care (12). If the legal circumstances does not justify a minor's consent to medical treatment, the minor's views and opinions can still be respected by obtaining *assent* (13,14). This is an ethical rather than a legal concept. Seeking the assent of a minor who is not legally authorized to consent demonstrates respect for the decision-making skills of a non-autonomous individual to the extent that he/she is able to participate in the decision. This is particularly relevant for adolescents who are cognitively maturing, but below the age of legal majority and still dependent upon adults for their basic health care decisions. Respect for the decision-making capabilities of an adolescent demands both confidentiality and privacy.

Reasons for Confidentiality

The Needs of Clinical Practice

The most practical reason for clinicians to grant confidentiality to adolescent patients is to facilitate accurate diagnosis and appropriate treatment. Experienced clinicians recognize that candid and complete information can be gathered only by speaking with the adolescent patient alone, and by clarifying with whom the information will be shared. If an assurance of confidentiality is not extended, this may create an obstacle to care since the adolescent may withhold information, delay entry into care, or refuse care.

A growing body of research has examined whether minors would seek health care if it were not confidential (15-20). For example, a study of Massachusetts high school students found that 25% would forego health care if confidentiality were not assured (15). In another study, a majority of students reported they would not go to their private physician for care related to sexuality, substance abuse or emotional upset, nor would they seek care for these problems if their parents had to know about the office visit (19). Thus, most adolescents seek confidentiality when questioned about their specific health care needs. (21)

Many other barriers to optimal adolescent health care have been identified, including inadequate health insurance, lack of age-appropriate facilities, office policies, lack of training and sensitivity of physicians and office staff in adolescent issues, and inadequate physician time (22). These barriers limit the opportunity for adolescents to discuss important health and behavioral issues. In a recent California survey, most adolescents reported they were unable to discuss sexual matters with their physicians, despite recognizing the helpfulness of such discussions (23). Confidential care, unlike economic and facility barriers, can be easily addressed, and integrated into clinical practices.

Developmental Needs

Adolescents seek confidentiality for reasons that derive from their unique developmental circumstance. Some teens fear parental retribution (24). Others fear damage to reputation and self-esteem (25). Most adolescents are striving for maturity, independence and adult status. In fact, most individuals over age 14 years have the cognitive ability to process medical information in a manner similar to adults (26).

The developmental needs and abilities of adolescents as well as the issues under discussion, help shape the physician-patient relationship (27). For example, sexual behavior and orientation, are generally felt to be highly personal matters by both adolescents and adults. Like adults, adolescents seek privacy in discussing these sensitive topics and may worry about parental disapproval. The practitioner and parent can help the adolescent develop independent self-care skills for even the most sensitive of issues by allowing the adolescent to practice confidential self-disclosure to the provider.

The degree to which the confidential relationship contributes to the health of the teenager will depend on each adolescent's developmental, medical, and environmental circumstances. The scope of confidentiality must be flexible and carefully considered. The clinician should take into account the adolescent's developmental capabilities, the presenting problem, and the adolescent's individual needs. By mid-adolescence, most teens are able to reason like adults, but because of inexperience, may require more guidance in medical decision-making. Previous research has found developmental differences between younger and older adolescents in understanding confidentiality and whether the explicit discussion of confidentiality facilitates disclosure of personal information (28,29). For the younger adolescent, the process of building a trusting relationship and demonstrating that confidentiality will be preserved was found to be as important as what was said. Moreover, Messenger and McGuire (28) conclude that a real life experience with this process is superior to a verbal explanation. Gender differences have also been demonstrated (9,28,29). For example, males were found to be more open to disclosure and less concerned about confidentiality violations than females. Studies have demonstrated that adolescents of either gender view confidentiality differently depending upon the health care setting (e.g., family planning or public health clinic), where they expect confidentiality, as compared to private physician's offices, where they are less sure if they will be afforded this practice (15,19).

Moral and Ethical Requirements

Providing confidential care to adolescents is a professional duty deriving from the moral tradition of physicians and the goals of medicine. The first references to the principle of medical confidentiality are found in the codes of professional ethics (30). The fundamental statement on confidentiality in the Western tradition is embodied in the Hippocratic Oath, which influenced all subsequent medical ethical reflections on this matter (31). Two philosophical arguments have been advanced which justify the principle of medical confidentiality. The utilitarian argument refers to the consequences of behavior and states that because confidentiality encourages patients to fully disclose their symptoms and life circumstances, the clinician's capacity to help them will be enhanced. Confidentiality allows for beneficence, or the moral duty to benefit the patient.

The second philosophical argument is based upon the moral-

ity of the action itself distinguished from its anticipated consequences. In this case, confidentiality concerns basic respect for adolescent patients as persons, respect for their autonomy and recognition of their right to privacy. Only recently have these principles been applied to the medical care of teenagers (32). This has created a dilemma for professionals who must balance their interest in protecting the health of their adolescent patients by providing appropriate, timely, confidential care and the desires of parents to know about the condition of their minor children and make decisions regarding their care.

Because adolescents vary in their psychosocial and economic autonomy, it becomes impossible to apply a single moral prescription in all cases. It is necessary to ground confidentiality in the moral necessity of respect for the individual while recognizing that it is permissible to breach confidentiality in selected instances, and only when certain requisites have been fulfilled. Should these special circumstances not be respected because a professional thinks it would be inconvenient or difficult, a clear moral breach will have occurred in which a physician places personal needs above those of the patient. Excessive paternalism results if confidentiality is disregarded because the physician decides what is "best" for the adolescent without a strong and persuasive reason.

Paternalism has been defined as either an interference with a person's freedom of action (33), as a "refusal to accept or acquiesce in an individual's choices, wishes and actions," (34) or as an act of coercion (35). Clinicians need to be extremely cautious when deciding to break confidentiality because it may seriously jeopardize the provider-patient relationship (36). However, in cases of suicidal or homicidal ideation or gestures, serious chemical dependence, the youth's disclosure of physical or sexual abuse and life threatening medical conditions (i.e., eating disorders), it may be necessary to disclose private information to the adolescent's caretakers or others. Silber (37) has proposed that "justified paternalism" in the care of adolescents could be appropriate under these circumstances, provided two conditions are met: reasonable evidence that an adolescent's capacity for autonomy is impaired; and, protecting the adolescent's life is the central goal. Thus, protecting life outweighs the principle of autonomy.

Should the physician encounter a circumstance in which "justified paternalism" and disclosure better serves the adolescent, there is still a moral duty to respect the adolescent. This can be accomplished by explaining the reason for breaching confidentiality and involving the patient in the process of revealing the confidential information.

Legal Issues and Guidelines

Legal provisions which support confidentiality include, among others, avoiding embarrassment and humiliation, protecting personal and family security, and avoiding discrimination or denial of service (38). For adolescents, legal protection for the maintenance of confidentiality serves two primary purposes. The first purpose (as has been discussed) is clinical utility and encourages them to seek necessary medical care. The second legal purpose is to grant adult rights to those minors who deserve them by virtue of their maturity. The minor who has achieved a level of maturity sufficient to enable him or her to give informed consent generally is entitled to the associated privacy of information.

The law has evolved in important ways over the past several decades in the degree to which it protects, or at least, does not impede the provision of confidential health services for adolescents. Nevertheless, there continue to be areas in which the current legal system fails to provide adequate protection, particularly with respect to current changes in the health care delivery system, such as the rapid shift to managed care. Moreover, care management will attempt to standardize health care delivery methods and might threaten the unique privacy needs of adolescents in such areas as medical records, care pathways, and gatekeeper functions.

Sources of the Confidentiality Obligation in the Law

There are numerous sources of the general legal obligation to maintain the confidentiality of medical information for adolescents (12,38). These sources include federal and state statutes, constitutional provisions, and regulations, policies, and protocols of federal and state agencies. Many, but not all, of these provisions have been interpreted in court decisions. In particular, the concept of the "mature minor" has been developed by state and federal courts over the past several decades. The concept of the "mature minor" applies to those situations in which an adolescent has the capacity to give an informed consent and is being provided with non-complex care that is within the mainstream of medical practice (39). Thus, the extent to which the law impedes or facilitates the protection of confidentiality in adolescent health care depends not only on the consideration of a broad range of overlapping and interconnected legal provisions, but also on an understanding of how those provisions have been, or might in the future, be interpreted by the courts.

Confidentiality and Consent

The dual concepts of confidentiality and consent are inextricably linked in the way the law affects the delivery of health care to adolescents who are younger than 18 years, the age of majority in almost every state. First, whenever consent for care is required from a parent or other third party, such as a court or child welfare agency, it is not possible for complete confidentiality to be maintained. Second, some laws authorizing minors to consent to their own care also require (or permit) that a parent or another person or entity be informed. Third, some laws governing the confidentiality and disclosure of medical information explicitly rely on the medical consent laws in delineating who controls the confidentiality of health information for minors, and even when they do not, the consent laws may provide implicit support for confidentiality (40).

Generally the law requires the consent of a parent when health care is provided to a minor child, although there are numerous exceptions to this requirement (12). Exceptions include medical emergencies, laws which specifically authorize minors to consent to their own care and care for the "mature minor." Consent may also be required from a third party such as a legal

guardian or conservator, for a severely mentally incapacitated person who is older than age 18 years.

A legal basis for minors to consent to their own care also provides a strong foundation for assuring that the care may be confidential. Every state has statutes which authorize minors to consent to medical care under a variety of circumstances (41-43). In some statutes, the authorization is based on the minor's status such as when the minor is emancipated, married, serving in the armed forces, pregnant, a parent, or a high school graduate; is living apart from parents; has attained a certain age; or has qualified as a mature minor. In other statutes, the authorization to consent to health care is based on the type of care needed, such as contraceptive services; pregnancy related care; diagnosis and treatment of sexually transmitted disease, human immunodeficiency virus or reportable diseases; treatment for drug or alcohol problems; care related to a sexual assault; or mental health services. These laws reflect policy judgments that certain minors have attained a level of maturity or autonomy which makes it appropriate for them to make their own medical decisions or that adolescents generally are unlikely to seek certain sensitive but essential services unless they are able to do so independent of their parents. While not every state has statutes covering minors in each of the above categories or all types of "sensitive" services, every state has some of these provisions.

Often the laws which authorize minors to consent to their own care also explicitly or implicitly restrict the disclosure of that information without their permission. In addition, other state laws, such as medical confidentiality statutes, sometimes refer back to the minor consent provision, specifying that a minor who has the right to consent also has the right to control the disclosure of confidential information. Finally, the United States Supreme Court, in decisions about the extent to which the constitutional right of privacy protects minors, has made it clear that when a minor is sufficiently mature to give her own consent for an abortion she must also be able to choose to seek an abortion without the knowledge or involvement of her parents, albeit with a judicial order affirming her maturity (44).

Confidentiality and Payment

The relationship between confidentiality and payment for services is a very important consideration. The laws which authorize minors to consent to their own care generally do not make any provision for payment for services, and in some cases, actually relieve parents of financial liability. It may be difficult, even impossible, to assure full confidentiality unless an adolescent has a way to pay for services, or the services are provided without charge.

Generally, parents are financially liable for the health care services provided to their minor children. However, families often rely on private or public health insurance to pay for part or all of the cost of care. Adolescents may be eligible to receive certain services without charge or at an affordable cost in a variety of settings such as community or migrant health centers, school-based and school-linked health clinics, and family planning clinics, among others. Legal provisions applicable to many of these funding sources do provide some degree of confidentiality protection (43). In some cases, such as federally funded family planning clinics, there are sliding fee scales based on income, and adolescents are permitted to qualify based upon their own income. In the absence of free care or the ability to pay themselves, adolescents may have to rely on direct payment for services by their parents or on utilizing their family's insurance coverage, if any. The necessity for a parent to sign an insurance claim in the case of private insurance, or to furnish a Medicaid card, may dramatically threaten the confidentiality of services. In such circumstances, the informal agreements reached between provider and the family with respect to confidentiality assume increased importance.

Protecting Confidentiality in Managed Care Settings

In recent years, there has been a dramatic increase in managed care, both as a service delivery method and as a financing mechanism. Increasing numbers of families - both those who are covered by private insurance and those covered by Medicaid - are receiving their care in settings such as staff model health management organization (HMOs) or through plans which use some form of managed care arrangement to restrict choice of providers, capitate costs, and perform gate keeping functions. Each of these situations pose problems for protecting a minor's confidentiality. Some adolescents are concerned that when other family members receive care from the same HMO or from the same primary care provider in a preferred provider network, confidential information may be shared with parents. Youth who receive care at sites such as school-based health clinics which may subcontract with managed care entities, may be concerned about the extent to which information communicated to the managed care plan will remain confidential. Unless adolescents can be assured that confidentiality will be maintained, or have the option of seeking care from other sources, they may avoid utilizing health services that would be otherwise accessible to them.

Legal Limits of Confidentiality

There are circumstances in which it is neither possible nor appropriate to maintain the confidentiality of information for legal and other reasons. These include situations in which the adolescent poses a severe risk of harm to himself or herself or to others, and cases of suspected physical or sexual abuse for which there is a legal reporting requirement. In addition, as previously mentioned, there are situations in which the law requires a health professional to notify the parents when a minor has received care, even care based on her own consent. The most common situations in which this occurs is with respect to abortion and drug or alcohol treatment. It should be remembered that under current constitutional law pertaining to abortion, if a state requires parental notification, it must also permit the minor to seek the alternative of court authorization without parental involvement. Finally, when confidentiality must be breached for ethical or legal reasons, the adolescent must be so informed.

Medical Records

Confidentiality protections apply to written information contained in medical records as well as to information that is communicated verbally between an adolescent and a health care professional. Adult patients, and by extension, mature adolescents who are permitted to consent to their own health care, should be allowed to review their own medical records and to protect their medical records from review by others. However, it is often more difficult to protect the confidentiality of written medical records than to do so for verbal communications-both as a practical matter, and as a result, of certain legal requirements. As electronic medical records are becoming more common, the task of protecting their confidentiality becomes complex.

Numerous legal requirements apply to medical records; many of these embody the same principles of confidentiality that also apply to verbal communications. There are, however, specific provisions that pertain to written records, in general, and heightened protections that apply to particular types of records related to substance abuse or mental health treatment (45). While basic rules of confidentiality apply to medical records, numerous exceptions require disclosure to a variety of funding entities such as Medicare and Medicaid, to other governmental agencies such as law enforcement, or to peer review organizations (45). In addition, with the permission of a patient or legally authorized representative, medical records can be disclosed to a wide variety of persons and entities, particularly insurers (45). Nevertheless a wide range of civil liability and criminal penalties may apply to the unauthorized disclosure of confidential records (45).

The same basic framework applies to medical records documenting health care provided to adolescents. However, when those adolescents are minors and the care involves sensitive issues such as pregnancy, Sexually transmitted diseases, substance abuse, or mental health concerns, disclosure of the records may be subject to specific legal requirements that balance-more or less successfully-the interests of adolescents and their parents. For example, some states have enacted specific provisions that give minor patients the right to decide whether or not to release medical records that pertain to care for which they can give their own consent (46,47). In some cases these laws even require that parents' requests to review such records be refused if the minor objects (46). This is not the case in every state or for all sensitive services, however, and even where such requirement applies, a parent might be able to seek a court order to compel release of the records. Therefore, it is essential to be aware of the requirements of state law.

As a practical matter, most hospitals and outpatient facilities follow a standardized policy that requires authorization from a parent or guardian for the release of records if the patient is below the age of 18 years. In most cases, with parent or guardian authorization, records are released without requiring the permission of the minor adolescent patient or even if the adolescent objects (45). This usually means that a parent or guardian, possibly even including a non-custodial parent, is allowed to review the medical records of a minor child. In some cases such a policy would be consistent with state law; in others there might be a legal basis for modifying the policy to entrust greater authority to the minor patient to decide whether records should be released.

Health care professionals who treat adolescents should be aware that protecting the confidentiality of medical records for their patients who are below the age of 18 years is far more difficult than protecting verbal communications. Practitioners should review all requests for disclosure of records related to their adolescent patients and should consider that sensitive or damaging information might be revealed if records are transferred. The clinician who cares for adolescents should seek to ensure that hospital or clinic policies prevent release of records without the permission of the treating professional. When disclosure of records is sought, treating professionals should err on the side of seeking the adolescent patient's permission before releasing the information. In some cases, such as reporting of child abuse pursuant to legal requirements, the caregiver may not have discretion to refuse disclosure. However, in such cases ethical principles would require that the mandatory release of information be explained to the patient. Whenever a clinician feels that releasing records might result in harm to the adolescent patient, consultation with legal counsel should be sought.

Practical Issues

Working to support a confidential relationship with an adolescent in a health care setting requires commitment. This section will review some practical issues and the implementation of confidentiality.

At an appropriate age for the patient, the health provider should set forward a "contract," either verbal, or in writing, so that the patient and parent understand the concept of confidentiality. Most providers discuss this at the beginning of an encounter and reinforce it at later encounters. Some compose a letter to patients and parents at a certain milestone age (12 or 14 years) and describe the changes that adolescent status will confer to the clinician/patient/parent relationship and how it will affect office procedures.

The contract should clarify the basic meaning of confidentiality. For younger adolescents it is necessary to describe in simple language that it means: "What we talk about will be private; I will not discuss it with anyone else." Some adolescents may assume that if you are discussing confidentiality, you must assume they have "secrets." Therefore, it is useful to say, "Our discussion will be private and confidential, even if you don't mind your parents knowing about anything that we talk about."

The conditional nature of confidentiality should be discussed with the adolescent patient. The risk of imminent physical harm or suspected abuse are necessary exceptions to the assurance of confidentiality. It is helpful to use examples that make this understandable. For example, "Everything will be confidential unless something happens, such as if you become suicidal, or you have a severe problem for which you cannot help yourself."

It should be mentioned that clarifying the confidential nature

of the discussion is not a time consuming task. Most providers learn by experience to do this quickly and efficiently. Although this confidential contract is necessary to clarify routinely, adolescents learn to trust the health provider by more than the initial discussion. Every aspect of the relationship, from the first discussion through meeting with the parent after the teenager's examination, to the follow-up phone call, if needed, will show the teen whether the provider can be trusted to follow the confidential agreement.

The parent or parents might wish to give information to the clinician without the teenager in the room. The provider might learn important information from an adult about a behavior that the teen is minimizing, hiding or in denial about. It is best to conduct these meetings after discussing the ground rules with the teen and parent. The provider should attempt to minimize the numbers of these private encounters with parents and to confine them as much as possible to the early stages of treatment. For most encounters, the goal is that everything that concerns the parents should be discussed in their presence. The health professional attempts to improve communication rather than set up separate relationships between physician and parent. This process helps adolescent patients recognize that the care is centered upon their needs and that they will not be excluded. If a provider accepts a parent's request to talk apart from their adolescent, the discussion should be kept confidential.

Health providers have recognized that verbal information is easier to keep confidential than information on the patient's chart. Some state laws mandate release of records to adults who request them. Various approaches have been taken to protecting written information. Some providers have created systems of abbreviations for commonly recorded bits of sensitive information; for example, "SU" to denote : sexually active; unprotected intercourse. Others have kept separate written or computer records with the most sensitive information recorded. It should be remembered that "shadow" files are legally retrievable in the same manner as the standard medical record, if discovered. For practical purposes, most health professionals record the important points of information on the chart in the standard fashion. Every request for records should come to the provider for permission. If there is information that might harm the adolescent if released, the advocacy effort to block the release can be started by postponing signature for the release and seeking legal support.

References are available online at: http://www.adolescenthealth.org/html/confidential.html

Prepared by:

Garry Sigman, M.D.

Tomas Silber, M.D.

Abigail English, J.D.

Janet Gans, Ph.D.

1. Council for Scientific Affairs, AMA. "Confidential Health Services for Adolescents," *JAMA Vol. 269 No.11, March 1993.*

This report reviews adolescents' need for confidential health services and major barriers to confidential care including the prerogative to provide informed consent for medical treatment and payment for health services. Privacy is generally acknowledged to be essential to a patient's trust in a health care provider and to a patient's willingness to supply information candidly. Recent exceptions to the traditional parental consent requirement have been made to consider adolescents in the armed forces, those living away from home or those considered emancipated minors. The legal need for parental consent triangulates the adolescent patient-physician relationship by bringing a third party into health care decision making. Confidential health care may ultimately be compromised by economic realities. Few adolescents can afford to pay for their own medical care, and few physicians can provide subsidized care on a regular basis. The article recommends that 1) providers reaffirm that confidential care for adolescents is critical to health improvement, 2) physicians involve parents in the medical care of their teens, 3) physicians discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated, 4) health care payers develop a method of listing of services that preserves confidentiality for adolescents, and 5) state medical societies review laws on consent and confidential care for adolescents and eliminate laws that restrict the availability of confidential care.

2. Ford, Carol A., MD, et al. "Foregone Health Care Among Adolescents," *JAMA Vol. 282 No. 23, December 1999.*

No annual national population estimates exist of the number of adolescents who think they need but do not receive health care or of their risk of health problems. Ford, et al. describe the proportion of young people who report foregone health care each year and the influence of sociodemographic factors, insurance status, past health care, and health risks/behaviors on the foregone care. Cross-sectional analyses of data from the 1995 National Longitudinal Study of Adolescent Health showed that on average, 18.7% of adolescents reported foregone health care within the past year. Factors associated with decreased risk of foregone care included continuous private or public insurance, or a physical examination within the past year. Factors associated with increased risk of foregone care included older age, minority race/ethnicity, single-parent household, and disability. In addition, adolescents who reported daily cigarette use, frequent alcohol use, and sexual intercourse were more likely to report foregone care. The results of this study suggest that adolescents who forego care are at increased risk of physical and mental health problems. If health care professionals are to address major causes of adolescent morbidity and mortality, strategies are needed to decrease foregone care. Factors that influence adolescents to forego care must be considered when designing systems to address adolescents' unique health needs.

3. Ford, Carol A., MD, et al. "Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care," *JAMA Vol. 278 No.12, September 1997.*

As part of a larger study on asymptomatic genital Chlamydia, Ford, et al. examines adolescents' willingness to be tested for sexually transmitted diseases (STDs) under varying confidentiality conditions. Participants

between the age of 15 to 24 completed an anonymous written survey measuring willingness to provide specimen for STD testing as part of routine health care under three different confidentiality conditions: if their parents 1) would find out; 2) might find out; or 3) would not find out that they were tested. Of 1,114 subjects enrolled in the larger study, 72% consented to participate in this questionnaire. Nearly all (92%) reported they would agree to STD testing if their parents would not find out. Significantly fewer would agree to testing linked to potential (38%) or definite (35%) parental notification. More male than female subjects were willing to agree to testing linked to potential or definite parental notification (49.5% vs. 33%). It is significant that the vast majority of sexually active adolescents report they would agree only to confidential STD testing. Privacy concerns may place infected female adolescents at risk of complications. Since most adolescents receive routine health care in private practice or HMO settings, confidential testing should be available at these sites. If physicians' abilities to provide confidential testing are limited because of threats to privacy associated with billing and reimbursement, changes to the systems will be necessary.

4. Hofmann, Adele D., MD. "A Rational Policy Toward Consent and Confidentiality in Adolescent Health Care," *Journal of Adolescent Health Care 1:9-17, 1980.*

Hofmann's review examines current conflicts surrounding consent and confidentiality in adolescent health care. She contends that rules governing consent and confidentiality must respond to the unique developmental status of youth as individuals who are increasingly capable of exercising rational choice and giving informed consent, yet still need flexibly proffered guidance and support by parents and/or other adults. Specific policy recommendations include: (a) the provision of options for adolescents to obtain confidential health services as necessary for health protection and/or as suitable for their level of maturity; (b) the establishment of counseling standards that require confidential services to adolescents to include developmentally appropriate guidance and support rendered by professionals trained in adolescent health; (c) the encouragement of adolescents receiving confidential care to consider whether or not they should involve their parents, recognizing that most young people are advantaged thereby; and (d) when confidentiality is not an issue, the active participation of adolescents in their health care decisions are affirmed by obtaining their informed consent.

5. Reddy, D., et al. "Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services," *JAMA Vol. 288, No. 6, August 2002.*

A study was performed to determine the effect of mandatory parental notification for prescribed contraceptives on use of sexual health care services by adolescent girls. 950 girls younger than 18 seeking services at all 33 Planned Parenthood family planning clinics in Wisconsin were surveyed. 59% indicated that they would stop using all sexual health care services, delay testing or treatment for HIV or other STDs, or discontinue use of specific (but not all) sexual health care services if their parents were informed that they were seeking prescribed contraceptives. Results of the study showed that mandatory parental notification of prescribed contraceptives would impede girls' use of sexual health care services, potentially increasing teen pregnancies and the spread of STDs.

FEDERAL MEDICAL PRIVACY REGULATIONS ("HIPAA RULES"): A BRIEF OVERVIEW

Prepared by the Center for Adolescent Health & the Law

What are the federal medical privacy regulations?

The "Standards for Privacy of Individually Identifiable Health Information" are federal medical privacy regulations (sometimes referred to as the "HIPAA rules") that broadly regulate access to and disclosure of confidential medical information. These regulations were promulgated by the Department of Health and Human Services (HHS) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

When were the regulations issued?

Proposed regulations were initially published in November 1999. Following the submission of thousands of comments, a final rule was published on December 28, 2000. The effective date of this final rule was postponed until April 14, 2001. Proposed modifications were published in March 2002. Following a public comment period, final modifications were issued on August 14, 2002.

What is the scope of the regulations?

The regulations address a broad range of issues related to the privacy of individuals' health information. They create new rights for individuals to have access to their health information and medical records and also specify when an individual's consent is required for disclosure of their confidential health information. The regulations also contain provisions that are specific to the health information of minor children.

Who must comply with the regulations?

The regulations apply to "covered entities," which include health plans, health care providers, and health care clearinghouses. According to the way each of these is defined in the regulations, the vast majority of health care professionals who provide care to adolescents will be required to comply with the regulations.

When must the new rules be implemented?

Large health plans, health care providers, and health care clearinghouses must comply with the rules by April 14, 2003. Small health plans must comply with the rules by April 14, 2004.

What do the new regulations mean for adolescents?

The new regulations contain numerous provisions that will affect the confidentiality of information regarding health care provided to adolescents. Most of the general provisions of the regulations are relevant. Adolescents who are age 18 or older are adults and have the same rights under the regulations as other adults. In addition, there are provisions of the regulations that address the specific issues related to confidentiality of information for minors, including adolescents who are under the age of 18 and not emancipated. This summary provides only a brief introduction to the provisions pertinent to minors. Detailed information regarding those provisions and information regarding other provisions of the regulations is available from other sources.

What are the specific requirements for adolescents who are minors?

Parents (including guardians and persons acting in loco parentis) generally are considered the personal representatives of and have control over and access to protected health information for their unemancipated minor children. In specific circumstances, parents are not necessarily the personal representatives of their minor children.

When is a parent not the personal representative of his or her minor children?

A parent is not necessarily the personal representative of his or her minor child in one of three specific circumstances; (1) when the minor is legally able to consent for the care for himself or herself; or (2) the minor may legally

receive the care without the consent of a parent, and the minor or someone else has consented to the care; or (3) a parent has assented to an agreement of confidentiality between the health care provider and the minor. In these circumstances, the minor may exercise many of the rights under the regulations. In these circumstances, the minor also may choose to have the parent act as the personal representative or not.

What happens when a parent is not the personal representative?
When a parent is not the personal representative of the minor, the minor may exercise most of the same rights as an adult under the regulations. With respect to the question of whether a parent who is not the personal representative of the minor may have access to the minor's confidential information ("protected health information"), the regulations defer to state or other law. If state or other law explicitly requires or permits information to be disclosed to a parent, the regulations allow a health care provider to comply with that law and to disclose the information. If state or other law prohibits disclosure of information to a parent, the regulations do not allow a health care provider to disclose it. If state or other law is silent on the question, a health care provider has discretion to determine whether or not to grant access to a parent to the protected health information.

What do the regulations mean for health care providers in California?
California has numerous laws that allow minors to give their own consent for health care. In addition, California has laws that specify the circumstances under which parents may or may not have access to information regarding the care for which minors may give their own consent. The federal privacy regulations would defer to those California laws. For adults, including adolescents age 18 or older, the federal regulations defer to state laws that provide stronger privacy protections than the federal rules do. Many other provisions of the regulations would remain applicable to health care providers in California.

What happens if a parent is suspected of domestic violence, abuse, or neglect?
When a parent is suspected of domestic violence, abuse, or neglect of a child, including an adolescent, a health care provider may limit the parent's access to and control over protected health information about the child by not treating the parent as the personal representative of the child.

Where is additional information available that explains the regulations?
Implementation of the regulations is being overseen by the Office for Civil Rights (OCR) within HHS. OCR has established a web site with comprehensive information about the implementation of the regulations: http://www.hhs.gov/ocr/hipaa/. The Health Privacy Project at Georgetown University also maintains a web site with extensive information and links regarding the regulations: http://www.healthprivacy.org/newsletter-url2305/newsletter-url_show.htm?doc_id=33936.

What are the official citations for the regulations?
Standards for Privacy of Individually Identifiable Health Information: Final Rule, 65 Federal Register 82461 (Dec. 28, 2000); and Standards for Privacy of Individually Identifiable Health Information: Final Rule, 67 Federal Register 53182 (Aug. 14, 2002). The original rule and the modifications will be merged and codified at 45 Code of Federal Regulations Parts 160 and 164. In the meantime, the August 2002 modifications must be read together with the December 2000 version of the rules to understand the full range of what is required.

How does a health care provider know what is required?
This overview does not provide legal advice. Health care providers should consult with legal counsel to be sure they are aware of the specific requirements of the regulations that apply to them and how to comply with those requirements.

CONFIDENTIALITY AND MINOR CONSENT-RELATED RESOURCES AVAILABLE ONLINE

- **National Center for Youth Law**
  http://www.youthlaw.org

  See Articles and Analysis about Adolescent and Child Health

  CA Minor Consent Laws – National Center for Youth Law, 8/01
  http://www.youthlaw.org/CaMinorConsentLaws.pdf

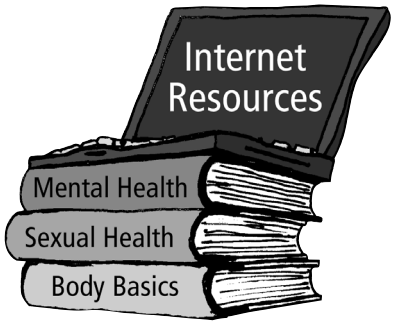
  CA Minor Consent Laws: Who can consent for what services and providers' obligations
  http://www.youthlaw.org/MinorConsentandObligations.pdf

  An Analysis of Assembly Bill 327: New CA Child Abuse Reporting Requirements for Family Planning Providers, 5/98
  http://www.youthlaw.org/AB327.pdf

- **Advocates for Youth**
  http://www.advocatesforyouth.org

  See Recent Publications

  Adolescent Access to Confidential Health Services, 1997
  http://www.advocatesforyouth.org/publications/iag/confhlth.htm



- **Society for Adolescent Medicine**
  http://www.adolescenthealth.org

  See Publications

  Confidential Health Care for Adolescents
  http://www.adolescenthealth.org/html/confidential.html

- **California Adolescent Health Collaborative**
  http://www.californiateenhealth.org/

  See Strategic Plan

  Investing in Adolescent Health: A Social Imperative for California's Future
  http://www.californiateenhealth.org/strategic.html

- **California Healthcare Association**
  http://www.calhealth.org/

  See Publications and Manuals

  Minors and Health Care Law: A Handbook in Consent for Treatment of Infants, Children, and Adolescents (order form)
  http://www.calhealth.org/public/pubs/gms/minors.html

Mandated Reporting Laws

About Child Abuse Mandated Reporting Laws

The Child Abuse Prevention and Treatment Act (CAPTA)—Federal Guidelines

- Under the Federal Child Abuse Prevention and Treatment Act (CAPTA) passed in 1974, all 50 states have passed laws mandating the reporting of child abuse and neglect.
- CAPTA provides a foundation for the States by identifying a minimum set of acts or behaviors that characterize physical abuse, neglect and sexual abuse.
- These laws vary from state to state.
- Each state is responsible for:
  - providing its own definition of child abuse and neglect.
  - describing the circumstances and conditions that obligate mandated reporters to report known or suspected child abuse.
  - providing definitions for juvenile/family courts when to take custody of the child.
  - specifying the forms of maltreatment that are criminally punishable.
- Mandated Reporting Laws change from time to time. You should consult your local Child Protective Services for the most current statute, if you have any questions or concerns about your responsibilities. See below for links to resources for information.
- Child Protective Service Agencies in California
- Child Abuse Prevention Councils in California
- National Child Abuse Reporting Hotlines
- California Penal Code at sections 11164 - 11174.3, can be accessed via the internet site titled California Law at: http://www.leginfo.ca.gov/calaw.html
- Each state's statute can be accessed via the internet at: http://www.calib.com/nccanch/services/statutes.htm

California Child Abuse and Neglect Reporting Act

- The most current Child Abuse and Neglect Reporting Act, which is contained within the California Penal Code at sections 11164 - 11174.3, can be accessed via the internet site titled California Law at: http://www.leginfo.ca.gov/calaw.html

The Intent of California Law

- To protect the child and any other children in the home.
- To provide help and resources for the parent or caretaker.
- Be a catalyst for change in the home environment and prevent the risk of further abuse.

Who Can Make a Report?

- Any citizen can make a report of suspected or known child abuse to a child protective services agency.

- However, Mandated Reporters are required by law to make a report.

What is a Mandated Reporter in California?

- In the scope of their employment, a Mandated Reporter has a special relationship or contact with children or the home. (The California Penal Code defines a "child" as a person under the age of 18 years.)
- A Mandated Reporter Is legally required to report if they know of or have "Reasonable Suspicion" of child abuse and neglect, encountered in the scope of their employment. Employers of Mandated Reporters are required to inform them of their responsibilities.
- Prior to commencing employment and as a prerequisite of that employment, Mandated Reporters must sign a statement to the effect that he or she has knowledge of the provisions of the Mandated Reporter Law, and will comply with those provisions.

Legal Obligations of a Mandated Reporter in California if Child Abuse is Known or Suspected

- The Mandated Reporter must call a "Child Protective Agency" as soon as possible to make verbal report of "Reasonable Suspicion."
- Then, the Mandated Reporter must file a written report on Department of Justice Suspected Child Abuse Report Form SS 8572 within 36 hours of their verbal report.
- Mandated Reporters are required to give their name.

What is "Reasonable Suspicion" as defined by the California Penal Code?

- "Reasonable Suspicion" occurs when "it is objectively reasonable for a person to entertain such a suspicion, when based upon the facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse." (California Penal Code 11166[a])

Child Abuse Report Form—Department of Justice Form SS8572

- Mandated Reporters and/or their employers should keep blank copies of the form on file at all times.
- If a blank form is not available when a report is made, the Mandated Reporter can request that the agency to whom the report is being made, send a blank form to them immediately.
- Copies of the form are available from your local Child Protective Services Agency or by writing to:

California Department of Justice
Bureau of Criminal Identification and Information
P.O.Box 90317
Sacramento, CA 94203-4170

Record Keeping

- Good record keeping or documentation is important and helpful in recognizing

child abuse…Why?
    - Helps refresh memories
    - Bolsters testimony of witnesses
    - The child's history stays behind if you change jobs
    - Helps build a "case" for reporting and CPS's response
    - Documentation of reasons when the decision is made to not make a report

Who are Mandated Reporters in California?

- Child Care Custodians
- In Public and Private Schools
    - Teachers
    - Instructional Aides
    - Teacher's Aides
    - Teacher's Assistants
    - Classified Employees
    - School Bus Drivers
    - Administrative Officers
    - Supervisors of Child Welfare and Attendance
    - Certificated Pupil Personnel Employees
    - School District Police or Security
    - Administrators, Presenters or Counselors of Child Abuse Prevention Programs
- Social Workers
- Law Enforcement
- Fire Fighters
- Probation Officers
- Parole Officers
- District Attorney investigators, inspectors and family support officers
- Public or Private Day Camp, Youth Center, Recreation Program or Organization Administrators
- Administrators and employees of child day care facilities
- Headstart Teachers
- Licensing Workers
- Public Assistance Workers
- Foster Parents
- Employees of Child Care Institutions:
    - Group Homes
    - Residential Care Facilities
- Health Practitioners
    - Physician
    - Surgeons
    - Psychiatrist
    - Psychologist
    - Psychological Assistants
    - Mental Health and Counseling Professionals
    - Dentist
    - Dental Hygienist
    - Registered Dental Assistants
    - Residents

    - Interns
    - Podiatrist
    - Chiropractors
    - Licensed Nurses
    - Optometrist
    - Marriage, Family and Child Counselors, Interns and Trainees
    - State and County Public Health Employees
    - Clinical Social Workers
    - EMT's and Paramedics
    - Coroners and Medical Examiners
- Clergy
    - Priest
    - Minister
    - Rabbi
    - Religious Practitioner
    - Or similar functionary of a church, temple or recognized religious denomination or organization.
- Other
    - Animal Control Officers
    - Film and Photographic Print Processors

Reporting and the Clergy

- The Mandated Reporter Law exempts clergy members from reporting known or suspected child abuse when the knowledge is acquired during "penitential communication."
- "Penitential communication" means a communication, intended to be in confidence, including, but not limited to, a sacramental confession, made to a clergy member who, in the course of the discipline or practice of his or her church, denomination, or organization is authorized or accustomed to hear those communications, and under the discipline, tenet, customs, or practices of his or her church, denomination, or organization, has duty to keep those communications secret."
- In other words, clergy members have many roles in the administration of their parish, I.e., bible study leader, committee work, etc. During those times, clergy are not exempt from the reporting mandate.

Sources of Reports

- Since 1990, statistics shown that 52% of the child abuse reports each year are made by Mandated Reporters.
- Mandated Reporters have the best opportunity to identify a child abuse problem before it becomes a statistic.
- A Mandated Reporter may be the only responsible adult in a particular child's life.

Immunities—California Penal Code Section 11172[a]

- Mandated Reporters have immunity from civil and criminal liability (unless the report was made maliciously, while knowing it was false).
- Immunity, however, does not eliminate the possibility that actions may be

taken against the Mandated Reporter. Therefore, the state will reimburse up to $50,000 in legal fees in case of a suit.

Penalties—California Penal Code Section 11172[e]

- A Mandated Reporter who fails to make a report of known or suspected child abuse:
    - Is guilty of a misdemeanor crime, which is punishable by up to:
        - six months in the county jail
        - and/or up to $1000 in fines
    - May lose their license or credential

Safeguards for Mandated Reporters in California

- Mandated Reporters cannot be prevented from reporting nor lose their job for making a report
- Identity is kept confidential (see more below on confidentiality issues)
- Employers are required to inform Mandated Reporters of their responsibilities
- May photograph or X-ray child without parent's consent
- Physician- and therapist-patient privilege does not apply
- Is not required by law to inform parents of report

Confidentiality—California Penal Code Section 11167

- A Mandated Reporter's name is to be held confidential at all times and can only be shared:
    - Between Child Protective Agencies
    - Child Protective Agency's Council
    - The Child's Council
    - District Attorney in cases of:
        - Criminal Prosecution
        - Parental Rights Termination
    - Licensing Agencies in Abuse Cases in Out-of-Home Care
    - By Court Order
    - If the Mandated Reporter Waives Confidentiality
    - Never to Mandated Reporter's employer except by consent or Court Order

Violations of Confidentiality—California Penal Code Section 11167.5

- Any violation of the confidentiality provided in California Penal Code Section 11167 is a misdemeanor, punishable by imprisonment in a county jail not to exceed six month, by a fine of $500 or both.

TEEN HEALTH RIGHTS

II. Confidentiality

Who controls access to medical information?

California's Confidentiality of Medical Information Act (CMIA) regulates the disclosure of most health care records.[5] It states that, in general, health care providers cannot share or release individual medical information without written authorization. Cal. Civil Code § 56.10(a).

The authorization must be signed by a parent or guardian when the parent or guardian consented for the minor's health care . Conversely, the authorization must be signed by the minor when the minor consented for health care or could have consented to the care under law. Cal. Civil Code § 56.11(c)(1)&(2).

There are exceptions . State law allows certain persons to inspect records without the need for an authorization. For example, minors have the right to inspect their own records when the records pertain to health care for which the minor consented or could have consented. Cal. Health & Safety Code § 123110(a). And parents and guardians have the right to inspect their children's records, as long as the records do not pertain to care for which the minor consented or could have consented. Cal. Civil Code § 56.10(b)(7); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1).

Federal regulations also address access to medical records . Federal HIPAA regulations generally restate California law — establishing that when a parent consents for an unemancipated minor's health care, that parent generally has a right to control access to the minor's medical information . The HIPAA regulations also honor a minor's right under state law to control access to her own records when the minor consented for that care . 45 C .F .R . §§ 164 .502(a)(1)(i)&(iv); (a)(2)(i); (g)(1); (g)(3)(i) .

CMIA and HIPAA establish certain general rules about access to medical information; however, there are exceptions to both the federal and state laws that change access rights in some instances.

What exceptions impact parent access to medical information about minors?

When Access Will Have A Detrimental Effect

Under state law, providers may refuse to provide parents or guardians access to a minor's medical records when "the health care provider determines that access to the patient records requested by the [parent or guardian] would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being." Cal. Health & Safety Code § 123115(a)(2).

Providers applying this exception in good faith to limit parent access to records shall not be liable for their refusal to share records. Cal. Health & Safety Code § 123115(a)(2).

EXCEPTIONS based on minor's status

The following confidentiality rules apply when minors satisfy these status conditions:

Emancipated Minor

When an emancipated minor consents for care, a health care provider is not permitted to share information or records with a parent without the minor's written authorization. Cal. Civil Code §§ 56.10, 56.11; Cal. Health & Safety Code §§ 123110(a), 123115(a)(1).

Minor Living Separate and Apart from Parents

When a minor consents for care under this section, "A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian." Cal. Family Code § 6922(c).

EXCEPTIONS based on services PROVIDED

The following confidentiality rules apply when minors receive these services:

Abortion

A health care provider is not permitted to share information or records regarding abortion services with a parent or legal guardian without the minor's written authorization. Cal. Civil Code §§ 56.10, 56.11; Cal. Health & Safety Code §§ 123110(a), 123115(a)(1).

Drug- and Alcohol-Related Problems

Federal regulations establish special protections for substance abuse treatment records . Providers who meet certain criteria must follow the federal rule . (For criteria, see footnote six below.)[6]

For those providers who must comply with federal rules, the federal regulations prohibit disclosing any information to parents without a minor's written consent if the minor acting alone under applicable state law has the legal capacity to apply for and obtain alcohol or drug abuse treatment. 42 C.F.R. § 2.14. However, a provider or program may share with parents if the individual or program director (if it is a program) determines the following three conditions are met: (1) that the minor's situation poses a substantial threat to the life or physical well-being of the minor or another; (2) that this threat may be reduced by communicating relevant facts to the minor's parents; and (3) that the minor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to her parents. 42 C.F.R. §2.14.

For providers who do not have to follow the federal rules, state law applies. Under state law, if a parent or guardian consents for a minor's drug or alcohol treatment, "the physician [must] disclose medical information concerning the care to the minor's parent or legal guardian upon his or her request, even if the minor child does not consent to disclosure, without liability for the disclosure." Cal. Family Code § 6929(g).

State law says that when a minor consents for her own drug or alcohol treatment, a health care provider is not permitted to share records with a parent or legal guardian without the minor's written authorization. Cal. Civil Code §§ 56.10(a), 56.11(c); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1). At the same time, state law

requires health care providers to involve the minor's parent or guardian in the treatment plan, if appropriate, as determined by the professional person or treatment facility treating the minor. The professional person providing care to the minor must state in the minor's treatment record whether and when the professional attempted to contact the minor's parent or guardian, and whether the attempt was successful, or the reason why, in the opinion of the professional person, it would not be appropriate to contact the minor's parent or guardian. Cal. Family Code § 6929(c).

Involving parents in treatment will necessitate sharing certain otherwise confidential information; however, having them participate does not mean parents have a right to access all confidential records . Providers should attempt to honor the minor's right to confidentiality to the extent possible while still involving parents in treatment.

Family Planning (Title X-Funded)

Federal regulations establish special confidentiality protections for family planning information gathered during a Title X funded service . Providers delivering services funded in full or in part with Title X monies must comply with the federal regulations.

For agencies delivering services funded in full or in part by Title X, federal law mandates that "[a]ll information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality." 42 C.F.R. 59.11. This regulation supersedes any state law to the contrary.

Thus, if a minor receives Title X funded services, the records cannot be disclosed to parents without obtaining the minor's documented consent.

Family Planning, Including Contraception

For agencies delivering services funded in full or in part by Title X, federal law mandates that "[a]ll information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality." 42 C.F.R. § 59.11.

For all other services, state law applies. California law says that a health care provider is not permitted to share information or records regarding the prevention or treatment of a minor's pregnancy with a parent or legal guardian without the minor's written authorization. Cal. Civil Code §§ 56.10(a), 56.11(c); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1).

HIV/AIDS

For agencies delivering services funded in full or in part by Title X, federal law mandates that "[a]ll information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality." 42 C.F.R. § 59.11.

For all other services, state law applies. California law says that a health care provider is not permitted to share information or records regarding a minor's HIV/AIDS services with a parent or legal guardian without the minor's written authorization. Cal. Civil Code §§ 56.10(a), 56.11(c); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1).

Infectious, Contagious, or Communicable Diseases (Reportable)

A health care provider is not permitted to share information or records regarding a minor's treatment for reportable diseases with a parent or legal guardian without the minor's written authorization. Cal. Civil Code §§ 56.10, 56.11; Cal. Health & Safety Code §§ 123110(a), 123115(a)(1).

Mental Health Treatment and Counseling

A health care provider is not permitted to share records regarding minor consent mental health care with a parent or legal guardian without the minor's authorization. Cal. Civil Code §§ 56.10(a), 56.11(c); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1).

At the same time, state law requires health care providers to involve a parent or guardian in the minor's treatment unless, in the opinion of the professional person who is treating the minor, the involvement would be inappropriate. The professional must state in the client record whether and when the professional attempted to contact the minor's parent or guardian, and whether the attempt was successful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian. Cal. Family Code § 6924(d).

Involving parents in treatment will necessitate sharing certain otherwise confidential information; however, having them participate does not mean parents have a right to access all confidential records . Providers should attempt to honor the minor's right to confidentiality to the extent possible while still involving parents in treatment.

Pregnancy

For agencies delivering services funded in full or in part by Title X, federal law mandates that "[a]ll information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality." 42 C.F.R. § 59.11.

For all other services, state law applies. California law says that a health care provider is not permitted to share information or records regarding the prevention or treatment of a minor's pregnancy with a parent or legal guardian without the minor's written authorization. Cal. Civil Code §§ 56.10(a), 56.11(c); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1).

Rape Treatment

For minors 12 and older:

A health care provider is not permitted to share information or records about rape treatment with a parent or legal guardian without the minor's written authorization. Cal. Civil Code §§ 56.10, 56.11; Cal. Health & Safety Code §§ 123110(a), 123115(a)(1).

For minors under 12 years of age:

The health care provider must attempt to contact the minor's parent or guardian and must note in the minor's rape treatment record the date and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent or guardian committed the sexual assault. Cal. Family Code § 6928(c).

Sexual Assault Treatment

The health care provider must attempt to contact the minor's parent or guardian and must note in the minor's sexual assault treatment record the date and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent or guardian committed the sexual assault. Cal . Family Code § 6928(c) .

Sexually Transmitted Diseases

For agencies delivering services funded in full or in part by Title X, federal law mandates that "[a]ll information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality." 42 C.F.R. § 59.11.

For all other services, state law applies. California law says that a health care provider is not permitted to share information or records regarding a minor's STD services with a parent or legal guardian without the minor's written authorization. Cal. Civil Code §§ 56.10(a), 56.11(c); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1).

Suspected Child Abuse Victims

Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported pursuant to this law in any court proceeding. Cal. Penal Code § 11171.2(b).

In what situations might I be allowed or required to give others access to a minor's medical information?

State and federal confidentiality laws contain many exceptions that allow or require providers to share medical information, whether or not they have parent or minor authorization. Examples include:

Reporting Certain Diseases and Conditions to Health Authority

“It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed [in the regulations], to report to the local health officer for the jurisdiction where the patient resides as required . . . .” 17 C.C.R. § 2500(b).

Sharing For Treatment Purposes

The CMIA permits, but does not require, a health care provider to furnish medical information, without need of an authorization, to providers of health care, health care service plans, contracts, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. Cal. Civil Code § 56.10(c)(1). However, a recipient of medical information pursuant to this exception may not further disclose that medical information --except with an authorization signed by the patient or the patient representative, or as otherwise required or permitted by law. Cal. Civil Code § 56.13.

Sharing For Payment Purposes

The CMIA permits, but does not require, a health care provider to disclose health information, without need of an authorization, to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, contractor, or any other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made. Cal. Civil Code § 56.10(c)(2). However, a recipient of medical information pursuant to this exception may not further disclose that medical information -— except with an authorization signed by the patient or the patient representative, or as otherwise required or permitted by law. Cal. Civil Code § 56.13.

Reporting Child Abuse

Mandated reporters of child abuse must make a child abuse report whenever they have knowledge of or observe a child whom they know or reasonably suspect has been the victim of child abuse or neglect. Cal. Penal Code §§ 11165.7, 11166.

To the extent that this reporting requirement conflicts with CMIA, the reporting requirement prevails. People ex rel. Eicheberger v. Stockton Pregnancy Control Medical Clinic, Inc., 249 Cal. Rptr. 762, 768 (3rd Dist. Ct. App. 1988).

Can individuals be held liable for revealing confidential information outside the exceptions listed in federal or state law?

Providers can only share information without client authorization if an exception in state or federal law specifically allows the release. If no exception applies that would allow a provider to share information, providers who reveal confidential information without authorization may be held liable. For example, providers who reveal confidential information in violation of California’s Confidentiality of Medical Information Act can be held criminally and civilly liable. Cal. Civil Code §§ 56.35, 56.36. In addition, the Department of Health and Human Services has the authority to enforce HIPAA confidentiality regulations and to impose sanctions on providers who breach those rules. See 42 U.S.C. 1320d-6; 45 C.F.R. § 160, Subpart C.

Beyond criminal and civil sanction, professionals who violate confidentiality also put their medical license at risk. For example, certain health care providers who “willfully” fail to respect the laws related to patient access to health records (Health and Safety Code sections 123110 et seq.) are guilty of “unprofessional conduct.” State law requires the state agency, board or commission that issued the providers’ professional license to consider such a violation as grounds for disciplinary action, including suspension or revocation of the license. Cal.

Health & Safety Code § 123110(i).

---

5. The CMIA applies to most but not all medical records. For example, it does not apply to certain mental health and drug treatment records. Other statutes protect the confidentiality of these records. See Cal. Civil Code § 56.30 for complete CMIA coverage list.

6. Federal confidentiality law applies to any individual, program, or facility that meets the following two criteria:

1. The individual, program, or facility is federally assisted. (Federally assisted means authorized, certified, licensed or funded in whole or in part by any department of the federal government. Examples include programs that are: tax exempt; receiving tax-deductible donations; receiving any federal operating funds; or registered with Medicare.) 42 C.F.R. §2.12;

And:

2. The individual or program:

1. Is an individual or program that holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral; OR
2. Is a staff member at a general medical facility whose primary function is, and who is identified as, a provider of alcohol or drug abuse diagnosis, treatment or referral; OR
3. Is a unit at a general medical facility that holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral. 42 C.F.R. § 2.11; 42 C.F.R. § 2.12.

MINOR CONSENT, CONFIDENTIALITY, AND CHILD ABUSE REPORTING IN CALIFORNIA

This publication is also available as a pdf file: **download now**