PART I: CLEARLY DEFINED PROBLEM AND NEEDS

INTRODUCTION

The Kanaka Maoli, also known as Native Hawaiians, are the indigenous people of Ka Pae ʻĀina, now called the Hawaiian Islands. As of 2000 Native Hawaiians compose approximately 20% of the State of Hawaii's population; however, nearly 50% of Native Hawaiians live on the mainland U.S., mostly in California, Oregon, Washington, and Nevada (2000 United States Census). Native Hawaiians have been forcibly assimilated into the current government and health system of care in Hawai'i. As with many other Polynesian groups, Native Hawaiians are not organized into tribal nations or entities and there is no one organized entity that represents the Native Hawaiian people or provides sole leadership. Although some maintain that Native Hawaiians are not a federally recognized entity, there are many Congressional Acts and events of precedence which establish recognition of Native Hawaiians as an indigenous peoples of what now is the United States **(see Appendix A & B)**. One of these Acts established the Native Hawaiian Health Systems and *Papa Ola Lokahi* (POL), the Native Hawaiian Health Board, in 1988. In collaboration with the Native Hawaiian Partnership for the Improvement of Co-Occurring Outcomes for Native Hawaiians, POL respectfully submits this response to SAMHSA to address co-occurring substance use and mental health disorders among the Native Hawaiian peoples.

CURRENT PREVALENCE/INCIDENCE RATES

Although the State Department of Health (DOH) collects the largest amount of statistical data on mental health disorders and substance abuse (COD), there are no large scale prevalence studies specifically for Native Hawaiians from either government or private sources. Limited data from small studies completed in Native Hawaiian communities are available from government and private groups, some of which are summarized below:

- Native Hawaiian students in grades 6 through 12 had higher rates of substance abuse than statewide rates of alcohol, tobacco and drug use. By 12th grade 60% of Hawaiian students have used drugs, compared to 46% state wide. (Ka Leo O Na Keiki, DOH, 2003)
- Native Hawaiians exceed any other ethnic group in the state for use of marijuana (8%), crystal methamphetamine (1.3%), hallucinogens (1.7%) and heroin/opiates (2.1%). (Substance Abuse in Hawaii, DOH, 2000)
- Arrest rates for drug manufacturing or sales are higher among Native Hawaiians than any other ethnic group. The three-year average arrest rate for Native Hawaiians is 7.4 per ten thousand, compared to the statewide rate of 5.5 per ten thousand. (Hawaii Department of Public Safety, 2002)

Statistics gathered from the DOH Alcohol and Drug Abuse Division (ADAD) show that Native Hawaiians make up approximately 38% of clients served statewide in FY 2006, which is a significant percentage of clients in need of COD services (DOH, ADAD, 2006). This percentage increases in some rural areas, such as communities on the islands of Hawai'i, Moloka'i, and the leeward coast of O'ahu. Rural substance abuse providers, Ho'omau Ke Ola and the DASH Hui Hōʻola O Nā Nahulu O Hawaiʻi report a large percentage of their client population are Native Hawaiian **(See Appendix C Table I)**.

Recent figures obtained from the DOH Adult Mental Health Division (AMHD) report a 60% co-occurring prevalence rate among its client population. Analyses of these data show that Native Hawaiians are disproportionately more likely to have co-occurring disorders than most other racial and ethnic groups. A graph depicting percentages of Native Hawaiians served within AMHD, by county, can be found in **Appendix D Table II**.

There are limited data available concerning Native Hawaiians with co-occurring disorders and treatment sub-group populations. The Salvation Army's Women's Way, a residential program in Honolulu offering alcohol and other drug treatment for pregnant and parenting women and their children, reports that over the past five years, 55-60% of all admissions have been Native Hawaiian. PTSD and depression are common among these women, who also report a high incidence of physical and sexual abuse and domestic violence. A review of collaborating data from other major State agencies show that Native Hawaiians make up a large percentage of those served in public welfare, judiciary and public safety, all areas that generally contain a large population of clients with mental health and substance use issues.

GAPS, NEEDS, BARRIERS & RESOURCES

As with virtually all colonized peoples, Native Hawaiians and their culture have been overwhelmed and minimized by Euro/Western cultural beliefs and practices. The near exclusivity of using Euro/Western approaches for treating co-occurring disorders creates a belief that is reinforced by the State that the Native Hawaiian way of healing or recovery is unacceptable, even to be shunned. This exclusive approach to treating co-occurring disorders reinforces the loss of cultural identity, damages the meaning of Native

Hawaiian health, and perpetuates the belief that Native Hawaiian treatment practices, values and beliefs are to be ignored. Subsequently the message becomes, to achieve health, one must leave behind thinking, being and acting "Hawaiian" to a more Western style of thinking and behavior.

The efficacy of using Native Hawaiian healing practices in the treatment of co-occurring disorders is slowly being recognized. These practices are asset-focused, resilience-building and provide a sense of protection which can strengthen the individual, family, and community. This provides not only healing but resolution of problems for future generations. It enables psychological decolonization and the formation of a new society where cultural pride and health are passed on from generation to generation.

Experts within the field of substance abuse and mental health services and Native Hawaiian cultural practitioners, from both government and private groups, have been meeting for the past two years in Honolulu, to discuss the availability, acceptability, and accessibility to culturally responsive mental health and substance abuse treatment services for Native Hawaiians. The COSIG Hawaii project and the Co-Occurring Center for Excellence (COCE) have provided leadership and technical assistance for this group, which now calls itself The Native Hawaiian Partnership (Partnership) **(See Appendix E Vision**). The Partnership has identified the following gaps and needs in serving Native Hawaiians in the areas of substance abuse and mental health:

- **There are few integrated mental health and substance abuse services that honor culturally responsive treatment for Native Hawaiians.**
- **There are few culturally responsive mental health and substance abuse providers able to implement these programs and provide such services.**
- **Governmental policies/practices can often create barriers to creating and providing culturally responsive treatment services.**

The group also recommended the following action areas for the improvement of treatment outcomes:

- **Improve our understanding of specific cultural practices that improve treatment outcomes for Native Hawaiians with co-occurring disorders.**
- **Improve data collection and analysis of culturally appropriate treatment for Native Hawaiians with co-occurring disorders.**
- **Reduce the need for future resources in this area due to improved prevention and treatment outcomes for Native Hawaiians and other special populations.**

The Native Hawaiian Partnership, the COSIG project and COCE worked together to present a first of its kind community forum called Kūkulu I Nā Hūlili (Bridging the Gaps), held on April 11, 2006 to bring community groups together to discuss and identify important areas of need that would lead to a plan of action to improve treatment outcomes for Native Hawaiians. The forum was attended by nearly one hundred forty representatives representing fifty community groups statewide. A representative from COCE, Anthony Ernst, attended the forum and completed on-site visits of two substance abuse treatment programs that provide integrated Hawaiian and Western treatment practices. Action areas for improvement were identified in the final forum evaluation report, published in April 2007 and noted below:

- **Explore methods of allocating specific funding for projects that can demonstrate successful culturally competent practices that treat consumers with substance abuse and mental health disorders.**
- **Develop funding streams for cultural practitioners, cultural interventions/strategies and *kūpuna* (respected elders) used in substance abuse and mental health treatment programs.**
- **Explore the application of this effort's culturally appropriate practices to other special populations in Hawaii to improve prevention and treatment outcomes.**
- **Explore methods of allocating funds to increase access of treatment programs in Native Hawaiian communities that experience limited access to treatment, i.e. rural areas.**
- **Explore resources for additional technical support to current providers in the development and application of culturally appropriate programs.**
- **Increase research and evaluation efforts to measure the effectiveness and efficiency of Native Hawaiian culturally appropriate practices.**
- **Develop a partnership with the Hawaiian community to help define and implement standards of practice for culturally appropriate treatment for Native Hawaiians with co-occurring disorders.**

Based on these final forum recommendations, the Native Hawaiian Partnership developed a three year strategic plan to address the above areas and also the sustainability of the group after the COSIG leadership ends **(See Appendix F – Strategic Plan**). The Plan's implementation will require top leadership buy in,

along with policy and system changes. Implementation of the Plan has already been initiated in several areas such as research and evaluation, education and mentorship of community providers.

PART II: SERVICE SYSTEMS/INFRASTRUCTURE

CURRENT SYSTEM OF DELIVERY

The current system of delivery contains two primary entry points: public and private. The majority of the under and uninsured population are served by the public system of care. Due to existing rate schedules among private insurance and public funding for services, provider agencies often tend to use public funding to provide services for Native Hawaiians who have no private third party insurance. There are no dedicated funding streams in the public sector to provide support for provider agencies who want to enhance and/or build culturally competent Native Hawaiian behavioral health services. Currently the majority of services, both public and private, follow a predominately Western model of care to which Native Hawaiians must adjust and assimilate. Lack of federal recognition prevents the public system of care from examining healthcare issues, including co-occurring disorders, as an effect of colonization. Hawaii is known as the *health state* because of longevity of life and health insurance for most. The indigenous people of Hawaii have not shared in that abundance like other groups have. In addition the indigenous people of Hawaii continue to have unmet health needs that are severe and far exceed that of the general population of the United States.

There have been several historical efforts involving both private and government groups to integrate Native Hawaiian tradition, practices, beliefs and values into the public mental health system. One of the most important efforts occurred in 1985 and produced a report called *E Ola Mau* – The Native Hawaiian Health Needs Study-Mental Health Task Force Report. The report was a collaborative effort between the DOH and Native Hawaiian groups. The report recognized barriers and gaps and produced solid recommendations for service improvement and understanding of cultural areas important to the understanding of treatment of Native Hawaiians with mental health issues. There was minimal follow up on the study with the public delivery system, but the study did add to the momentum and energy that led to the Native Hawaiian Health Act of 1988 that led to the formation of the Native Hawaiian Health System-Papa Ola Lokahi.

In addition, the certification process for substance abuse counseling (CSAC) in Hawaii, which is administered and maintained by ADAD, has no culturally relevant component. Certified counselors have had great difficulty in understanding and accepting the role of culture in learning and teaching styles, client values and historical significance and impact on cultural values and recovery. This leaves a gap in the workforce to create more culturally accessible programs.

PUBLIC SYSTEM OF CARE

Many Native Hawaiians enter the public behavioral health system through the judiciary system. Court-ordered treatment is a primary vehicle that brings Native Hawaiians into contact with the public system of care. The public system of care is comprised of several State entities that have primary responsibility for services, which are AMHD, ADAD and Judiciary.

The State of Hawaii has a Governor's cabinet level department, the DOH, which is the responsible authority for all of the health needs of its citizens. The DOH has three separate administrations, Behavioral Health Services, Health Resources, and Environmental Health. The Behavioral Health Services Administration includes ADAD, which is responsible for providing care for adults who have substance use disorders and AMHD, which is responsible for the care of adults who have serious mental disorders. The COSIG project is working to integrate care for co-occurring disorder consumers entering into both public systems.

Alcohol and Drug Abuse Division (ADAD)

The target population of ADAD includes adults and youth in the State of Hawaii who meets DSM IV-TR criteria for substance abuse or dependence and fall below 300% of the federal poverty level. For treatment services procured in the current state fiscal year (July, 2006 through June, 2007), a total of $21,473,661 was allocated, $16,608,400 of state resources and $4,865,261 of federal Substance Abuse Prevention and Treatment Block Grant funds. ADAD procures both treatment and prevention services via contracts with private agencies throughout the state via a competitive bid process.

ADAD contracts with private agencies for an array of services from residential to outpatient to therapeutic living programs to clean and sober housing to case management for criminal justice clients. These providers serve approximately 3000 adults statewide. Targeted populations include pregnant and parenting women and their children, injection drug users, dually diagnosed (mental illness and substance abuse), the homeless, youth through school-based services and Native Hawaiians. Specialized services include

methadone maintenance, social detoxification, interim services for pregnant women and injection drug users, and early intervention services for HIV disease.

Some challenges exist within ADAD for providing care for people who have co-occurring disorders. Most of the staff at its contracted agencies, while knowledgeable in treating individuals with substance use disorders, have limited to no training in mental health disorders. Additionally, few ADAD-contracted agencies have the availability of a psychiatrist, on staff or as a consultant, for medication management of behaviors associated with co-occurring disorders.

Adult Mental Health Division (AMHD)

The target populations that AMHD serves are primarily adults with severe and persistent mental illnesses and people who are court ordered for treatment within the DOH. AMHD is responsible for the care of approximately 13000 persons, and services and planning are divided into 4 counties. According to information in the AMHD client database, approximately 60% of individuals within the entire system have a co-occurring substance abuse disorder and severe and persistent mental illness. However, in rural areas where Hawaiians are heavily populated, the prevalence rates are much higher. AMHD is currently improving its methodology for identifying and recording the occurrence of co-occurring disorders and it is anticipated that these rates will rise in urban areas as well. As an example, within the AMHD administered Hawaii State Hospital, recent assessments have indicated that more 110 of the 168 patients have co-occurring disorders (Quadrants II and IV).

AMHD, in part, consists of eight state-operated community mental health centers (CMHC) and approximately 40 privately contracted providers who offer an array of mental health services including crisis intervention, specialized residential housing, psychosocial rehabilitation, supportive employment, acute care, and case management. AMHD operates the only state psychiatric hospital and contracts with private acute facilities for beds on some of the islands within the State. The State psychiatric hospital is equipped to handle 168 patients, and maintains contracts with private psychiatric facilities for approximately 27 additional beds. While mental health service delivery encompasses six major islands within the State, the majority of service recipients (approximately 60%) are located on the island of Oahu. In addition, the AMHD system has developed positions in the clinic system for COD and peer specialists.

NATIVE HAWAIIAN HEALTH SYSTEMS AND FEDERAL QUALIFIED HEALTH CENTERS

In 1985, the E Ola Mau Studies were submitted to the United States Congress. Congress responded in 1988 with P.L. 102-396, the Native Hawaiian Health Care Act (NHHCA). The NHHCA authorized Papa Ola Lokahi and the Native Hawaiian Health Care Systems (NHHCS) to address the poor health status of Native Hawaiians. Initially, Papa Ola Lokahi was charged with several tasks including facilitating the development of five NHHCSs located on five of the major Hawaiian Islands. The NHHCSs would provide targeted health care services to Native Hawaiians beginning with the provision of community health outreach services to address the mistrust of Native Hawaiians with healthcare systems, mistrust developed from historic interactions with culturally unskilled Western systems of care. Since 1988, the NHHCSs have expanded to provide primary care services including behavioral and oral health services. Each NHHCS has evolved to address the particular health care needs on its particular island including the provision of traditional healing services. Since this system of healthcare was created to address the particular healthcare needs of Native Hawaiians, its mission and programs differ significantly from other systems of healthcare.

A separate system of healthcare in which Native Hawaiians can choose is the Federally Qualified Community Health Centers (FQCHC). The FQCHCs are authorized under the Public Health Service Act, Section 330(e),(g),(h),(i), Public Law 104-299 and are charged to provide comprehensive primary and preventative healthcare services to underserved and vulnerable populations, generally those who are uninsured and underinsured. The NHHCSs and FQCHCs are distinguishable systems of health care with separate authorizing legislations, funding sources, missions, and targeted populations.

CURRENT SUBSTANCE ABUSE/MENTAL HEALTH PROVIDERS AND RELATIONSHIPS

Providers in both public and private sector have developed various relationships which involved sharing of information, training, research and evaluation. The public system of care has developed relationships with the University of Hawaii Social Science Research Institute, which provides research and evaluation services for AMHD. Graduate students provide technical support to AMHD's research and evaluation efforts. AMHD also has contracts with both the University of Hawaii Schools of Medicine and Social Work.

The COSIG Project in Hawaii has served to form linkages among ADAD, AMHD, their contracted providers, community stakeholders and consumers for the purpose of coordinating services. In addition, the Native Hawaiian Partnership has served to promote discussion among clinicians and researchers in the public and private sector in order to assess treatment practices, both Western and Native Hawaiian, and to offer service

recommendations. There is still a need to develop stronger and long lasting relationships between the Native Hawaiian organizations, community federal health clinics and the public system of care.

IMPLEMENTATION OF CLINICAL ISSUES

ADAD, through a SAMHSA-CSAT grant, funded the first culturally based Native Hawaiian program in the State (1997). This effort created a mechanism to provide a contract that was flexible and able to integrate mainstream funding and billing mechanisms for traditional cultural healing modalities. Through innovative contracting, the State was able to continue the program, collect data, evaluate and monitor culturally based approaches, with minor modifications, in its overall Purchase of Service billing systems. This has been a partnership between provider and State for the past 10 years. This experience can lay the groundwork for AMHD and ADAD to fund other culturally based projects. ADAD has recently formed a cultural committee within its Community and Consultative Services Branch (Treatment Contracts section) to explore the provision of culturally appropriate services through its contracts. Some providers are seeking federal and private funding to enhance programs through training and consultation with cultural experts, including *kupuna* or respected elder. This effort was developed largely through partnership efforts and education with the Native Hawaiian Partnership.

The greatest need to successfully treat Native Hawaiians is the ability to translate cultural perceptions and approaches into a Western format. Clinical and program supervision seem best achieved if the priority is hiring staff knowledgeable in Native Hawaiian culture rather than employing staff with only expertise in Western understanding of treatment practices. Addiction/recovery and mental health treatment practices are much easier taught than learning specific cultural beliefs and practices. In treatment, being able to make the connection between culture and recovery is of utmost importance for positive outcomes for Native Hawaiians. Addiction and recovery are Western concepts that demand serious revision in order to become viable treatment packages for Native Hawaiians, as well as to obtain local, state, and national funding. Other issues that need addressing include confidentiality, especially within a community cultural framework.

BARRIERS – IMPLEMENTATION AND INTEGRATION

One of the barriers to improving services until recently was the lack of integration between the public systems of care. Both ADAD and AMHD have evolved into separate systems of care with no coordination of services beyond the exceptions described above. In 2004 the State of Hawaii was awarded a Co-Occurring State Incentive Grant (COSIG) by SAMHSA designed to provide strategies for infrastructure change within both Divisions. The grant is near completion and will provide the State system with a Five Year Strategic Co-Occurring Service Plan, a Statewide Needs Assessment on Co-Occurring Services, and evaluation on a mobile team pilot project which provided services to rural areas with large percentages of Native Hawaiians. Both the COSIG Strategic Plan and Needs Assessment contain areas addressing Native Hawaiian co-occurring needs.

A second barrier to implementation is the diverse but fragmented system of care of behavioral health services that involves not only the public system of care, but the Native Hawaiian Health System, primary care system, and other Native Hawaiian organizations that fund SA/MH services in various communities. The Hawaii COSIG project identified a need for partnership and collaboration and has provided leadership for the formation of a community collaboration involving substance abuse and mental health providers, Native Hawaiian groups, State government and private community representatives to address the needs of Native Hawaiians who suffer from co-occurring disorders. The group has been meeting for almost two years attempting to provide a safe and productive venue for diverse Native Hawaiian groups to come together to discuss, plan and implement strategies to improve treatment outcomes for Native Hawaiians with co-occurring disorders. The Native Hawaiian Health System, Papa Ola Lokahi, a founding member of the group, has demonstrated a strong commitment to this effort by submitting this response to SAMHSA. The Office of Hawaiian Affairs (OHA) has also become a recent member of the Native Hawaiian Partnership. OHA provided support to this response and will play a key role in strategic planning for the Native Hawaiian community. OHA has a long-standing relationship with the Native Hawaiian Health Systems and Papa Ola Lokahi.

The core benefit of this response is that both the public and private systems, including the Native Hawaiian organizations will have an opportunity to collaborate, problem solve and identify system changes to improve SA/MH delivery to Native Hawaiians.

FUTURE PRIORITIES AND SIGNIFICANCE OF A STRATEGIC PLAN TO ADVANCE PRIORITY RECOMMENDATIONS

Members of the Native Hawaiian Partnership stakeholder group have identified the following key action areas to implement into a strategic plan. They are:

- **Identify traditional cultural approaches that promote treatment engagement, retention, and/or positive outcomes for Native Hawaiians who have co-occurring disorders.**
- **Identify evidence - (EBP) and consensus-based practice (CBP) approaches that promote treatment engagement, retention, and/or positive outcomes for Native Hawaiians who have co-occurring disorders.**
- **Examine the integration of culturally proven approaches in EBP and CBP for Native Hawaiians with COD.**
- **Train mental health and substance abuse treatment practitioners and provider organizations in how to integrate Hawaiian specific cultural approaches in EBP and CBP for COD.**
- **Build a coalition of provider and other community stakeholders with expertise in cultural competency for Native Hawaiians with COD in order to disseminate that information and impact systems change.**
- **Identify elements in traditional Hawaiian cultural approaches that have applications to persons/families of other cultures**

The Partnership has developed a Three Year Strategic Plan for the group's sustainability which can provide a foundation for the basis of a larger statewide Strategic Plan for the improvement of co-occurring disorder services to Native Hawaiians **(See Appendix F)**. The hope is that through a larger collaborative effort like the Policy Academy, involving additional policy makers and leadership, resources will be made available to improve the Plan advance it into action

PART III: POLICY COMMITMENTS

In order to improve care for Native Hawaiians there is the need to identify connecting points within public, private, community health centers, and the Native Hawaiian systems of care in order to partner and collaborate for benefit of Hawaiians. Current efforts of the Native Hawaiian Partnership have fostered improvement in stakeholder development efforts between government, Native Hawaiian organizations, and other private sector groups. Since the system of care for Native Hawaiians is complex and diverse, it is essential that partnerships and collaborations be nurtured and respected by all parties involved. The Policy Academy effort will provide an important point in this movement to bring together support mechanisms needed to improve the Partnership's plan to integrate these efforts into current initiatives such as the State Mental Health Transformation Grant, current research efforts, and other health initiatives to improve all systems of care for Native Hawaiians. A list of individuals and their qualifications, authority, and role in this effort has been included in this submission (**See Appendix G**). Team members were selected based on their ability to provide cultural consultation, leadership and policy expertise to implement changes for the sake of Native Hawaiians.

Through the efforts of the COSIG Grant and the Partnership, leadership in the public systems has been made aware of the needs of Native Hawaiians and their presence in the current system of care. Through the Native Hawaiian Partnership, other Native Hawaiian organizations and other interested stakeholders have joined in this effort. These many entities are committed to supporting all positive and applicable initiatives that emerge from the Policy Academy. The agencies and groups are committed to a minimum of a one year follow-up process with the Strategic Plan, including participating in an evaluation process with SAMHSA or its representatives. Primary policy and decision makers will be the board members of the Native Hawaiian organizations, leadership of the public systems of care and Native Hawaiian organizations, and community providers and *kūpuna* who make up the current system of care to Native Hawaiians. Contracted providers and their *kūpuna* are important representatives in these efforts because they provide a key role in how co-occurring services are delivered.

PART IV: FINANCING SYSTEM

Since there is no single system of care that delivers behavioral health to Native Hawaiians, financing for care is a diverse mix of public funding, third party insurance, and Med-Quest, a state funded health care plan. Native Hawaiians can enter services for substance abuse and mental health treatment services through many different systems of care, which makes the process complex in nature. It is probable the State systems will serve Native Hawaiians that are most in need, the underinsured and the uninsured.

It is estimated that at least 90% of the State's population is insured. Those who are not, are generally the "working poor" (the under-employed), or the unemployed. The State legislature guarantees parity for substance abuse treatment, so all of the 90% of persons who are covered by insurance have a system in place to cover costs of their substance abuse treatment (if deemed medically necessary and meet criteria universally acknowledged and used by ASAM-the American Society of Addiction Medicine). The State's

largest private insurance group is the Hawaii Medical Services Association and the second largest, is Kaiser Medical System. Many facility providers who utilized Native Hawaiian *kūpuna*, or elders, to provide cultural activities as part of the treatment plan and process are not reimbursed under HMSA or Kaiser because it is via a "per diem" payment system, not a fee for specific services. The plans do not exclude specific approaches, such as cultural activities. The issue is not necessarily of access, since there are services available, but more so, education about services and promoting health seeking behavior. The exception is reports by providers and consumers that rural areas continue to experience a need for additional services, such as treatment, case management, supportive housing and employment (2006 Hawaii COSIG Statewide Needs Assessment on Co-Occurring Services). The issue with Native Hawaiians is determining why they do not seek or access care.

There were no estimate funding levels for mental health and or substance abuse services available from the Native Hawaiian health systems or FQH Clinics available for this report.

Public System of Care

The public system actually services many individuals with private insurance, if one includes QUEST, the State managed insurance plan. Providers often receive better rates from pubic coverage than private coverage plans. Within ADAD there is a very limited Dual Diagnosis Services continuum of care that exists, due to limited availability of funding resources. The Division budgets for $407,491 for co-occurring services that are contracted to two community providers; Po'ailani and Queen's System. Po'ailani, provides a small amount of residential and outpatient treatment and the Queen's Medical Center provides $107,591 in outpatient treatment services only.

Funding for public mental health services comes primarily from State legislature allocations to AMHD and from Block Grant funding. AMHD is actively pursuing diversifying its funding streams to access additional federal support. For instance, AMHD has recently secured an agreement from the Hawaii Department of Human Services for the Medicaid Rehabilitation Option. This agreement negotiated reimbursement for four costly outpatient services previously paid by state funds (ACT, mobile crisis outreach, day treatment, and psychosocial rehabilitation). In addition, AMHD is seeking to become a health plan.

PART V: RELATIONSHIP WITH THE STATES

Because Native Hawaiians are not organized in tribal entities there is no formal relationship with the State of Hawai'i. There have been several initiatives made throughout history to bring a Native Hawaiian "voice" to collaborate with the public delivery system. These efforts have made small steps towards improving treatment outcomes for Native Hawaiians with co-occurring disorders. Currently, the most recent collaborative effort to bring this voice into the treatment arena has been the Native Hawaiian Partnership, a community collaboration fostered by the Hawaii COSIG project. Members of the Partnership were brought together in efforts to identify service delivery needs of this high risk population group. Partnership members conducted focus groups in Hilo, Hawai'i in the summer of 2005 with community providers to identify elements of effective services to Native Hawaiians. The basis of this effort drew together many representatives from provider groups, Native Hawaiian organizations, and other interested parties.

The Partnership is not the first effort to bring a cultural perspective together on a systems level. The E Ola Mau group in the 1980's brought diverse groups together to address the behavioral health needs of Native Hawaiians. Substance abuse and its related diagnostic categories were not addressed in this effort, however the spiritual distress related to cultural destruction and resulting diseases were discussed.

There are promising efforts being made throughout the State to bring forth what was identified by the E Ola Mau effort. Recently, the Hawaii State Senate in a resolution (118) called for the creation of a taskforce to determine the feasibility of developing a statewide healing program for ex-offenders and parolees that employ Native Hawaiian cultural practices. Similar efforts are being implemented into a Girl's Court program for female juvenile offenders in the Judiciary system.

Through SAMHSA's Policy Academy, efforts and attention to address this important issue will be accomplished through the development of a collaborative strategic plan. Representatives from important areas of the system will be represented. Letters of support from major groups are included in this submission packet.

PART VI: SHARING OF LESSONS LEARNED

If selected, Hawaii would be willing to share lessons learned not only from the gains made from the Policy Academy, but share lessons learned from the implementation of the CO-Occurring State Incentive Grant and the Evidence Based Practice Grant Project, both SAMHSA funded efforts. There are several culturally adapted evidence-based practices that AMHD have already completed or is on the verge of completing. Cultural modifications of the Integrated Dual Diagnosis Treatment Initiative are close to completion and cultural modifications for the Illness Management evidenced-based practice was completed six months ago. With Illness Management, several AMHD researchers and consultants worked collaboratively with the Hawaiian community in leeward Oahu to culturally adapt this "best practice." Again, modifications were made without compromising the fidelity. For example, instead of Illness Management, the community wanted to use the term Wellness. Also, the entire curriculum was adjusted to suit the cultural values and perspectives of the consumers who reside in that area. There is also a strong collaborative relationship with Oahu-based researchers and practitioners from the South Pacific that has possible implications for evidence based practices modified to the Pacific Islander culture.

The Native Hawaiian Health Systems and Papa Ola Lokahi have a lengthy history of partnering with traditional healers and dispensing their knowledge with other Native Alaskan and American Indians groups such as the Southcentral Foundation in Anchorage Alaska and the Haudenofaunee Nation (formerly known as the Iroquois Confederacy). The Department of Native Hawaiian Health (DNHH), with the University of Hawai'i John A Burns School of Medicine, demonstrated a training methodology which included expertise from Native Hawaiian healers and Native Alaskan healers from the Southcentral Clinic in Anchorage, Alaska. DNHH has established a medical student placement program with the Southcentral Clinic, allowing Native Hawaiian medical students the opportunity to work within a Native Alaskan traditional and western healing facility.

The Co-Occurring Center for Excellence (COCE) has been engaged in a sub-state entity technical assistance request since October 2005 with two substance abuse providers providing services to large Native Hawaiian population: Ho'omau Ke Ola (HKO) and Hui Hō'ola O Nā Nahulu O Hawaii (Hui) are lead agencies, on behalf of the Native Hawaiian Partnership. HKO is a non-profit community provider of substance abuse and co-occurring disorder services; the Hui is a treatment program of the Kū Aloha Ola Mau program (formerly the Drug Addiction Services of Hawaii). The Partnership has been developing resources and partnerships to begin examining the effectiveness of traditional cultural approaches in promoting treatment engagement, retention, and positive outcomes for Native Hawaiians who have co-occurring disorders. Through the efforts of COCE representative Anthony J. Ernst, the Native Hawaiian Partnership has been able to engage in a consultant session with Ray Daws of New Mexico to explore implementation and integration of Native Indian traditional healing practices into western recovery strategies. The technical request focuses on the identification and provision of culturally specific evidence - and consensus-based treatment services to individuals of Native Hawaiian ancestry who have co-occurring substance abuse and mental health disorders. Related areas of interest include stakeholder development and organizational readiness.

If selected to participate in the Policy Academy initiative, the Hawaii team would be able to share lessons learned through teleconference sessions, face-to-face meetings, and strategic planning efforts, sharing of evaluation reports and data, statistical data, website resources, toolkits, training events, consultant sessions and on site visits. All information and knowledge obtained from the Policy Academy efforts will be shared with partner groups and SAMHSA.

APPENDICES

APPENDIX A	**The Beginning: A Historical and Cultural Understanding**
APPENDIX B	**Acts, Plans, Hearings, Studies, Reports, Related to Indigenous Rights**
APPENDIX C	**Dept. of Health, Alcohol, Drug, Abuse Table I**
APPENDIX D	**Dept. of Health, Adult Mental Health Division Table II**
APPENDIX E	**Native Hawaiian Partnership Vision Statement**
APPENDIX F	**Native Hawaiian Partnership Three Year Strategic Plan**
APPENDIX G	**List of Policy Academy Team Members**

APPENDIX A:
ACTS, PLANS, HEARINGS, STUDIES AND REPORTS RELATED TO INDIGENEOUS RIGHTS

FEDERAL ACTS

Organic Act (Newlands Resolution), 1900 (31 Stat 141, Ch 339)
Hawaiian Homes Commission Act, 1920 (42 Stat 108, Ch 42)
Act of June 20, 1938 (52 Stat 781)
Admissions Act, 1959 (48 USC pres 491)
Older Americans Act, 1965 (42 USC 3001 et seq)
Rehabilitation, 1973 (29 USC 701 et seq)
Native American Programs Act, 1974 (42 USC 2991 et seq)
American Indian Religious Freedoms Act (42 USC 1996)
Native American Graves Protection and Repatriation Act (25 USC 3001 et seq)
Anti-Drug Abuse Act, 1986 (21 USC 801 note)
Development Disabilities Assistance and Bill of Rights Act Amendments of 1987 (42 USC 6000 et seq)
Native Hawaiian Health Care Act, 1988 (42 USC 11701 et seq)
Health Professions Reauthorization Act, 1988 (102 Stat 3122)
Nursing Shortage Reduction and Education Extension Act, 1988 (102 Stat 3153)
Handicapped Programs Technical Amendments Act, 1988 (PL 100-630)
Indian Health Care Amendments, 1988 (PL 100-713)
Disadvantaged Minority Health Improvement Act, 1990 (PL 101-527)
Native Hawaiian Health Care Improvement Act, 1992 (reauthorization)
Apology Resolution, 1993 (PL 103-150)
Defense Appropriations, Oct. 25, 1999 (PL 106-79, sec. 8141)
NATIVE HAWAIIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS, 2005 (S. 216)

FEDERAL STUDIES AND REPORTS

ALU LIKE Needs Assessment, 1976
ALU LIKE Special Reports-Health, 1977,1979
Native Hawaiian Study Commission Report, Vol 1 and 2, 1983
Federal-State Task Force Report-Hawaiian Homes Commission, 1983
E Ola Mau Health Study, 1985
Native Hawaiian Health Report-US Congressional Office of Technology Assessment, 1986
From Mauka to Makai: The River of Justice Must Flow, US DOI & US DOJ, 2000
Reconciliation at a Crossroads, US Commission on Civil Rights, 2000
Unequal Treatment, Institute of Medicine, 2003

THE PEOPLE SPEAK

"Hearings -Establishing the Hawaiian Aboriginal Claims Settlement Study Commission," 1976
"Hearings-Hawaiian Native Claims Settlement Study Commission," 1977
"Hearings-To Establish the Native Hawaiian Study Commission," 1979
"Hearings-Native Hawaiian Study Commission," 1984
"Proceedings of the Native Hawaiian health Needs Study Conference," 1985
"Hearings-Reauthorization of the Native Hawaiian health Care Improvement Act," 1992
"Ka `Uhane Lokahi," 1998
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MASTER PLANS

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APPENDIX B:
THE BEGINNING- A HISTORICAL AND CULTURAL UNDERSTANDING

This is our story. We must tell it in our way. We must do justice for the Native Hawaiian people. This provides the context and understanding of where we came from, who we are and where we are going. That is the Hawaiian way.

The *Kumulipo*, a Hawaiian creation chant which opens with lines describing the mating of Wakea, sky father, with Papa, earth mother. Out of this union came everything in the cosmos, including Kanaka Maoli, or Native Hawaiians. Thus, Kanaka Maoli, believed everything in the cosmos to be living, communicating and conscious. They believe they could communicate with these cosmic forces and used these forces to guide their thinking and acts. Kanaka Maoli (Native Hawaiian) chants contain the ability to take on the forces of the cosmos. Kanaka Maoli believe they are one with everything in the cosmos. They believed they were all siblings, with the same parents, and thus respected everything in their environment. Kanaka Maoli communicated with all forces in their universe, such as; the wind, sea, birds, forest, fish and other natural elements. They believe in maintaining *pono* or balanced relationships with each other and everything in their environment. The greatest virtue was to remain *pono* in their thinking and actions. The importance of maintaining proper relationships, harmony within ourselves, between ourselves and others and with everything in the cosmos, was the essence of being Kanaka Maoli. Kanaka Maoli's connection to their environment is a deep spiritual connection that binds Kanaka Maoli today to their '*aina* or land (Kekuni Blaisdell, Aloha Quest, Kumulipo/Hawaiian Cosmos).

The Kanaka Maoli were descendents of voyagers who settled in *Ka Pae'aina*, known today as the Hawaiian Islands. They sailed from afar using only celestial guidance, belief and knowledge of their cosmos. For over 500 years, they were isolated from the rest of the world. The voyaging settlers grew to become a healthy thriving society of an estimated count of 800,000 -1 million by the time western explorers reached the chain of islands. The *'aina* and *kai* or sea provided all the society needed to thrive in their new homeland. Prior to western contact, Kanaka Maoli existed in a well defined society connected to gods, a system of *kapu* (religious codes or laws) and the natural elements.

According to a study by Mary Francis Mailelauli'i Oneha, entitled, *"Ka Mauli O Ka 'Āina a He Mauli Kānaka:* An Ethnographic Study from a Hawaiian Sense of Place, Kanaka Maoli had a spiritual connection to a higher power, to self, and others, and to the natural elements which evoked a feeling of belonging to a place that created the importance of having and feeling a "sense of place". Kanaka Maoli felt *"Ka mauli o ka 'āina a he mauli kānaka,* the life or spirit of the land is the life of the people. In other words, if the land is not healthy, we are not healthy. Oneha identified five cultural themes to describe the basis of *ola* or life/health for Kanaka Maoli. They are:

- Health for Kanaka Maoli is a spiritual connection to their ancestral place.
- Health for Kanaka Maoli relates to the past, present, and future.
- Health for Kanaka Maoli is experienced with intention and understanding.
- Health for Kanaka Maoli means openness to the flow and use of energy.
- Health for Kanaka Maoli is experienced as a *pu'uhonua* or safe place.

The study also identifies several cultural values and concepts that are recognized as important to Kanaka Maoli in maintaining health. They are:

- ***Lokahi*** or Unity and Harmony
- ***Mana*** or Energy
- ***Pono*** or balance
- ***Kuleana*** or responsibility
- ***Ohana*** or family (extended and nuclear)

There are many other cultural themes, sources and values that were important to Kanaka Maoli in maintaining balance or *lokahi* in their lives.

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The Kanaka Maoli society quickly declined after Western contact due to introduced foreign diseases bringing their population count down steeply from almost 800,000-1 million by 1893 to about 40,000 (Stannard, David, 1989 Before the Horror: The Population of Hawaii on the Eve of Western Contact). Tragically, decimation was caused primarily by gonorrhea, syphilis, viral hepatitis and probably tuberculosis. Following those diseases, others arrived in the island like leprosy, plague, scarlet fever, diphtheria and smallpox, causing more destruction to Native Hawaiians who had not built up a immunity to foreign diseases. By 1893, Hawaiians were outnumbered by foreigners. Census figures in 2000 report that Native Hawaiians roughly constitute about 20 percent of the total state population. Most of these individuals report one or more other racial areas, other than Hawaiian. The accuracy of this count is difficult to determine because of deficiencies in survey methodologies, as well as racial/ethnic diversity that characterizes the population. There are few full blood Native Hawaiians remaining (1990 census showed about 8,000, current estimate run about 6,000 and future predictions estimate that in the year 2044, there will be no Hawaiians of pure ancestry).

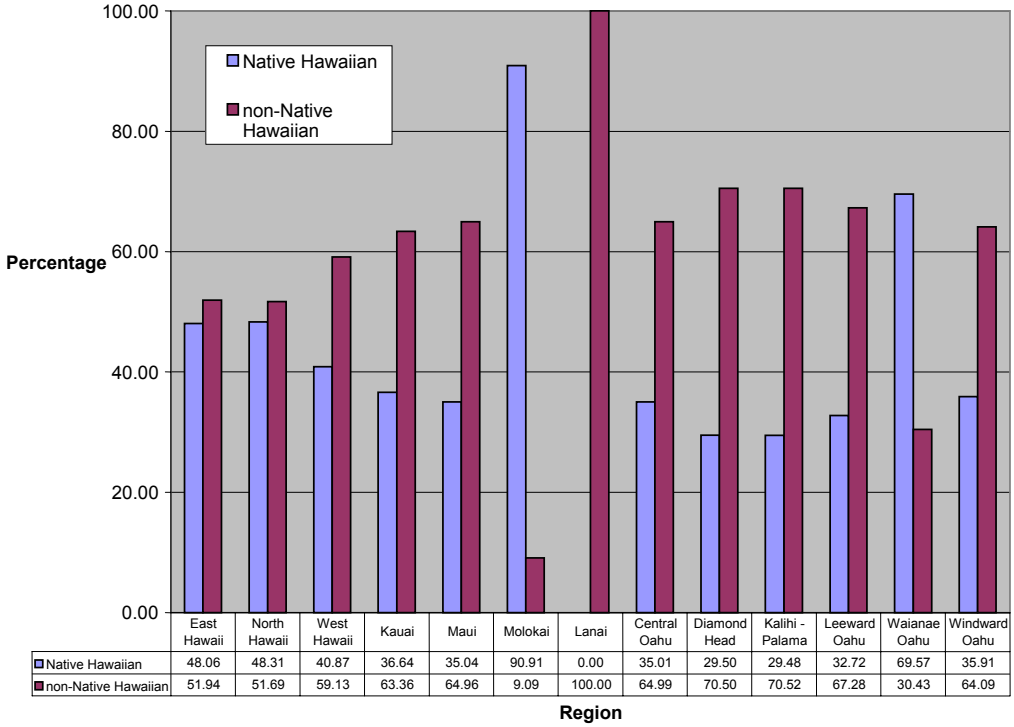
Historical assimilation and cultural trauma factors all resulted in a century of decline of health status of Kanaka Maoli, resulting in Hawaiians having the worst overall health profile in the State (Kekuni Blaisdell M.D. History and Cultural Aspects of Native Hawaiian Health 1989 Social Process). Only a recent resurgence of cultural pride in areas of language, dance, song, traditional practices and values have sparked a new and vibrant interest and commitment to regaining Hawaiian identify and those things important to being Hawaiian. But sadly social, economic and health statistic have in many areas remained the same or only slightly improved. Hawaii has experienced three generations of crystal methamphetamine abuse which has devastated our communities, especially Native Hawaiian communities.

Unfortunately, these historical factors have contributed to disproportionate high rates of substance abuse, arrest and incarceration, child abuse and neglect, and domestic violence for Kanaka Maoli (Ka Huaka'i 2005 Native Hawaiian Educational Assessment). This data corroborates the susceptibility of Kanaka Maoli to social stressors and a poor mental health profile. The concept of mental health is uniquely Western in nature and origin and has little validity for indigenous groups. Indigenous groups do not separate physical, mental and spiritual functioning which results in the separating of body and mind in health professions and professionals. As a result, assessing mental health needs of Native Hawaiians is a far more complex process than simply tallying numbers of admissions (E Ola Mau, Alu Like December, 1985). A study by Kamana'o Crabbe, Ph.D. in 1999 noted Hawaiians to have multiple meanings of sadness, adding complexity to the treatment of depression for Hawaiians within a western model of treatment and assessment. Currently, there are limited service options offered to these communities that provide treatment models that incorporate host cultural values and practices. There is also a lack of appropriate outreach efforts in some areas to engage this high risk population into MH/SA services. Compare to many other special population groups, Native Hawaiians have historically underutilized mental health services because these services fail to accommodate Native Hawaiian values and life styles.

In addition to physical decimation, Kanaka Maoli suffered a loss of language, arts and cultural practices resulting in a loss of cultural identity, self-worthiness, and self confidence resulting in despair, and a loss of willingness to live in a no longer meaningful society. Christian missionaries and others often brought insensitivity and viewed traditional practices, such as hula and language as threatening to Judeo-Christian beliefs. Shortly after the arrival of outside groups to the island chain, Kanaka Maoli had become strangers in their own homeland forcing to assimilate into the culture of foreign groups to their soil in order to survive.

APPENDIX C:

Table I: FY 2006 ADAD Admissions



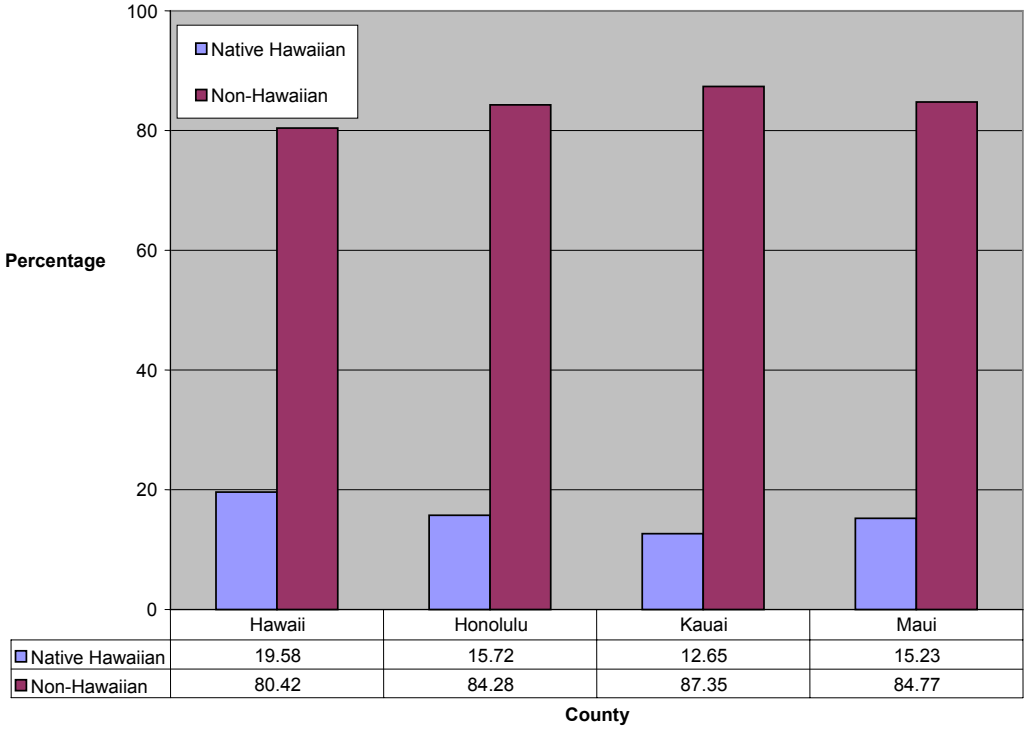
	East Hawaii	North Hawaii	West Hawaii	Kauai	Maui	Molokai	Lanai	Central Oahu	Diamond Head	Kalihi - Palama	Leeward Oahu	Waianae Oahu	Windward Oahu
Native Hawaiian	48.06	48.31	40.87	36.64	35.04	90.91	0.00	35.01	29.50	29.48	32.72	69.57	35.91
non-Native Hawaiian	51.94	51.69	59.13	63.36	64.96	9.09	100.00	64.99	70.50	70.52	67.28	30.43	64.09

Table I - Population breakdowns by percentages and state regions. The total number of ADAD admissions for FY 2006 = 6,551.

East Hawai'i	**876**
North Hawai'i	**118**
West Hawai'i	**504**
Kaua'i	**292**
Maui	**742**
Moloka'i	**44**
Lāna'i	**3**
Central O'ahu	**357**
Diamond Head	**478**
Kalihi Pālama	**1211**
Leeward O'ahu	**492**
Wai'anae	**437**
Windward O'ahu	**997**

APPENDIX D:

Table II: FY 2006 AMHD Admissions



	Hawaii	Honolulu	Kauai	Maui
Native Hawaiian	19.58	15.72	12.65	15.23
Non-Hawaiian	80.42	84.28	87.35	84.77

Table II: Population breakdowns by percentages and county. Total number of AMHD consumers served for FY 2006 = 11,217.

Hawai'i County	**2,844**
City & County of Honolulu	**6,412**
Kaua'i County	**689**
Maui County	**1,272**

APPENDIX E:
The Native Hawaiian Partnership for the Improvement of Substance Abuse and Mental Health Services for Native Hawaiians

History:
Native Hawaiians are an indigenous people, unique to the Hawaiian Islands. In the years since Western contact, the health of this group has shown a steady decline. Native Hawaiians are over represented in statistics concerning child abuse and neglect, prison population, substance abuse, suicide, and crime. They exhibit high rates of demoralization and low self esteem. Although limited data regarding mental health has been collected, personal moʻolelo, along with data collected in other social and educational areas, indicate Native Hawaiians are also at high risk for mental health problems.

Community studies, especially those from the University of Hawaiʻi, School of Social Work and Kamehameha Schools, indicate cultural pride, when present is a strong indicator of resiliency against preventing substance abuse and violent behavior amongst Native Hawaiians. These studies recommend that programs be developed that contain culturally appropriate treatment and engagement strategies that reflect traditional Native Hawaiian values and practices.

A newly formed collaboration began in September 2005, (hereinafter "Partnership") which included two lead community provider agencies; Hoʻomau Ke Ola (Waiʻanae) and the Hui Hōʻōla O Nā Nahulu O Hawaiʻi (Puna)-a project of Drug Addiction Services of Hawaiʻi , Inc. The collaboration came together to address the serious problem of mental health and substance abuse disorders in the Native Hawaiian population.

The Partnership recognizes that our State, in the midst of a serious crystal methamphetamine problem, is at a critical turning point that calls for all applicable groups and individuals to come together to address the issue of substance abuse and mental health problems that plague this high risk group and their communities. The Winds of Change or "Nā Makani Huliau" (turning point, a time of change, to change direction) are a strong force to bring together in a spirit of collaboration, both government, private individuals and groups to address this multi-faceted and complex problem.

Mission:
The mission of the group is to develop relationships and to establish a partnership of government agencies, Native Hawaiian groups, community advocates, and private agencies that support and are committed to the improvement of the health and welfare of Native Hawaiians through the development and support of services that incorporate traditional Native Hawaiian cultural practices and values.

Vision:
Native Hawaiians of all ethnicities will have access to effective mental health and substance abuse services that incorporate and respect traditional Hawaiian cultural practices, values and healing practices.
Principles:

- **The Partnership will promote community and government collaboration to identify and increase appropriate substance and mental health services to Native Hawaiians and their communities.** Members of the Partnership recognize the seriousness of these problems in our communities and the devastating impact upon families. It also recognizes that remedies come from community awareness and action along with strong, committed and collaborative efforts between government and private entities. The lead community agencies of the Partnership serve as role models and have an established history of providing recovery services to their predominantly Native Hawaiian communities and integrating evidence based practices with Hawaii's host culture's traditions and values.

- **The Partnership will promote, maintain, and protect the rich traditional heritage of the indigenous population of these islands and lift up their rich cultural practices and values**

to their rightful place in the recovery process. The Partnership supports the idea of every individual's right to reconnect with their spiritual self and life force to bring one's life back to whole and reconnect again with others in his or her 'ohana (family) and community. The Partnership upholds the value of meaningful work in the process of recovery, as eloquently stated in the following 'ōlelo no'eau (wisdom) by Kupuna (respected elder) Mary Kawena Pukui, "Aia ke ola i ka hana" or "Life is in labor" or "Life produces what is needed". The connection of life force with meaningful work offers any individual the opportunity to become whole and contribute to others' well being. This is the concept of sovereignty of self or returning one's life back to whole.

- **The Partnership will promote a research and evaluation process that is respectful of generations past who are now in spirit, those who are living, and future generations to come**. In addition, the Partnership will advocate for leaving a positive legacy to communities they serve, rather than removing resources or using them inappropriately.

Partnership Objectives:

- Identify the core traditional cultural elements that influence positive outcomes for Native Hawaiians in their recovery.

- Develop partnerships with defined actions and strategies between private and government groups/individuals serving and supporting effective recovery services within Native Hawaiian communities to help define and implement standards of practices for culturally appropriate recovery services for Native Hawaiians with mental illness and co-occurring substance use disorders.

- Provide education, mentorship and awareness on the appropriate manner by which to integrate both traditional practices and Western treatment methods when serving Native Hawaiian communities.

- Explore methods of allocating specific funding and resources needed for projects that can demonstrate successful culturally competent practices that treat Native Hawaiians with substance abuse and mental health disorders. Develop funding streams for traditional cultural practitioners, interventions/strategies and kūpuna used in substance abuse and mental health treatment programs.

- Explore methods of allocating funds/resources to increase access of treatment programs in Native Hawaiian communities that historically experience limited access to treatment, i.e. rural areas.

- Explore and develop resources for technical support and training to current providers in the development and application of culturally appropriate programs.

- Increase research and evaluation efforts to measure the effectiveness and efficiency of integrating traditional Native Hawaiian cultural practices into Western based recovery services for individuals with mental health and substance abuse disorders.

The following agencies and individuals are active members of the Native Hawaiian Partnership:

Coalition for a Drug Free Hawaii
Papa Ola Lokahi
J. Kuhio Asam, M.D.
Dept. of Health, Adult Mental Health Division, Office of Multi-Cultural Affairs
Salvation Army Treatment Facilities
Kū Aloha Ola Mau *(formerly known as Drug Addiction Services of Hawaii – DASH)*
Dept. of Health, Adult Mental Health Division, COSIG
Dept. of Health, Office of Health Equity

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Mental Health Services Research, Evaluation, and Training Program Social Science Research Institute - University of Hawaii
Ka Hau Naupaka
Office of Hawaiian Affairs
Ohana Makamae
Ho'omau Ke Ola
Dept. of Health, Alcohol and Drug Abuse Division
Queen Liliu'okalani Children's Center

APPENDIX F:
NATIVE HAWAIIAN PARTNERSHIP THREE YEAR STRATEGIC PLAN

Vision: Native Hawaiians will have access to mental health and substance abuse services that honor culturally responsive treatment.

Mission: To establish ***hana pono partnerships*** with all entities who support mental health and substance abuse recovery for Native Hawaiian communities and individuals.

Statement of the Problem: Native Hawaiians are an indigenous people, unique to the Hawaiian Islands. Reports indicate a distressing health profile for Native Hawaiians in need of culturally competent services for mental health and/or substance use disorders.

Experts within the field of Native Hawaiian mental health and substance abuse treatment met over the past year to discuss the availability, acceptability, and accessibility to cultural services for Native Hawaiians. Some of their findings include:

1. There are very few integrated mental health and substance abuse services that are culturally competent for Native Hawaiians.
2. There are few culturally competent providers to implement these programs and provide services.
3. Governmental policies/practices often create barriers to creating and providing culturally appropriate treatment services. .

At the Kukūlu I Nā Hulili Forum on April 11, 2006 on Oahu, 80 of 138 participants submitted evaluations. Of the 80, 28 percent worked at not-for-profit agencies, 23 percent at substance abuse treatment programs, and 19 percent at state government. A major theme that emerged from the evaluations identified recognition of the importance of culture and a longing for the integration of Native Hawaiian approaches in treatment. This forum identified for many:

1. The need to experience a sense of belonging and place
   a. Validation of Native Hawaiian approaches and practices as paths for healing.
   b. Reaffirmed the importance of Na Kupuna: Na Kupuna helped to explore a deeper understanding of self and place; connected me with my beliefs, behaviors and becoming (growth); need for Kupuna and Native Hawaiian cultural experts (practitioners) to lead in planning/delivery of substance abuse/mental health services
2. The need for education about existing culturally appropriate treatment programs
3. The need to develop relationships and promote partnerships between private and state groups/individuals, especially groups whose mission is to improve the health and welfare of Native Hawaiians, in order to support mental health and substance abuse recovery .

Research strongly indicates that cultural values play a significant role in determining an individual's view of the problem and treatment. Lack of access to treatment programs in which Native Hawaiians have a sense of belonging and reflect their cultural values poses an unacceptable barrier to the individual's recovery from mental illness and/or substance use disorders. Statistical data show that Native Hawaiians composite a significant group of client population engaged in substance abuse treatment agencies.

Solution: Form a collaborative of community providers and interested groups/individuals to develop and implement a state-wide plan that integrates and honors Native Hawaiian values, practices, and processes in mental health and substance abuse treatment services.

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NATIVE HAWAIIAN PARTNERSHIP THREE YEAR STRATEGIC PLAN

Goals	Objectives	Action	Outcomes	Kuleana	When
1.0. The creation of a strong and sustainable Partnership that provides leadership and consultation to the community in the development and implementation of culturally respected mental health (MH) and substance abuse (SA) services to Native Hawaiians of all ethnicities..	1.1. Develop a sustainable administrative infrastructure for the Partnership	1.1. Identify and recruit Kupuna to guide the Partnership 1.2. Identify the process of decision making and leadership 1.3. Create a process by which Kupuna routinely review and confirm the vision and mission of the Partnership 1.4. Develop criteria for membership and recruit new members 1.5. Represent and publicize the Partnership to help establish it within the community 1.6. Solicit support from national partners such as Co-Occurring Center for Excellence (COCE) , SAMHSA, APA, etc. 1.7. Create a brochure about the Partnership 1.8. Align the goals and activities of the Partnership with the mission and vision 1.9. Maintain and update a three year strategic plan that reflects evidence and developing practices in the development of a responsive MH/SA treatment system in NH communities. 1.10. Create a budget and identify	1. The following philosophies and beliefs guide the Partnership: a) Partners share a respect for kupuna, Ke Akua, the spirit of Ha. Partners feel a strong “heart aspect” in their connection. b) Partners understand the needs and share the importance of serving Native Hawaiians in ways that respect Native Hawaiian cultural traditions/values/practices and holistic view of life and health. c) Partners commit to doing the work and practice what they preach d) Partners share a collaboration of knowledge, experience, ancestry, & sense of shared responsibility to preserve and pass on this knowledge to future generations. 2. The Partnership is strong and actively working toward achieving and accomplishing its mission.	Partnership	3-year plan

		funding/sustaining efforts of the Partnership.			

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Goals	Objectives	Action	Outcomes	Kuleana	When
2.0. Establish, expand, and strengthen an effective collaborative Partnership with all who support MH and SA recovery for Native Hawaiians	2.1. Develop and support existing and new collaborative relationships	2.1. Define how Partnership will advocate for Native Hawaiian concerns with State MH and SA Divisions on policy decisions and programs 2.2. Identify a mechanism of understanding between State and Partnership outlining each group's commitment to work together and areas of responsibility to promote culturally appropriate services 2.3. Provide guidance/mentoring throughout State systems on culturally appropriate MH and SA services to Native Hawaiians 2.4. Identify and engage key large community groups for collaboration and partnership such as the University of Hawaii, School of Social Work, Alu Like, etc.	1. The Partnership helps others to understand and support the mission and vision of the Partnership. 2. Government SA and MH authorities demonstrate respect for the language, values, practices, arts, and history of the host culture by actively supporting these areas of culture and integrate them into the service array for treatment and efforts for Native Hawaiians of all ethnicities. 3. Engagement of additional key Native Hawaiian and community groups who are interested in supporting the wellness and welfare of Native Hawaiians.		

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Goals	Objectives	Action	Outcomes	Kuleana	When
3.0. Establish a MH/SA system of care that is culturally responsive to Native Hawaiians in all island communities which will contribute to and support an improvement in treatment outcomes for this high risk group..	3.1. Increase services that integrate Native Hawaiian traditional cultural practices and appropriate Western best practices for Native Hawaiians of all ethnicities..	3.1.1. Review current State system of accessing MH/SA care for Native Hawaiians 3.1.2. Evaluate demonstration projects that integrate Native Hawaiians and Western best practices in MH/SA services 3.1.3. Develop strategies to incorporate Hawaiian traditional practices and values into existing MH/SA programs 3.1.4. Identify and develop adequate resources for both land and ocean-based cultural sites for use within MH/SA treatment for Native Hawaiian communities. (e.g., lo`i, farmland, fishpond, etc.)	A knowledge base of integrated Native Hawaiian cultural practices and Western best practices is created and accessible to the public.	Partnership & State	
	3.2. Incorporate culturally competent practices into the existing MH/SA system of care.	3.2.1. Create or incorporate practices into a State strategic plan that comprehensively integrates Native Hawaiian practices into the continuum of MH and SA services for Native Hawaiians. 3.2.2. Develop a mentorship program that includes a resource of cultural practioners/healers and teachers, available to MH/SA providers who want to implement culturally appropriate services to Native Hawaiians.	Providers acquire and be able to apply traditional Native Hawaiian values/practices in the treatment of MH/SA and be able to integrate with Western best practices More MH/SA treatment providers integrate cultural best practices within their programs, increasing access and choice of treatment programs and providers for Native Hawaiians of all ethnicities. Agencies and providers actively utilize a mentoring service to incorporate Native Hawaiian healing practices	Partnership & State	

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Goals	Objectives	Action	Outcomes	Kuleana	When
	3.3. Improve access to culturally competent and best practice services for rural areas and neighbor islands communities, especially those with high rates of Native Hawaiian population.	3.3.1. Create policies/practices that eliminate barriers to Native Hawaiians access to care in the State MH/SA system of care. 3.3.2. Identify and implement strategies to increase access of Native Hawaiian practices in MH/SA care in rural and neighbor islands	Greater access for rural areas and neighbor islands to Native Hawaiian and Western best practices treatment services.	Partnership & State	

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Goals	Objectives	Action	Outcomes	Kuleana	When
	3.4. Increase resources for culturally relevant services to Native Hawaiians of all ethnicities in all island communities.	3.4.1. Solicit and secure funds for programs currently providing traditional cultural programs that demonstrate efficacy for treatment of Native Hawaiian consumers with co-occurring disorders 3.4.2. Allocate/identify funds for cultural experts (kupuna, healers, etc.) to provide training, technical support, mentorship and quality oversight of programs wishing to incorporate Native Hawaiian healing practices. 3.4.3. Secure funds to Partnership to cover administrative resources for meetings and leadership 3.4.4. Develop respectful and adequate reimbursement schedules with government and private insurance for traditional healing practices such as Ho`opnopono and Lomilomi 3.4.5. Assist ADAD and AMHD to create cultural specialist positions to monitor RFPs, contracted providers, training coordinators, RFP reviewers, and all other activities include culture appropriateness throughout the grant and implementation processes. 3.4.6. Actively solicit private funds and in-kind services to promote health and welfare of high risk Native Hawaiian communities	Programs with proven efficacy such as the DASH HUI and HO`OMAU KE OLA are reimbursed for cultural services. There is a financial source established from which programs receive help in developing integrated cultural/best practice services. All State contracted agencies have the opportunity to be reimbursed for cultural services. The Partnership provides leadership and consultation to all services	Partnership & State	

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Goals	Objectives	Action	Outcomes	Kuleana	When
4.0. Form research collaboration/partnerships to increase research/evaluation efforts that honor customs and traditional practices/processes and result in positive treatment outcomes for Native Hawaiians receiving MH/SA services..	4.1. Collect data relevant to Native Hawaiian communities as related to MH and SA 4.2. Define culturally appropriate Native Hawaiian standards of care. 4.3. Disseminate data relevant to services for Native Hawaiians to relevant groups promoting the health, welfare of Native Hawaiians 4.4. Develop products from the Partnership	4.1.1. Conduct need assessments of MH and SA services for Native Hawaiians communities 4.1.2. Identify methods to address needs. 4.2.1. Evaluate culturally appropriate community based programs such as the DASH Hui and Ho'omau Ke Ola to identify elements that make these programs successful. 4.2.2. Develop criteria of service that successfully engage, retain, and treat Native Hawaiian clients and their communities 4.3. Publish data and reports on MH and SA care for Native Hawaiians for public and strategic planning 4.4 Support the use and acknowledge of past SA.MH research efforts that offer technical recommendations to improve MH and SA services to Native Hawaiians-such as E Ola Ma Report.	Research on culturally validated treatment practices are promoted & and financially supported The needs of Native Hawaiian communities and means to address the needs are documented Best practices for Native Hawaiians are researched and documented.		

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Goals	Objectives	Action	Outcomes	Kuleana	When
5.0. Improved Quality and Accountability: Utilize Native Hawaiian core elements to evaluate initiatives and protocols addressing mental health and substance abuse for Native Hawaiians.	5.1. Ensure that the quality and accountability of services to Native Hawaiians are guided by Native Hawaiian core elements.	5.1.1 Identify and educate what core elements are necessary for the development of a quality SA and MH program for Native Hawaiians. 5.1.1. Develop a mentorship program to MH/SA providers to improve programs and quality assurance for Native Hawaiian clients. 5.1.2. Create a State/Partnership committee to oversee fidelity of cultural standards 5.1.3. Encourage agencies to designate a cultural staff to oversee cultural services	All state contracted MH and SA contracted agencies have cultural service plans and/or a schedule of weekly cultural activities for each haumana. All state contracted MH and SA contracted agencies have their cultural services reviewed regularly by an appropriate cultural monitor. All MH and SA contracted agencies have cultural coordinators/experts who are recognized by the community in which they serve to oversee cultural services.	State & Partnership	
	5.2.1. Increase public awareness of disparities of care for Native Hawaiian of all ethnicities. 5.2.2. Increase public awareness and promote discussions on culturally appropriate and best practices for Native Hawaiians	5.2.1. Plan and implement yearly Statewide Forums on culturally appropriate and effective MH/SA services for Native Hawaiians 5.2.2. Conduct quarterly open meetings inviting people to discuss how they would like to participate in the Partnership 5.2.3. Provide reports to the public addressing the improvement in both MH and SA care for Native Hawaiian communities that demonstrate positive outcomes.	A follow-up forum whose objectives are to expand and elaborate on the Kukūlu I Nā Hulili's recommendations and discussion areas.	Partnership & State	

		5.2.4 Provide education and promote awareness of the serious of the issue within Native Hawaiian groups and community agencies.			

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Goals	Objectives	Action	Outcomes	Kuleana	When
6.0. Improve data systems and information sharing among Native Hawaiian groups, government, and community groups.	6.1. Collect accurate demographic data on clients served, client outcomes, treatment methods, and identify gaps in service	6.1. Identify the type of data needed to address client demographics, outcomes, treatment success, and gaps in service 6.2. Review the current state system, suggest, and modify data collection to reflect the above.	The State data collection system produces accurate information that helps to improve the quality of care and treatment outcomes for Native Hawaiians	Partnership & State	

APPENDIX G:
LIST OF POLICY ACADEMY TEAM MEMBERS

Name	Qualifications	Strengths
Sarah Kelaukila Carter (ADAD Provider and cultural expert)	Project Director for CSAT grants- Rural Remote and Culturally Distinct Populations and Targeted Capacity Expansion HIV grant	Strong coordinator; able to work with kupuna elders and the "system" to provide needed services within a business and contract context. She has the ability to translate governmental requirements into terms kupuna can understand. Understands contract requirements and reporting as well as funding issues.
	Project Coordinator for culturally based program Hui Ho`ola O Na Nahulu O Hawai`i for past ten years.	Able to create a strong foundation for culturally and spiritually based program. Has been very active in the community and garnering support for these approaches. Supervises and manages well. Able to deal with business needs of the program. Member of the Native Hawaiian Partnership
	Native Hawaiian raised and well-versed in her culture. Taught by many kupuna (elders)	Has great knowledge of the culture and protocols and is able to negotiate through Western and Native cultures. Able to work closely with other Native cultures and is very respectful. Understands and provides healing arts. Understands the kauna (deeper meaning) of the language. Able to translate into Western thoughts/ideas. Able to teach the essence of the Hawaiian culture. Positive role model of a soon to be "kupuna" elder.
	Served on CSAT spiritual committee	Strong sense of spirituality. Her life experiences undoubtedly portray spirituality in her life. Is able to teach it and elicit it from others.
Lisa Cook (ADAD Provider)	Executive Director for past twenty years over an addictions treatment agency.	Understands and has experience with a wide range of approaches to include pharmacotherapies, behavioral approaches, traditional cultural approaches, etc. Able to work with government and with the day to day cultural programs. Able to write and understand policies and descriptions of Native Hawaiian approaches and evidenced based practices. Member of the Native Hawaiian Partnership
	MSW, ACSW, LSW	Able to connect culture with evidenced based practices; to create crosswalks when appropriate between culture and healing and treatment. Prior experience in mental health and child welfare. In the human services field for over 30 years.
	Project Director for CSAT rural remote and culturally distinct grant and targeted capacity expansion	Continued project after CSAT funding ended. Attended many TA meetings by CSAT for Native American, Native Hawaiian, Alaska Native and Mexican populations.
	Director of agency running culturally/spiritually based program for ten years	Taught by kupuna elders over a period of 10 years in the Hawaiian culture and spirituality. Learned many lessons from the Native Hawaiian staff and Haumana (students of the program).

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Uncle Howard Pe`a (ADAD Provider and Cultural expert)	Recognized kupuna elder by the Kupuna Council.	Studied under kupuna Aunty Abigail Napeahi for over 10 years. Strength of spirituality and in the culture. Excellent role model for makua or middle age Native Hawaiians..
	Traditional cultural provider and policy steering committee member for traditional culturally based addictions program	Providing ho`oponopono for 20 years, 10 with Hui Ho`ola. Served as policy steering member guiding the project on it mission, vision, goals and objectives.
	Member of Kū Aloha- Hui Ho`ola Independent Review Board	Served as a member of the review board. Has advocated for the need for cultural appropriateness and relevance in evaluation.
	Consultant to Kū Aloha	Provides spiritual guidance, training sessions to management and staff of the agency as well as of Hui Ho`ola in group and individual formats. Member of the Native Hawaiian Partnership
Randal Kaipo Like (ADAD-Provider)	Clinical Director for Hui Ho`ola for 9 years; clinical director for Ho`omau ke ola in the past.	Serves as curriculum developer, data gatherer, provides clinical supervision and direct practice work in culturally based program (Hui Ho`ola).
	Culturally competent	Serves as a role model of a makua and male in Hawaiian culture. Has studied the culture and Western evidenced based practices. Is able to translate evidenced based practices and apply the technology for Native Hawaiian populations. Member of the Native Hawaiian Partnership
	Community leader	Serves on a personal level to inform and advocate with the community about the needs of Native Hawaiians and participates in community cultural activities. He has strong interpersonal skills and a clear sense of self as a Native Hawaiian.
Patrick Uchigakiuchi (State-AMHD)	Psychologist-Researcher for (SRET) Research, Training Program –Adult Mental Health Division, State of Hawai‘i, Dept of Health. Specializing in the areas of multi-cultural issues.	Principal Investigator for three SAMHSA-CSAP research grants that investigated the efficacy of culturally adapted substance abuse prevention interventions for at-risk Hawaiian, Samoan, Micronesian and Filipino youths. Member of the Native Hawaiian Partnership. Will represent the leadership of the Dept. of Hawaii, Adult Mental Health Division.
	Cultural Competent Practitioner	Worked as a clinical psychologist in hospital settings serving primarily Asian and Pacific Islander consumers. Has broad experience in diverse professional areas with particular emphasis on Asian, Pacific Islander population in Hawai‘i
	Academic and Cultural Competency	Taught undergraduate and graduate courses in cross-cultural psychology, supervised interns serving Asian and Pacific Islander consumers. Lead academic roundtable discussions on cultural competency issues at Hawai’i Psychological Association conferences.

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Keith Yamamoto (State-ADAD)	Professional and Leadership	Chief of the Dept. of Health, Alcohol and Drug Abuse Division Policy Leader, Asian, Leadership roles in State government with Children and Youth.
Lt Governor James "Duke" Aiona, Jr. (State Executive Branch)	Professional and Leadership	Current Lt. Governor of the State of Hawaii. Leadership role in the COSIG Hawaii project-Co-Chair for COSIG Project Taskforce, policy maker. If Lt Governor is unable to attend, a representative from his office may be selected as an alternate.
James Siebert, Ph.D (community provider)	Leadership Executive Director of Ho'omau Ke Ola (HKO) , Wai'anae, O'ahu for years. HKO is an addiction facilities serving primarily Native Hawaiian population. HKO provides both outpatient and residential treatment, integrating Native Hawaiian cultural areas with western evidence based practices	Understands and has experience with a wide range of approaches to include pharmacotherapies, behavioral approaches, traditional cultural approaches, etc. Able to work with government and with the day to day cultural programs. Able to write and understand policies and descriptions of Native Hawaiian approaches and evidenced based practices. Member of the Native Hawaiian Partnership
	Professional expertise	Substance abuse treatment and homelessness population for over thirty-three years national and international in India. Has presented nationally on television and radio on the integration of spirituality and sexuality.
	Academic and cultural competency expertise	Practicing Psychologist. Taught psychology at both college and graduate levels and conducted lecture, seminars, and classes national on spirituality.
Palama Lee, MSW (Native Hawaiian organization)	Director, the Native Hawaiian Scholarship Program, Papa Ola Lokahi, Native Hawaiian Health System	Social Worker in the Native Hawaiian Health System serving as an Administrator and representative of Papa Ola Lokahi. Provides consultation and technical assistance to the administration and board of Papa Ola Lokahi on co-occurring issues.
	Academic and cultural competency	A doctoral student in Social Work specializing in cultural competency and mental areas. Instructor in social work at the college level.
	Leader in the community	Past Director of adult mental health services at Hale Na'au Pono, a SA provider on Oa'hu serving a large percentage of Native Hawaiians. Active in various community efforts, such as the HIV/AIDs community, etc.
Betty Jenkins (ADAD provider and cultural expert)	Respected community elder or kupuna. Former Educator. Consultant to Ho'omau Ke Ola, a SA provider, and POL.	Serves on the Kupuna council for Ho'omau Ke Ola as Kupuna consultant. Member of the Native Hawaiian Partnership.
	Professional and cultural competency areas	Provides community training and technical assistance on Native Hawaiians values and practices.

		Currently works with providers on integrating Native Hawaiian practices into SA/MH treatment programs.
Steve Morse (Native Hawaiian organization)	Lead Human Service Advocate for the Office of Hawaiian Affairs, Social Worker in community	Provides consultation and technical assistance to the Office of Hawaiian Affairs on COD issues affecting policy and decision making and strategic planning. Community social worker providing services to Native Hawaiian communities for many years.
Iwalani Else, Ph.D.(State – University of Hawaii)	Assistant Professor, Department of Psychiatry Associate Director, National Center on Indigenous Hawaiian Behavioral Health.	Researcher on co-occurring disorders, behavioral health issues, suicide and culture in Native Hawaiians and Pacific Islanders.
	Academic and cultural competency	Received a doctorate in Sociology with a specialization in mental health and culture. Teaches medical students and faculty. Health Disparities Scholar, National Institute of Health Former Minority Fellowship Program in Mental Health, American Sociological Association
	Leader in the community	Active in Hawaiian communities to improve behavioral health, violence and substance use issues through translational research (i.e. research that informs culturally based and appropriate prevention and intervention).