Statewide Needs Assessment of Co-Occurring Substance Use and Mental Disorders for the State of Hawaii: Phase I, II and III – Final Report

Conducted by the State of Hawaii
Co-Occurring State Incentive Grant
(Hawaii COSIG)

Report Prepared for the March 4, 2008 Project Taskforce

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Executive Summary

This report summarizes the results of a three-pronged Statewide Needs Assessment on Co-Occurring Substance Use and Mental Disorder Services conducted by the Co-Occurring State Incentive Grant (COSIG) Project. The COSIG project aimed to develop and enhance the capacity and infrastructure of the State of Hawaii's publicly funded mental health and alcohol and drug service systems to provide integrated, evidence-based treatment services to people who have co-occurring substance use and mental disorders (COD).

The primary purpose of the COSIG's Statewide Needs Assessment was to provide the COSIG Project with information that would facilitate the following activities: a) assess the status of the State's co-occurring disorder services system; b) identify unmet needs, gaps, and other problems within this system; c) provide data to plan for development and enactment of strategies to resolve these obstacles to COD care; and, d) provide information to assist in developing plans to build capacity and infrastructure to sustain a high-quality, integrated, and seamless system of COD care.

Phase I of the COD Statewide Needs Assessment involved convening 46 focus groups (335 participants) statewide to obtain information from Hawaii's COD consumers/family members, providers, and administrators about their perceptions, experiences, and priorities for which to better serve consumers with COD. **Phase II** included conducting six key informant interviews to validate focus group information and to explore any unidentified priorities which may not have been gleaned from the focus groups. The third, and final, phase of the Statewide Needs Assessment, **Phase III,** included the development and administration of a survey instrument to validate further the information obtained from Phase I and Phase II and to identify and clarify priorities for improving the statewide system of care for COD consumers.

Phase I

Results of **the Phase I** Focus groups conducted between February 2005 and December 2005 identified 14 major themes which are described below.

Theme 1 – **Scope of Co-Occurring Disorders**- provided a variety of descriptive information from participants regarding the scope of the problem of co-occurring disorders (COD) in Hawaii, challenging issues for staff and consumers participating in COD treatment, and the complexities of treatment and "personal recovery" for COD consumers. One major sub-theme emerged under Theme I, the identification of methamphetamine as the prominent drug of choice for COD consumers in Hawaii.

Theme 2 – **System Issues**- centered on a myriad of "system" issues that challenge the provision of care to consumers with COD such as barriers in bureaucracy and paperwork requirements.

Theme 3 – **Integration Issues**- described the problem of lack of integration and coordination between Hawaii's state Alcohol and Drug Division (ADAD) and the Adult Mental Health Division (AMHD), as well as among programs and individual providers of substance abuse and mental health services.

Theme 4 – **Interagency Collaboration**- focused on the importance of the need for better collaboration of both the mental health and substance abuse systems and services.

Theme 5 – **Access**- described problems with access to services for COD consumers, eligibility, admission and reimbursement for services in both the mental health and substance abuse services system.

Theme 6 – **Quality of Care**- centered around problems and issues related to the quality of care of COD services for consumers in both the mental health and substance abuse systems of care.

Theme 7 – **Continuum of Care**- discussed the gaps and problems in the continuum of care services for COD consumers in both the mental health and substance abuse systems.

Theme 8 – **Treatment Approaches**- focused on treatment approaches for COD consumers and consisted of several principles identified by participants as useful and helpful in guiding effective treatment for individuals with COD.

Theme 9 – **Treatment Modalities**- discussed treatment modalities consisting of a variety of approaches and interventions identified by participants as helpful in treating or recovering from COD.

Theme 10 - **Cultural Considerations**- focused on cultural considerations with participants voicing a myriad of issues concerning the need for infusing more cultural competency into COD services.

Theme 11 – **Living in Recovery** -described aspects which encompasses what is needed for consumers to obtain needed supports to maintain COD recovery.

Theme 12 – **Public Education and Public Perception of COD**- centered on the need for public education and public perception of COD to decrease the stigma and the stigma carried by both substance abuse and mental health professionals regarding COD.

Theme 13 – **Resources**- detailed the need for improved availability and access to a myriad of resources to support recovery for consumers with COD including human resources, financial resources, physical resources, consumer resources, and treatment resources.

Theme 14 – **Special Populations**- described special populations which need specialized care and services within the COD care delivery system.

<u>Phase II</u>

Phase II, the Key Informant interviews conducted between July 2006 and December 2006 identified 11 themes all with similar elements as the Phase I - Focus groups. These 11 themes included the following;

Theme A **- Scope of Drug Problem**
Several participants mentioned concerns over the scope of Hawaii's drug (methamphetamine) problem and it was observed that the overall system needs to improve its strategies to address Hawaii's drug problem including both legal and social solutions.

Theme B **- Service System Issues**
Most participants noted that the service system's needs should be assessed and that any strategies proposed to improve services for COD consumers should include a multifaceted approach. This multifaceted approach needs to be inclusive and coordinated, and represent not only the health and human service system, but also the criminal justice system, and focus on implementing comprehensive strategies that are bio-psycho-social (legal, economic, cultural) in nature for addressing and treating COD.

Theme C **- Service Level Coordination**
Many participants mentioned the importance of the need for close communication and coordination among mental health and substance abuse professionals and agencies and other entities, such as criminal justice, health care providers and other community resources that COD consumers use in their quest for recovery.

Theme D **- Barriers to Treatment**
Some participants mentioned that barriers to COD treatment should be alleviated. Such barriers listed included misdiagnosis of COD, lack of insurance coverage, lack of qualified professionals to assess COD accurately, and lack of bed space and funding for co-occurring treatment programs.

Theme E **- Evaluation of Outcomes**
The majority of participants noted that attention to program evaluation to include both process and outcome evaluation was a necessary ingredient to improve and expand upon quality services.

Theme F **- Service Delivery**
This theme encompassed the following 4 components: a) Improving clinical assessment of COD; b) Enhanced case management; c) Increase bed capacity for COD treatment services; and d) Improve transitioning services to community after treatment.

Theme G **- Treatment Approaches**
This theme included the need to accent the following areas available for COD treatment options: a) Evidence based practices (EBP's); b) Holistic approach; c) Stagewise Treatment; d) Cognitive behavioral therapy; e) WRAP crises planning; f) Therapeutic alliance; g) Multidisciplinary approach; and, h) Increased availability of MD's.

Theme H **- Cultural Considerations**
This theme consisted of the following areas all focused on the importance of attention to cultural sensitivity and awareness in COD services: a) Improve cultural competency; b) Integrate cultural practices: and, c) Hire diverse staff. All participants mentioned that it is important to improve cultural sensitivity and competency in all levels of services provided to COD consumers.

***Theme I* - Foundations for Recovery**
Theme I centered on important components necessary to support COD consumers' recovery and included: a) Need for strong Support Systems; b) Housing; c) Self Help support; and, d) Vocational Rehabilitation.

***Theme J* - Resources**
This theme focused around training, consultation, and funding resources needed to support and improve services for COD consumers and included the following; a) Training for professionals; b) Technical assistance; and, c) Increase funding for COD treatment services.

***Theme K* -Special Populations**
This final theme focused on the need to study, plan and improve services for COD consumers who are homeless.

Phase III

Finally, **Phase III** (Survey) implemented between March 2007 and September 2007 and developed from Phase I and Phase II results, included 942 respondents (534 females, 387 males, 10 transgender and 10 "prefer not to answer"). The majority of respondents were White (34.9%), followed by Hawaiian (14.8%) and Japanese (13.5%). Nine hundred-ten (96.6%) respondents resided in Hawaii. All islands were represented in the statewide total, with the majority, 73.5%, from the island of Oahu, followed by the islands of Hawaii (9.8%), Maui (8.4%), Kauai (5.8%), Molokai (1.6%), and Lanai (0.9%).

Survey respondents were system stakeholders who were defined by their roles within the system of care and grouped according to the following categories; consumer, family member, direct service provider, concerned citizen, and managerial/administrative. Moreover, this phase of the statewide needs assessment and study's recruitment efforts focused on attempting to obtain participant representative of a statewide sample of stakeholders in the public sector substance abuse and mental health systems (State of Hawaii Department of Health Alcohol and Drug Abuse [ADAD] and Adult Mental Health [AMHD] Divisions). Additionally, private providers and other stakeholders (e.g. criminal justice, health care) were invited to complete the survey. Just over half of respondents represented the mental health system category (51.6%), followed by substance abuse system (35.0%) and lastly the criminal justice system (13.4%).

In terms of overall findings of the Phase III - Survey, 69.0% of survey respondents declared Item #1 on the survey, the **"Methamphetamine drug problem"** as their number one concern. The top 10 priorities identified by respondents are listed below.

Rank

1. Methamphetamine drug problem.
2. More housing for people with CO-OCCURRING DISORDERS.
3. Having substance abuse and mental health agencies work together better.
4. More money for programs already set up.
5. Helping persons with CO-OCCURRING DISORDERS get services faster.
6. More substance abuse treatment on our island.
7. Having Adult Mental Health Division (AMHD) and Alcohol and Drug Abuse Division (ADAD) work together to help consumers.
8. Being able to get help from crisis services 24 hours a day.
9. Making outreach services better.
10. More services for families

Moreover, ten themes emerged from the 538 comments received to the open ended question included at the end of the survey which asked respondents to note other priorities or make additional general comments. These 10 themes supported the overall Phase I, Phase II and Phase III survey results as they accented such concerns as need for more education and training on COD, improved collaboration across services and professionals, more housing options for COD consumers, more programs to serve COD consumers, and the need to improve the quality of services currently being provided.

Taken together, results of Phase I, II and III of the comprehensive statewide needs assessment described similar unmet needs, gaps, and problems within Hawaii's COD's service system. The top 10 COD priority service needs identified by the Phase III survey overlapped with findings from both Phase I and Phase II. Listed in Table 12 (see Appendix G) are the 14 primary Phase I Focus group themes cross referenced with the 11 themes gleaned from the Phase II Key Informant interviews. These 2 sets of themes are then cross-referenced with the top ten Phase III Survey results noted by survey respondents.

As one can note from Table 12 (see Appendix G), the Phase III - Survey results of the top 10 ranked items created a cluster of priorities - (which had also been identified in Phase I - Focus groups and Phase II Key Informant interviews) to be addressed for which to improve services to COD consumers across the state of Hawaii. These priorities include the following:

a) **The need to address the scope of the methamphetamine problem among COD consumers;**

b) **Improved integration and state level coordination between Hawaii's Adult Mental Health Division and the Alcohol and Drug Abuse Division and improved collaboration between substance abuse and mental health providers to serve COD consumers better;**

c) **Addressing the need for more housing for COD consumers;**

d) **Improving access to COD services including timeliness of crises services and enhanced outreach services;**

e) **Providing more funding to programs already reaching COD consumers and increasing substance abuse services on neighbor islands;**

f) **Providing services to families of COD consumers.**

Now, that all three phases of the COSIG statewide needs assessment have been completed, the results from Phase I, II and III are integrated into one comprehensive report described in this document. It is anticipated that these comprehensive needs assessment data can be used at a myriad of levels to help the COSIG project's leaders and other policy makers in developing and implementing statewide strategic plans, building infrastructure, and taking other actions to improve services for COD consumers.

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Introduction

Co-occurring substance use and mental disorders (COD) have been identified as a major and common complicating factor in the delivery of mental health care, substance use treatment, and primary healthcare (1-7). Recent national studies have estimated that approximately 50% of individuals with a serious mental illness (SMI) have a co-occurring substance use disorder.

Throughout the 1990's and into the 21st century, data have been collected leading to the conclusion that it is necessary to address the problem of co-occurring substance use and mental disorders to improve clinical and cost outcomes. Outcomes for people who have co-occurring disorders, for example, are poorer than those for persons who have substance use or mental disorders alone. In addition, individuals with co-occurring disorders are at higher risks for homelessness, emergency room admissions, traumatization and/or victimization, and admittance to psychiatric hospitals (8-12, 21). As the importance of the co-occurring disorder phenomenon becomes more clearly understood it is evident that systems designed to address the needs of persons with substance use disorders or persons with mental disorders are ill prepared to provide services to persons with both. To make matters worse, most states' mental health and substance use treatment services have been funded and structured separately. This separation has, in turn, contributed to difficulty in obtaining appropriate care for persons with co-occurring disorders.

Fortunately, there has been an emerging consensus on best practices for identification, assessment, treatment, case management, and system integration for persons with co-occurring disorders (11, 13-24, 25-29). Thus, barriers to effective delivery of services for persons with COD have been identified and are being overcome through the development of systems of care that integrate interventions and service strategies drawn from both the substance use and mental disorder treatment systems. The necessity for restructuring systemic, infrastructure elements to reduce barriers to treatment is now clearly appreciated.

Consequently, one of the first goals of the COSIG was to establish a system-spanning task force (the Project Taskforce) that was responsible for the continuing development and implementation of action plans and protocols to: **a)** assess the status of the State's co-occurring disorder services system; **b)** identify unmet needs, gaps, and other problems within this system; **c)** assist to develop and enact strategies to resolve these obstacles to care; **d)** and, build capacity and infrastructure to sustain a high-quality, integrated, and seamless system of care.

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This multi-stakeholder Project Taskforce (PT) was the major vehicle for providing oversight for completing this comprehensive statewide needs assessment (**Phase I, II & III**) described in this document to use in planning and implementing infrastructure and capacity enhancement and improvement. The PT was co-chaired by the State's Lieutenant Governor (LG) and the COSIG Project Manager. Committee members were representative of Hawaii's multicultural population and included two top level executives, one each from Alcohol and Drug Abuse Division and Adult Mental Health Division, mid-level administrators from Alcohol and Drug Abuse Division and Adult Mental Health Division, representatives each from Alcohol and Drug Abuse Division (ADAD) and Adult Mental Health Division (AMHD) contracted providers, consumers of co-occurring disorder treatment, and family members. The PT served as the advisory committee to the project. Overall, the statewide needs assessment **(Phase I, II & III)** was designed to allow all substance abuse and mental health system stakeholders the opportunity to present to the taskforce their ideas about the effectiveness of the current system of care in working with people who have co-occurring disorders and what they saw as needed for an enhanced system.

This report summarizes and aggregates observations from across the State obtained from this three-phase, mixed evaluation design that included conducting focus groups to gain participants perceptions and experiences of the service delivery, completing key informant interviews, and the development and administration of a survey to rank and prioritize participants' concerns about how to serve consumers with COD better. The integrated results reported in this report **(Phase I, II & III)** describe what respondents see as the most important areas of Hawaii's co-occurring disorder treatment service system that require attention, improvement, and change.

Purpose

The COSIG Statewide Needs Assessment is a statewide needs assessment initiative that included statewide focus groups **(Phase I**), key informant interviews **(Phase II),** and administration of a survey **(Phase III)**.

Specifically, **Phase I** of the statewide needs assessment was conducted through 46 focus groups held on each of the four major islands of the State (Hawaii, Kauai, Maui, and Oahu). Particular emphasis was given on how well or poorly the State's current system is meeting the diverse needs of consumers with co-occurring disorders and reaching out to its many ethnic and cultural groups. **Phase II** included conducting six key informant interviews to validate focus group information and to explore any unidentified priorities which may not have been gleaned from the focus groups.

After completion of Phase I and Phase II, the overall results of these data collection methods were used to guide the construction of a self-administered survey instrument for the purpose of refining the top priority COD system needs described in this report. Consequently, the final phase of the Statewide Needs Assessment, **Phase III,** included the development and administration of a survey instrument to validate further the information obtained from Phase I and Phase II and to identify and clarify priorities for improving the statewide system of care for COD consumers. The purpose of this survey was to generate specific priority rankings for what respondents believed were the most important areas needing attention to improve services to consumers in the co-occurring disorder treatment system.

The following report describes the development, implementation and results of the 46 statewide focus groups, the six key informant interviews, and the survey's construction, administration, and distribution efforts, and resulting identified priorities by 924 survey respondents for which to serve consumers with co-occurring disorders better.

Results from this comprehensive needs assessment report are anticipated to help the COSIG project's leaders and other policy makers in developing statewide strategic plans, building infrastructure, and taking actions to improve services for COD consumers.

Needs Assessment Methodology

In this section the methodology for **Phase I -** Focus groups, **Phase II -** Key Informant interviews, and **Phase III –** Survey, are described.

Phase I - Focus Group Methodology

Forty-six community based focus groups (N=335) administrators, providers, and consumers/family members) were held on the islands of Oahu, Molokai, Maui, Kauai and the Big Island of Hawaii from February 2005 to December 2005.

All of the focus group's recruitment efforts concentrated on attempting to obtain participants representative of a statewide sample of stakeholders in the public sector Substance Abuse (ADAD) and Mental Health (AMHD) systems. Additionally, private providers and other stakeholders (probation, health care, etc.) were invited to attend focus groups across the state.

System stakeholders in Phase I of this study were defined by their roles within the system of care. Stakeholders were grouped according to the following roles within the care system; consumers and family members, direct service provider staff, and managerial and administrative staff (See Table 1).

Table 1 -- Percent of Participation by Affiliation- Focus Groups (N=335)

Role	***AMHD***	***ADAD***	***Other (Neither AMHD or ADAD)***
Providers	19%	12%	6%
Administrators	9%	9%	6%
Consumers	15%	9%	15%
Total	**43%**	**30%**	**27%**

(Note: Table 1- Consumers = both direct recipients of services and family members).

Recruitment efforts for the focus groups included distributing invitation letters to Mental Illness and Substance Abuse (MISA) Coordinators in the AMHD Community Mental Health agencies, program administrators in the ADAD system of care, and other selected professionals, providers, and consumers who work with, or are familiar with Hawaii's substance abuse and mental health system. Referrals for participants were also solicited from the AMHD Office of Consumer Affairs, community providers, state system clinics, and administrative staff.

The overall goal for the focus groups was to identify "what works and what does not work" in the current systems of care for people who have co-occurring disorders. The focus group questions were framed somewhat differently based upon each stakeholder group's unique perspectives and experiences (see Appendix B). Consumers were invited to participate in the focus groups based on two criteria: those who had direct and first-hand experience with the treatment system, or those who had a more comprehensive understanding of the interrelations of the complex systems of care involved (e.g., consumers who were administrators or policy makers).

Members of the research team were trained to use the focus group technique and to facilitate the groups by prompting, encouraging, and supporting group members to answer questions about their perception, understanding, and experience with the co-occurring disorder care system. The focus group leader opened each group by reading a statement that briefly described the COSIG project and the purpose of the group (see Appendix A). This was followed with a series of questions (three separate sets of questions for each stakeholder group) that the leader posed to the group for their consideration and discussion (see Appendix B). Groups lasted from 1 1/2 to 2 hours. The group's leader and project assistants recorded the focus group discussions on laptops. Refreshments were served in the groups. The leader and

assistants met after each group to tabulate the statements. Group sessions were not audio recorded. Demographic characteristics of group attendees were recorded and kept on a separate information sheet.

Phase II - Key Informant Interview Methodology

A semi-structured interview guide approach was used to explore participants' views of and experiences and identify problems, gaps, and needs of the co-occurring service system. Semi-structured questions were developed, based on a participant's affiliation (see Appendix C), to explore participants' perceptions regarding the system of services for consumers with COD. Prior to conducting formal interviews, the interview guide was piloted with 2 participants and adapted for the final format. Between July 2006 and December 2006, six in-depth interviews were conducted which included 1 consumer and 5 administrators with experience in the co-occurring substance abuse service system. Each interview was audio taped.

Specifically, at the beginning of each interview, the interviewer explained the project, answered any questions and explained the informed consent process, allowed the participant time to read it and ask questions, and explained the sequence of the first questions and the general phases of the interview. Confidentiality, documentation, and taping matters were also reviewed with each participant prior to each interview, and participants were then asked to sign the informed consent form.

Phase III - Survey Methodology

The overall purpose of the survey constructed for Phase III of the needs assessment was to obtain information from interested persons in identifying the top ten current priorities and gaps in services for individuals with co-occurring disorders. Interested persons targeted as respondents included consumers, family members, direct service providers, concerned citizens, behavioral healthcare managerial and administrative staff, and criminal justice and primary care professionals.

The survey instrument construction included a number of developmental stages and took place over several months. First, using the results of the focus groups, survey items were crafted from each theme and subtheme resulting in the first draft of the survey. Second, after development of this first survey draft was completed, it was administered to five individual participants using a cognitive interviewing protocol. Cognitive Interviewing is a survey instrument refinement method that engages a small subset of likely respondents in a detailed inspection of the survey, both its instructions and items**.** Respondents are asked to read and comment upon every instruction and item with the goal of ascertaining the clarity of the content as well as its meaning to the respondent. Items that lack clarity or have ambiguous or unintended meaning are re-written until they achieve meaning that is accessible to the respondent.

The cognitive interview respondents were five consumers of services who provided feedback on the wording and phrasing of each item and suggested additional items. After the interviews were completed, staff analyzed the resulting data and the survey was refined resulting in a second draft. The third and final phase of the survey construction included conducting two focus groups, one consumer group and one group which included content experts. Results from these two focus groups were summarized and final adjustments were made to the survey instrument resulting in the final survey format (see Appendix D).

In terms of format, the final survey form consisted of an introductory paragraph explaining the COSIG grant and the survey followed by brief instructions for completing the survey and a

section for completing demographic information. A total of 30 items were included in the final version and respondents were instructed to rank their top 10 priorities by asking **"Please choose 10 items YOU BELIEVE are most important for making services for persons with co-occurring disorders better".** Lastly, a general comment section was included to provide respondents an opportunity to write down any further information or list other priority needs. ("Please write down any suggestions you have that are not in the list above that YOU BELIEVE or THINK will make services for persons with co-occurring disorders better").

A distribution list was created, and in March 2007, the survey administration was launched. Overall, three distribution methods were used, the first of which included mailing or delivering packets of 15-100 surveys to state and private agencies, groups, and individuals, for a distribution total of 3946 surveys. Second, the survey was distributed at three conferences, the John A. Burns School of Medicine He Huliau Health Disparities & Policies Conference, The University of Hawaii School of Social Work Indigenous Voices Conference, and the Adult Mental Health Division-sponsored Evidence-Based Practices Conference. Six hundred surveys were distributed in this manner. Third, the survey was posted on the Department of Health, Adult Mental Health Division (AMHD) website for respondents to complete on-line. Additionally, multiple follow-up calls, contacts, and reminders went out to a host of people, agencies, and departments asking them to complete and return the survey.

A concentrated survey distribution and data collection effort of six months duration from March 2007 to September 2007 was conducted. As surveys were returned to the COSIG project, results were entered into a Microsoft Excel spreadsheet database. Once the September 30th cutoff date passed, all data were then transferred into a Statistical Packages for the Social Sciences (SPSS) database, a software program that provides multiple statistical analyses procedures. Descriptive statistics were computed to determine frequencies and percentages, including cross-tabulated analyses of key demographic items (gender, race/ethnicity, affiliation, and Island) with the top 10 items to identify any substantial differences across the demographic domains. All results are reported in chart and bar graph form in the following results section. Those same results are also reported in table form in Appendix E.

Results – Phase I, II, & III

Phase I - Focus Groups

Results of the 46 focus groups were transcribed and analyzed for common and unique themes. Fourteen major themes, with a number of these themes manifesting sub-themes, emerged from the data analysis. These major themes and sub-theme results are presented below (Table 2). A brief narrative explanation of each follows, starting on page 17 .

Table 2 -- Results of Needs Assessment: Focus Groups

Theme 1 -- Scope of Co-Occurring Disorders
Sub-theme 1 -- Methamphetamine
Theme 2 -- Systems Issues
Sub-theme 1 -- Bureaucracy as a barrier
Sub-theme 2 -- Paperwork requirements
Theme 3 -- Integration Issues

Sub-theme 1 --	Lack of integration
Sub-theme 2 --	Positives and why integration is important
Theme 4 -- Interagency Collaboration	
Sub-theme 1 --	Lack of collaboration
Sub-theme 2 --	Communication issues
Sub-theme 3 --	Referrals
Theme 5 -- Access	
Sub-theme 1 --	Access issues (+/-)
Sub-theme 2 --	Eligibility criteria
Sub-theme 3 --	Insurance and reimbursement
Sub-theme 4 --	Timely access
Theme 6 -- Quality of Care (+/-)	
Theme 7 -- Continuum of Care	
Sub-theme 1 --	Screening and assessment
Sub-theme 2 --	Outreach and crisis management
Sub-theme 3 --	Level of care
Sub-theme 4 --	More programs
Theme 8 -- Treatment Approaches	
Sub-theme 1 --	Comprehensive, holistic
Sub-theme 2 --	Multidisciplinary
Sub-theme 3 --	Staged/motivational
Sub-theme 4 --	Recovery orientation
Theme 9 -- Treatment Modalities	
Sub-theme 1 --	Psychiatry and medication
Sub-theme 2 --	Psychology and individual counseling
Sub-theme 3 --	Group therapy
Sub-theme 4 --	Psychoeducation and skills training
Sub-theme 5 --	Clubhouse
Theme 10 -- Cultural Considerations	
Sub-theme 1 --	Lack of interpreters, bilingual resources
Sub-theme 2 --	Need for more programs incorporating cultural healing practices (primarily Hawaiian)
Sub-theme 3 --	Need for adaptation of Western EBP's for culturally competent application
Sub-theme 4 --	Lack of funding for cultural services

Sub-theme 5 --	Access community cultural events to disseminate COD information
Sub-theme 6 --	Need for cultural competency professional training
Sub-theme 7 --	Need for culturally competent providers and ethnically diverse staff (e.g. include cultural practitioners as recognized staff)
Sub-theme 8 --	Need for understanding of "local culture"
Theme 11 -- Living in Recovery	
Sub-theme 1 --	Meaningful structured activities
Sub-theme 2 --	Spirituality
Sub-theme 3 --	Social support/relationships
Sub-theme 4 --	Families
Sub-theme 5 --	Housing
Sub-theme 6 --	Employment
Sub-theme 7 --	Self-help
Theme 12 -- Public Education and Public Perception of COD	
Sub-theme 1--	Stigma-general
Sub-theme 2--	Stigma-professional and relational
Sub-theme 3--	Stigma-community and culture
Sub-theme 4--	Stigma as a barrier
Sub-theme 5--	Stigma-families
Sub-theme 6--	Community education to reduce stigma
Sub-theme 7--	Community education about MI and SUD to increase awareness
Sub-theme 8--	Raising community involvement and support
Sub-theme 9--	Misperceptions of programs
Theme 13 -- Resources	
Sub-theme 1 --	Human resources
Sub-theme 2 --	Financial resources
Sub-theme 3 --	Physical resources
Sub-theme 4 --	Consumer resources
Sub-theme 5 --	Treatment resources
Theme 14 -- Special populations	
Sub-theme 1 --	Homeless
Sub-theme 2 --	Children and teens

Sub-theme 3 --	Forensic
Sub-theme 4 --	Women and Children

Theme 1: Scope of Co-Occurring Disorders.
Overall, Theme 1 provides a variety of descriptive information from participants regarding the scope of the problem of co-occurring disorders (COD) in Hawaii, challenging issues for staff and consumers participating in COD treatment, and difficulties in the journeys of "personal recovery" for COD consumers. One major sub-theme emerged under Theme I, the identification of methamphetamine as the prominent drug of choice for COD consumers in Hawaii. This discussion of methamphetamine use by consumers also included a description of common complications that arise for consumers as a result of chronic drug usage.

Specifically, participants noted that a "large amount," "most," or "large percent" of consumers with whom they work or have contact experience COD and stated "it's a huge problem" among the consumers served in the mental health and substance abuse systems.

Participants also described the challenges of providing treatment for COD consumers and noted the specific diagnoses (e.g. major depression, bipolar disorder, PTSD, drug induced psychosis, and personality disorders) which often accompany consumers' substance abuse problems. Participants, particularly providers, expressed frustration and hopelessness in working with COD consumers; "they are extremely difficult to work with" noting that dishonesty about substance use, "denial," disruptiveness, "self-medication", "non-compliance", and "tricking or beating the system" are particularly challenging behaviors exhibited. Participants also pointed out the complexities of providing effective treatment to these consumers due to the nature of the chronic relapsing condition of both addiction and mental illness, "it's a lifelong process."

Sub-theme 1 - Methamphetamine.
Methamphetamine emerged as the prominent drug identified by participants used by consumers who experience a COD in Hawaii. Many participants from diverse geographical areas across Hawaii, especially the outer islands, expressed concern about the severity of Hawaii's methamphetamine problem. Additionally, participants focused their concern about the detrimental impact upon multiple generations of family members in Hawaii. As one participant stated, "ice is a really big thing."

Moreover, participants voiced concerns regarding the complexities of working with consumers who have both severe and persistent mental illness and chronic and long-term methamphetamine addiction. They accented the need for lengthier treatment episodes for consumers with this combination of COD. Finally, many participants expressed concern about the involvement of Hawaii's youth using methamphetamine, and the many who are becoming addicted at a young age. As one participant put it "my daughter is a binge user and it kills me."

Theme 2: Systems Issues.
Theme 2 centered on a myriad of "system" issues that challenge the provision of care to consumers with COD. Two sub-themes related to systems issues emerged.

Sub-theme 1 - **Bureaucracy as a barrier.**
Participants described the "system as entrenched" and "overwhelming" for consumers referencing inconsistent policies in state divisions, federal/state barriers such as rules and funding guidelines and requirements, cycles of abrupt changes in state and federal funding

mechanisms and requirements, rigid rules for providing programs and services, and lack of local control of funding and for program planning and development.

One concern that participants accented was that care is "fiscally driven" versus "clinically driven" and strictly guided by rules and regulations. Examples provided by participants included difficulty obtaining authorization and reimbursement for services, the lack of funding mechanisms and streams to provide the necessary care for consumers with co-occurring disorders, and the fact that care is dictated based on rules and criteria handed down by funding sources (e.g. insurance, Medicaid, federal block grants) versus being driven by clinical outcomes.

Sub-theme 2 - Paperwork requirements.
Participants noted that paperwork requirements affect consumer care as they are unwieldy and unstandardized. As one participant noted, "information is repeated, one form for the P.O., one for insurance, one for… so there is less time for the patient." Another participant explained, "things like the treatment plan become paperwork, the spirit of the plan gets lost."

Theme 3: Integration Issues.
Theme 3 centered around the lack of integration and coordination between Hawaii's state Alcohol and Drug Abuse Division (ADAD) and the Adult Mental Health Division (AMHD), as well as among programs and individual providers of substance abuse and mental health services. Two sub-themes emerged to include the challenges and problems associated with the "Lack of integration" of the two service systems with additional discussion centering around the "Positives and why integration is important."

Sub-theme 1- Lack of integration.
In this first sub-theme, participants described a general need for integration efforts across the ADAD and AMHD systems to serve consumers better at the levels of funding, program development, and the provision of integrated treatment. Specifically, participants described the current system of care as "fragmented" with the need to "integrate substance abuse and mental health treatment." Of note, were the difficulties that a fragmented system of care lends itself to, such as under-identification of those with co-occurring disorders and concerns that "some people fall through the cracks."

Further, participants described a number of concerns and issues that reflected the need for attention to system's issues which specifically impact COD treatment. Examples included the need to address the lack of cooperation in providing care for COD consumers between the AMHD and ADAD divisions especially evidenced by communication gaps between the two divisions. This gap, according to participants, impacts programs' and providers' abilities to meet COD consumers' needs and fails to address appropriately how to access funding streams and options for COD services. For example, one participant noted that "one division does not validate the other" and it is difficult to "bring out the best of each system." Participants accented the need for collaboration and communication across these systems (AMHD and ADAD), as well as the need for state and federal coordination.

Some participants provided solution based suggestions such as the need to share resources between AMHD and ADAD (e.g. beds, funding). Participants noted that both the AMHD and ADAD systems of care "need to be on the same page" and that the use of "partnering and a focus on consumer outcomes" might assist in future integration efforts. Participants noted that since AMHD and ADAD have divergent philosophies regarding consumers with co-occurring disorders, that efforts to "find common language" could assist

in developing and providing integrated care. Specific suggestions also included the possibility of opening a consumer's case for services to be provided at the same time in both divisions. Other participants suggested that there would be more continuity for providing care for COD consumers if one division (like AMHD) was the lead agency, yet a small minority felt that treating the COD population separately was important to better meet the needs of consumers, "we can't be all things to all people", they are "separate populations with specialized problems and without specialized treatment, their needs just don't get met."

Sub-theme 2 - Positives and Why Integration is Important.
Even though the majority of participants expressed concerns related to fragmentation of care for COD consumers and gaps in collaboration between AMHD and ADAD, many participants did mention that an enhanced awareness toward co-occurring disorders has begun to occur in both mental health and substance abuse programs across Hawai'i. Participants expressed hope that COSIG initiatives will continue to help advance this awareness bringing about continued sensitivity and change in the system. Specifically, many participants mentioned the addition of AMHD's MISA Coordinators to the community mental health agencies as a vehicle that has advanced awareness and launched a more concerted effort in providing care for consumers. As one participant put it, "on a philosophical level, the mental health system is now recognizing that there are substance abuse issues among people with mental illness and is willing to do something about it."

Theme 4: Interagency Collaboration.
Theme 4 centered on issues of collaboration of both the mental health and substance abuse systems and services with 3 specific sub-themes emerging as described below.

Sub-theme 1- Lack of collaboration.
Many participants accented the need for substance abuse and mental health providers and agencies to collaborate on COD consumers' care and how this lack of collaboration affected the overall quality of the delivery and appropriateness of services. One participant noted a need to, "work hand in hand with other agencies to keep services going." Many participants noted that if more collaboration occurred between both providers and agencies serving COD consumers that there could be simple practical clinical advances for those who were being served simultaneously.

Sub-theme 2 - Communication issues.
Participants noted that there was a need for forums (e.g. joint agency staffing) for providers to enhance communication regarding the treatment needs of COD consumers. Examples provided by participants included the need for improved communication between multiple providers and agencies serving consumers. One participant noted "it takes an act of congress to get information from other agencies." Suggestions such as implementing case coordination meetings and other mechanisms to enhance communication were suggested. Additionally, participants noted that collaboration with multiple community providers is essential to provide coordinated integrated care.

Sub-theme 3 - Referrals.
Some participants discussed difficulties in making referrals between mental health and substance abuse programs or even across similar agencies. Since COD consumers many times need to access both mental health and substance abuse services, simultaneously, in different agencies, it was noted the barriers identified in making these referrals impacts the quality of care provided.

Theme 5: Access.

Theme 5 centered on issues of access, eligibility and admission to both the mental health and substance abuse system of services with 4 specific sub-themes emerging as described below.

Sub-theme 1- Access issues (+/-).

Participants noted a number of barriers for entry of consumers into the mental health service system, specifically coordination with AMHD's ACCESS Line services and follow-up for consumers on outer islands. Examples included some disorganization and lack of follow through after referrals were made to the AMHD ACCESS Line for eligibility evaluations on outer islands. One consumer commented, "having a facility to come to, rather than calling a 24 hour access line" would be helpful. Other participants noted that the availability of the ACCESS Line to provide eligibility assessments was a very beneficial mechanism to initiate services for persons with mental health concerns.

Moreover, other participants identified that access to substance abuse programs on the outer islands was many times complicated and obstructive. For example, one outer island participant noted that they attempted to "bargain" with gatekeepers any way they could to gain access and admission for consumers needing substance abuse services.

Sub-theme 2 - Eligibility Criteria.

Some participants mentioned that at times the eligibility criteria for services present as a barrier for obtaining the appropriate services for COD consumers. For example, due to the population eligibility criteria for AMHD services, one participant noted, consumers with "SMI get services, but other quadrants are not served in terms of mental health, if they don't meet SMI criteria." Similarly, participants explained that if clients disclose mental health symptoms, they probably wouldn't meet [ADAD] criteria. Overall, participants expressed the need for more flexibility in determining eligibility for the COD population.

Sub-theme 3 - Insurance & Reimbursement.

Participants reported difficulties in obtaining adequate insurance reimbursement or funding for consumers needing treatment in both the substance abuse and mental health system simultaneously. It was noted that the continuity of providing care can also be blocked or interrupted by insurance reimbursement or funding regulations under the principle of "duplication of services" (e.g. "some consumers can not obtain mental health therapy from a designated outside mental health therapist if needed while participating in substance abuse treatment") thereby rendering providers and programs impotent in obtaining and providing the consumer with needed integrated COD services.

Sub-theme 4 - Timely Access.

Participants voiced concern regarding the waiting lists for both substance abuse and mental health services, "when someone needs treatment, they need it now, not a month from now." Providers expressed concern about people in need of help "falling through the cracks" because of having to wait "3-4 weeks", "3 months", "a month" to get needed assessments or treatment. This concern was expressed in all geographic areas of Hawaii, but specifically for psychiatric assessments on the Big Island and the admission waiting lists for substance abuse programs in Oahu. Additionally, substance abuse providers discussed the presence of waiting lists to obtain psychiatric services for consumers in need of medication evaluation while residing in a substance abuse program.

Theme 6: Quality of Care: pluses and minuses.
Theme 6 centered around issues related to the quality of care of COD services for consumers in both the mental health and substance abuse systems of care. No sub-themes emerged from this category. Participants varied in their descriptions of the services which provided poor quality of care. One participant mentioned **"**social workers who don't return calls; have to wait for days sometimes", another noted, "programs could be upgraded." Other participants felt the overall quality of care was good. Some discussed the introduction of evidence-based practices (EBP's) as a positive change, "EBP's may improve some areas", but also noted that what is "on paper, may be different from reality." Consumers had many specific positive comments about their current programs, for example, "thank God for this place", "I have found nothing but help here", and "they have helped me tremendously."

Theme 7: Continuum of Care.
Theme 7 centered on continuum of care issues in both the mental health and substance abuse systems with 4 specific sub-themes emerging as described below.

Sub-theme 1- Screening and assessment.
Participants called for the need for improved identification of consumers with COD and also for an increase in clinical capabilities for improved assessment and differential diagnosis in order to improve treatment planning. Specifically, one participant noted that "screening for mental health is a gap on the ADAD side." Another noted the importance of the identifying the "right diagnosis." Other participants discussed the difficulty of relying on self-report for identification of substance use disorders, the issues around drug screening, and the difficulties of teasing out symptoms related to both mental health and/or substance abuse problems early in the assessment process.

Sub-theme 2 - Outreach and crisis management.
Participants noted a lack of crises services and need for outreach. "Crisis shelters are already full; clients go to the hospital instead." Providers and consumers also expressed the need for and benefits of outreach "home visits would be good", "someone to come up to me on the street and ask if I want help."

Sub-theme 3 - Level of care.
A few participants discussed the need to "revisit" the current levels of care. They expressed the idea and need for individuals with co-occurring disorders to have their "own level of care", but also distinguished between high and low level COD needs. Some felt that this sort of change in the levels of care system would allow them to provide more direct care to consumers with COD.

Sub-theme 4 - More programs.
This sub-theme identified 5 different types of programs or levels of care that were noted as under-available for COD consumers. Participants called attention to the need for more programs to include detoxification services, specific COD programs, substance abuse programs, residential programs, and aftercare & transition services.

Specifically, participants described a number of gaps in services available to consumers with co-occurring concerns to include the lack of detoxification services especially on the outer islands. Additionally, participants noted a lack of specific COD or dual diagnosis programs overall, and the lack of availability of substance abuse treatment on outer islands. As a result participants noted that additional difficulties are added for consumers due to these deficits including the need to transport consumers to Oahu for substance abuse treatment.

As a result of this need for "off island" treatment, participants explained the consequences of fragmented follow-up care for consumers (e.g. lack of family and social support). As one participant noted, "there is only one substance abuse treatment facility here for the population, we have to send off island for dual diagnosis, if funds were available we could technically provide these services at our agency". Other barriers to more programs included discussion of the lack of community support for developing community based services and residential programs. Two outer island locations noted that community residents have blocked the development of these programs in the past in their areas- stating "not in my back yard!"

Theme 8: Treatment Approaches.

Theme 8, Treatment Approaches consists of several principles identified by participants as useful and helpful in guiding effective treatment for individuals with COD. These include the following four sub-themes.

Sub-theme 1 - Comprehensive, holistic.

Participants discussed the importance of taking a holistic approach to recovery, with a focus not only on mental health and substance abuse, but also on the physical, practical (e.g., financial), emotional, and spiritual realms. Specifically, participants mentioned the benefits for consumers of offering a "more full service" approach to treatment of COD, including medical and nutritional services. Additionally, they discussed the benefits of comprehensive or "wraparound" type services, particularly on site, and how this might decrease the problems associated with fragmented services (e.g., trouble getting to outside appointments) that hinder recovery.

Sub-theme 2 - Multidisciplinary.

Participants emphasized the importance of having a multidisciplinary team all working together for the consumer's recovery. We "need a team, with everyone doing their job," "it takes a village to raise a child." They noted the positive aspects of a team approach (e.g., can address different consumer needs), as well as some of the associated problems (e.g., difficulties in availability and communication between team members). Various disciplines were noted including social work, probation, child protective services, ministers, MD's, therapists, and nutritionists that might be involved in team meetings, a collaboration model of treatment, or shared treatment planning.

Sub-theme 3 - Staged/motivational.

"Some clients are more ready than others, so we need that continuum." "I was ready for help." Participants talked about the varying levels of motivation or readiness that individuals with COD have for treatment. They also discussed some of the advantages of a stage-wise approach to treatment (e.g., understanding and acceptance of relapse), as well as some of the frustrations associated with the lack of availability of stage-wise treatment (e.g., difficulty getting compliance).

Sub theme 4 - Recovery orientation.

Participants spoke of a number of concepts that facilitate recovery which fall under the sub-theme of "Recovery Orientation". These included the importance of a strong therapeutic alliance with a client-focus, individualized treatment ("cookie cutter treatment does not apply to everyone"), empowerment and taking personal responsibility ("I've gotta help myself now"), using peer mentoring; instilling and having hope ("Telling me I won't make it doesn't help, the belief has to change"), building a collaborative therapeutic alliance, and having providers who are genuinely caring, accepting, and supportive ("to have someone who

cares if you live or die"). Providing empathy and support to consumers while promoting the empowerment of consumers were priority concepts accented by a number of participants. Participants explained that consumers needed to be held accountable for choices with limits set where appropriate and provided consistent staff care and interventions.

Theme 9: Treatment Modalities.

The Treatment Modalities theme consists of a variety of interventions identified by participants as helpful in treating or recovering from COD. Major sub-themes included: Psychiatry and Medication, Psychology and Individual Counseling, Group Therapy, Psychoeducation and Skills Training, and Clubhouse services. In addition to these major sub-themes, participants noted clinical approaches such as cognitive behavioral therapy, experiential therapy, and contingency management that might be used within these more general modalities. Some specific techniques mentioned included; homework, repetition, incentives, physical reminders or cues, and separate programming (or groups) for men and women.

Sub-theme 1 - Psychiatry and medication.

Participants emphasized the importance of appropriate medication for co-occurring disorders, as well as the need for appropriate medication management for consumers. Both consumers and providers expressed a need for greater accessibility to psychiatric services by having more psychiatrists, better reimbursement rates for psychiatric services, more time with their psychiatrist, and/or more consistency in their psychiatric care. At the same time, participants discussed difficulties with medication side effects and "junk medications", and highlighted the importance of a combination of medication and therapy, "meds and therapy are the core of treatment." Suggestions also included the need for "better medications" and for such supports as regular medication groups.

Sub-theme 2 - Psychology and individual counseling.

Consumer and provider participants identified working individually with a psychologist on problems such as trauma and auditory hallucinations as a helpful aspect of their treatment. They also noted a need for more psychologists and other therapists to provide more access to individual therapy. Participants additionally identified one-on-one supportive counseling as helpful particularly for individuals who may not be prepared for a group setting.

Sub-theme 3 - Group therapy.

Group therapy and particularly dual diagnosis group therapy was discussed by participants as facilitating recovery, "that's where you can see miracles happen." Various aspects of the group setting were highlighted, such as the effect of peers and group norms and the support gained from being part of a group. Some participants also mentioned the need for more COD self-help groups.

Sub-theme 4 - Psychoeducation and skills training.

Consumer and provider participants talked about the learning that occurs in the process of recovery. They discussed both the knowledge and skill building that are needed, "learning about myself, about my condition, and how to deal with it." Specific areas for psychoeducation needs included: mental health diagnoses, medications, substance abuse education, and skills training in coping, life, social, and parenting skills training.

Sub-theme 5 - Clubhouse.

The continued support for Clubhouse programs were mentioned specifically by participants as providing a structured and social place to go, where consumers are "treated with respect"

and “as partners.” The need for more clubhouse programs in specific high-risk and rural areas was also noted.

Theme 10: Cultural Considerations.
Although, a small number of participants reported they believed that the services for COD consumers were culturally sensitive, the majority of participants voiced a myriad of issues concerning the need for infusing more cultural competency into COD services. Eight sub-themes emerged and are described below:

Sub-theme 1 - Interpreters and bilingual resources.
Many participants voiced concern regarding the lack of available interpreters to assist in providing culturally competent services for COD consumers. With the large number of diverse ethnic groups residing in Hawaii, participants noted that the lack of available interpreters is often a significant barrier to outreach, assessment, and appropriate COD treatment. Additionally, written materials in a variety of languages are rarely available for these consumers and participants suggested that providing COD written materials in a variety of languages would assist in providing better education and outreach to a variety of cultural groups.

Sub-theme 2 - Integration of cultural healing practices in COD services (primarily Hawaiian cultural practices) AND,
Sub-theme 3 - Adaptation of Western evidenced based practices.
Some participants suggested that the integration of traditional Hawaiian healing practices should be incorporated into services for both Native Hawaiians and non-Hawaiians seeking COD treatment. These participants highlighted the importance to assist consumers to “get in touch with their culture” and that “traditional practice incorporates traditional values (e.g. lokahi, laulima) into their lives.”

Additionally, other participants spoke to the importance of the cultural adaptation of Western evidence based practices and models of treatment to enhance cultural competency for the variety of cultural groups receiving services in Hawaii. As one participant noted “on national level get off of high horse and don’t have all the answers; answers may be in local cultural, there are alternative treatments”. In concert with this suggestion, others promoted the importance of using appropriate cultural interventions and incorporating cultural values. As one participant accented “incorporate more native healing practices” and “help consumers get in touch with their culture” as important ways to enhance cultural competency.

Sub-theme 4 - Lack of funding.
This sub theme centered on the need for specific funding to support the integration of cultural values, beliefs, and practices into COD services. Participants suggested that perhaps specific funds be allocated for programs interested in providing such services**.** Additional issues reflected by this sub-theme included consideration to the need for local control for planning and utilization of funds in rural areas to provide culturally appropriate services. Moreover, calls were voiced for specific funding earmarked to assist Native Hawaiians in need of COD services.

Sub-theme 5 - Access community cultural events to disseminate COD information.
Addressing the lack of information about COD and the stigma that many cultural communities hold about substance abuse and mental illness was expressed as important by participants. Suggestions included attaching informational events about substance abuse and mental health issues to community forums already embedded in the community.

Finally, participants discussed that outreach efforts tailored towards different cultural groups in the community need to occur in coordination with outreach to faith-based organizations and through the use of connections with cultural elders and leaders, such as Hawaiian Kupuna, as one participant noted it important to "engage native practitioners by going to them".

Sub-theme 6 - Need cultural competency professional training.
Participants requested information/training on a variety of cultures and how different cultural groups handle COD. Additionally, calls for training included more information to promote cross-cultural awareness of multiple cultures receiving services in Hawaii; "we need a curriculum that addresses cultural issues". Some participants noted that there is also a need for a "cultural" resource guide to help providers learn about the different cultural norms and practices of the variety of ethnic groups living in Hawaii.

Sub-theme 7 - Need for culturally competent providers and ethnically diverse staff (e.g. "include cultural practitioners as recognized staff").
Participants expressed the need for culturally competent providers and ethnically diverse staff (e.g. include cultural practitioners as recognized staff), "have Hawaiian providers be first class providers". Suggestions included that culturally diverse staff be mentored and trained specifically to provide services to Hawaii's COD consumers.

Sub-theme 8 - Need for understanding of "local culture."
Some participants noted that, in addition to enhancing cultural competency across services for different ethnic groups, it is also important to develop culturally competent practices sensitive to the "local" norms, values, and traditions unique to the state of Hawaii. "As we bring in national standards but don't have cultural sensitivity into standards, need to integrate local culture into standards, sometimes standards clash with local culture" noted one participant. In line with this focus, some participants accented that cultural practices and service needs differ depending on the consumer's home island, and additionally cultural beliefs and practices vary based on upon consumers' rural vs. urban geographical backgrounds.

***Theme 11: Living in Recovery*.**
The Living in Recovery theme, Theme 11, encompasses what is needed for a consumer to remain in recovery for COD. This theme also spoke to a number of barriers for recovery that either hinder recovery when present or make recovery more difficult when not.

Sub-theme 1 - Meaningful Structured Activities.
Participants expressed the need for structured activities as a way of coping. One participant stated that having "not so much free time helps." Having structured activities becomes, as one participant described it, "finding alternatives to drugs." In addition to having structured activities, participants described meaningful structured activities as those activities that not only provide a way to structure a consumer's time, but also connect with the consumer on a personal level. One example of such activities included gardening, where gardening held special meaning for this consumer.

Sub-theme 2 - Spirituality.
Another sub theme described was spirituality, attention not only to physical and mental health issues, but also to a more intangible aspect of a consumer's experience: his or her spirit. This not only included consumers participating in mainstream American forms of spirituality, like various religious activities, but also consumers participating in traditional

forms of spiritual practices, such as those found in the Hawaiian culture. Traditional forms of spiritual practices mentioned included having consumers returning to the land through caretaking of taro, or building and rowing traditional Hawaiian canoes. One participant stated that "the cultural spiritual journey opened my eyes" and that previous to the spiritual activities the participant had been "chasing earthly things." Participants also described the need, as one participant stated, to "respect individual's right to choose their spirituality."

Sub-theme 3 - Social Support/Relationships.
When a consumer has social support and healthy relationships, he or she has an asset for maintaining recovery, but when the social support is not present or the relationships are unhealthy, these social networks act as a barrier to maintaining recovery. One participant described that having "new social circles that are clean and sober" are important for recovery. Another aspect of social support and relationships that was identified as important is the "spirit of family", or as one participant commented, the "ohana spirit."

Sub-theme 4 - Families.
Like social support and relationships, participants described families as either assets or hindrances for maintaining recovery. This sub-theme also spoke to the notion that consumers are not the only ones in recovery. One participant said that there is a need for "family therapy." Another participant described this as a way of "integrating the family back together." Still another participant stated that there is a need to have a "support group for families." As one participant expressed, "families need education" on recovery. Relationship building skills were also stated as a need; there is a need to learn "how to get along with the family." It was noted that family members of consumers also need support and services as a way to provide a recovery oriented environment supporting consumers. A cultural aspect approach is having family conferences, or ohana conferences, and engaging in the Hawaiian cultural tradition of "ho`oponopono" where families can address issues and heal broken family bonds.

Sub-theme 5 - Housing.
Participants described the need for not only having housing as a necessity for maintaining recovery, but also the need for specialized housing, where housing provides supportive care; there is a need for "various levels of housing; supervised and long-term." This sentiment was echoed by another participant stating there is a need for "damp housing." However, there are barriers in providing specialized housing, as one participant explained: "Step-down houses are hard to establish because of residential zones." Another participant stated that "there is no transitional housing here." There is also a need for "transitional housing for families." Applying for and finding independent living/ housing is also difficult for many people who have COD, as expressed by one participant noting that there is a need "getting help with housing applications."

Sub-theme 6 - Employment.
Employment was noted as both an asset and hindrance to recovery. This sub-theme connects to sub-theme 4 "Consumer Resources" of the larger "Resources" Theme #13 (p.24). Having a job, as one participant described it, is empowering; "having a job helps" in the recovery process, which was echoed by another participant that employment has "benefits to self-worth." Participants described employment as an asset when the employment provides a support structure to a consumer's life, as well as a source of self-initiated of income. One participant stated that employment "helps keep me clean and take my meds." However in situations where the employment does not provide support and understanding to the consumer, employment can become a hindrance to recovery.

Sub-theme 7 - Self-help.
Not only are self-help support groups helpful in assisting consumers to maintain recovery, there is also a need for more self-help groups that address both MI and SUD (COD). This sentiment was echoed by other participants that there are "not enough support groups, like AA" and that there is a "lack of support groups for dual diagnosis." One participant described self-help groups as providing a "feeling of belonging". "Dual Diagnosis groups are helpful" was echoed by one participant. Alternative self-help groups were also identified as helpful for maintaining recovery, and one participant identified the need for "internet support groups".

Theme 12: Public Education and Public Perception of COD.
Public Education and Public Perception of Co-Occurring Disorders are distinct, yet, overlapping domains. They are interconnected as evidenced by the various sub-themes of Public Perception that refer to the need for Public Education as a vehicle for changing perceptions about COD. Within the Public Perception theme, the sub theme of stigma emerged a number of times. These sub-themes are described below.

Sub-theme 1 - Stigma- General.
The participants expressed that there is stigma attached to the identification of COD and this is intensified in certain geographic locations (e.g. rural areas in Hawaii). With respect to geographic stigma, one participant stated that "rumors perpetuate" about negative stereotypes of the rural areas. When speaking of addiction, one participant stated that some people "don't want to be associated with addiction" because those people "don't want to stigmatize themselves." There is also shame associated with having COD, "I was ashamed before to tell people I need help." This sentiment was echoed by other participants who stated that there is "shame to ask for help" and people "don't want to be seen as mental." One participant stated that "stigma is a major problem."

Sub-theme 2 - Stigma-Professional and relational.
This sub-theme centers on the perceptions of mental health and substance abuse professionals and consumers relationships as demonstrated by those in both areas; "chemical dependency was the step-child to MI" describing a substance abuse stigma held by some professionals. Other participants noted this stigma stating that "SA consumers don't want to be associated with MH consumers and vice versa, both at "consumer and staff levels."

Sub-theme 3 - Stigma- Community and culture.
Participants voiced that stigma is experienced from both community and cultural perspectives from the different islands in Hawaii. One participant stated that "cultural stigma hinders treatment." Another participant noted that "here I'm judged" and "it's spooky, I don't trust." Still another expressed "I don't feel accepted" and "I feel already judged." One provider participant noted that one consumer she worked with felt that she "may need to leave because she was a former ice user." Another provider participant explained that "adults often want to go off-island for treatment to maintain confidentiality."

Sub-theme 4 - Stigma as a barrier.
Barriers to treatment and recovery of COD emerge because of the double stigma associated with mental illness and substance abuse. One participant noted that "stigma attached to illness doesn't help." Another participant noted that stigma can be a barrier for consumers seeking treatment, and stated that a consumer "could be suicidal, but won't cop to it" and

that some consumers may need to be "almost court ordered to take medication", or to attend substance abuse treatment.

Sub-theme 5 - Stigma-Families.
Families feel the stigma and are also are proponents of stigma attached to those who have COD**.** This was expressed by one participant who noted "they don't want to accept that the parent has MI, kids are in denial." Another participant noted that "extended family don't accept MI." Still another noted that "clients don't want it getting back to families" because of the stigma of COD.

Sub-theme 6 - Community education to reduce stigma.
The sub-theme of community education to reduce stigma spoke to an avenue for the relief of stigma related issues, which connects the themes of Public Education and Public Perception of COD. One participant said that there is a need for "more empathy from the legislature." Another stated that there is a need to "demystify psychological disorders with psychoeducation." Lastly, another participant suggested that there is a need to educate the public on the "disease concept" which would "lessen the stigma."

Sub-theme 7 - Community education about MI and SUD to increase awareness.
Public Education was also seen as a way to increase community involvement for the betterment of the lives for those with COD. One participant suggested "advertise that help is available." Another suggestion was to "educate religious services, schools, bus drivers, and police" about COD.

Sub-theme 8 - Raising community involvement and support.
Public Education was recommended to target such community groups as police, employers, schools, and clergy and to implement a media campaign as another strategy to provide increased public awareness. One participant said that there is a need for "getting people more involved and invested." This was echoed by another participant who noted it important to find "ways to motivate the community."

Sub-theme 9 - Misperceptions of programs.
Another form of stigma expressed by participants was that some agencies were perceived in a negative light by other care delivery organizations (e.g. substance abuse vs. mental health). One participant stated that some organizations have intensified stigma attached to them and that these perceptions may "leave a bad taste in their mouth."

Theme 13: Resources.
Resources, as a major theme, include the sub-themes of Human Resources, Financial Resources, Physical Resources, Consumer Resources, and Treatment Resources. The major thrust of the Resources theme and its sub-themes are that there is a lack of needed resources at a number of levels to provide adequate services to consumers with COD.

Sub-theme 1 - Human Resources.
For Human Resources, there are a number of categories and sub-categories emerging from this sub-theme, which included training and education, the need for more staff, and staff burnout.

Category (A) Training and Education
For the area of training and education, participants expressed a need for more training, trainings on specific areas, and the need for easily accessible information on available training. Seven sub-categories emerged described below,

Sub-category:

1) How the care delivery system operates
Participants expressed the need for training on how the care delivery system operates in order to become more effective in navigating the complex array of services and organizations involved in the care delivery system for COD.

2) Supervision and consultation
Participants also expressed a need for COD clinical supervision and consultation. Moreover, participants voiced the need for continuing education and updated information on medication and areas of research in mental health.

3) Diagnosis and symptoms
Participants noted the need for training on DSM-IV-R diagnoses and symptoms within these diagnostic disorders.

4) Para-professionals and auxiliary professional
Participants felt that auxiliary professionals, like interpreters in the clinical setting, law enforcement officers, and care home operators and providers, would also benefit from trainings in the area of COD.

5) Ethnic and drug cultures
There was a concern for understanding both diverse ethnic cultures and the drug culture in order to better facilitate COD treatment.

6) Psychopharmacology
Participants stated a need for training in psychopharmacology, for example what medications are used, what these medications are used for, what the side effects of the medications are, and how to know if someone is not taking his or her medication.

7) Interventions
Participants expressed a need for training in specific COD interventions, how to use them, and trainings to improve skills already possessed. Participants also expressed the need for cross-training for those in the mental health field providing substance abuse treatment, and for those in the substance use treatment field providing mental health treatment. They accented the need for specific training in COD integrated treatment. When some participants discussed training needs they also identified the need for training materials for both consumers and providers to include available brochures and resource directories. Some participants mentioned that the availability of resource directories indicating services available also be provided in a variety of languages.

Category (B) More staff
In the category of the need for more staff, participants consistently mentioned the need for more substance abuse counselors in the state, specifically on the rural islands. Additionally, participants mentioned the need for more case managers.

Category (C) Staff burn-out
Finally, participants mentioned that large caseloads added to the problem of staff burnout and that staff turnover increased as a result of such burnout.

Sub-theme 2 - Financial Resources.
In the area of the Financial sub theme, participants expressed the need for more funding to serve those consumers with COD due to insurance barriers noted previously in serving this population. Additionally, poor reimbursement rates and services being "fiscally driven" vs. "clinically driven" added to the lack of funding options for this population. Suggestions made by participants included the need for ADAD and AMHD to coordinate funding mechanisms for COD consumers, assisting in overcoming insurance reimbursement barriers, and considering local control of funding sources for improved services planning and development.

Sub-theme 3 - Physical Resources.
In the area of the Physical Resources sub theme, participants expressed the need for more physical resources, enhancing options for space like buildings in which to provide treatment and other alternatives to provide more space for treatment.

Sub-theme 4 - Consumer Resources.
In the area of Consumer Resources, there were three categories, which included needed resources for consumers to include better dental care, more public benefits, and housing and transportation needs.

Category (A) Dental
One consumer stated that "half the people walk around with no teeth. How do they expect us to smile?" This statement related to the dental care many consumers receive where their teeth are pulled and not treated with fillings.

Category (B) Public benefits
Another category of consumer resources was the need for more public benefits, like child care.

Category (C) Housing and Transportation
The final category for the Consumer Resources sub-theme was housing and transportation. Participants expressed a lack of available housing for those with COD. One participant stated that "some [consumers] get together and rent housing; [but] hard to find landlords who will do this," which spoke to the difficulty for consumers to find landlords willing to rent to someone who has COD. Additionally, transportation was mentioned by a number of participants as a major barrier for COD consumers seeking services, and in some locations transportation was noted as non- existent due to lack of bus services in the rural areas of Hawaii.

Sub-theme 4 - Treatment Resources.
The last sub theme is Treatment Resources, where participants expressed the need for free brochures and handouts to give to consumers, the need for updated and local videos to show to consumers, and other materials that would be helpful in the treatment of people who have COD.

Theme 14: Special populations.
This major theme of Special Populations describes a number of sub-population categories which need specialized care and services within the COD care delivery system. These sub-populations include people who have developmental disabilities, are organically brain damaged, geriatric consumers, homeless consumers, children and teens, consumers with forensic issues,

and women and children. All of these sub-populations were noted to have specific needs. Some examples are described below.

Homeless.
For example one consumer stated that it is hard to be "homeless and stay sober."

Children and teens.
Participants expressed that there is added complexity in treating children and teens, because in addition to providing care there are the additional entities involved with care such as schools and parents and other organizations serving children and youth.

Forensic.
As with children and teens, the forensic population also has added complexity because of the interface between the complex COD care delivery system and the variety of forensic organizations that are connected in provided COD services to consumers with forensic issues.

Women and children.
Lastly, in the category of women and children, there were added challenges noted for provision of COD treatment, such as provisions of child care for single mothers seeking COD services.

Phase II – Key Informant Interviews
Results of the 6 key informant interviews conducted between July 2006 and December 2006 were transcribed and analyzed for common and unique themes. Eleven major themes emerged from the data analysis. These themes are detailed below in (Table 3). A brief narrative explanation of each follows starting on page 32.

As one can note, the 11 Key Informant interview themes represented elements from all of the major 14 themes from the Phase I Focus groups, with the exception of Theme 12 - Public Education & Public Perception of COD (See Table 12, Appendix G).

Table 3 -- Phase II- Key Informant Interview Themes

Theme A --	Scope of Drug Problem
Theme B --	Service System Issues 1 -- Multifaceted system approaches 2 -- System Level Coordination
Theme C --	Service Level Coordination
Theme D --	Barriers to Treatment
Theme E --	Evaluation Outcomes
Theme F --	Service Delivery 1 -- Improved Assessment 2 -- Enhanced Case Management 3 -- Increase Beds for COD

	4 --	Improved Transitioning to Community
Theme G --	Treatment Approaches	
	1 --	Evidence Based Practices
	2 --	Holistic
	3 --	Stagewise Tx
	4 --	CBT Approaches
	5 --	WRAP Crises Planning
	6 --	Therapeutic Alliance
	7 --	Multidisciplinary Team
	8 --	Increased Availability of MD's
Theme H --	Cultural Considerations	
	1 --	Improve Cultural Competency
	2 --	Integrate Cultural Practices
	3 --	Hire Diverse Staff
Theme I --	Foundations for Recovery	
	1 --	Need for Strong Support System
	2 --	Housing
	3 --	Self Help Support
	4 --	Vocational Rehab
Theme G. --	Resources	
	1 --	Training for Professionals
	2 --	Technical Assistance
	3 --	Increase Funding for COD programs
Theme H --	Special Populations	
	1 --	Improve Services Homeless COD

Theme A: Scope of Drug problem.

Several participants mentioned concerns over the scope of Hawaii's drug problem, noting the past societal trends in Hawaii regarding alcohol and drug abuse and that most families in Hawaii have been affected in some way by drug problems. Additionally, there was notation that the overall system needs to improve in strategies to address Hawaii's drug problem, including employing both legal and social solutions. Specifically, one participant noted the criminal justice system needs to also be involved in a role impacting the "supply and demand" of the drug economy.

Theme B: Service System Issues.
1) Multifaceted system approaches; 2) Systems level coordination.
Most participants noted that the service system's needs should be assessed and that any strategies proposed to improve services for COD consumers should include a multifaceted approach. This multifaceted approach needs to be inclusive, not only of the health and human service system, but the criminal justice system, and focus on implementing comprehensive strategies that are bio-psycho-social (legal, economic, cultural) in nature for addressing and treating COD.

Moreover, some participants noted the system must actively support the development of culturally relevant programs for COD consumers and evidence based practices for COD. Finally, a few participants noted it is important that coordinated leadership be provided by Hawaii's state level divisions including the Adult Mental Health Division (AMHD) and the Alcohol and Drug Abuse Division (ADAD), and the need for these divisions to listen to the community for proposing system needs and solutions.

Some participants mentioned that there have been recent awareness and changes at the system level in the last few years, to include: a) implementation of a pilot project for evidence based practices for Integrated Dual Disorders treatment; b) court and legal oversight propelling AMHD community plans towards focus on development of COD treatment; and, c) more overall awareness of the scope of COD among state and provider groups, thereby impacting the philosophy that COD can be treated in a holistic manner.

Theme C: Service Level Coordination.
Many participants mentioned the importance of the need for close communication and coordination among mental health and substance abuse professionals or agencies and entities, such as criminal justice, health care providers and other community resources that COD consumers use for recovery support. Accented by some participants, was the importance of coordination with the criminal justice system to mandate support and follow-up for successful or unsuccessful treatment efforts. One participant noted the importance of legal interventions in playing a role to motivate consumers for seeking and completing treatment.

Theme D: Barriers to Treatment.
Some participants mentioned that barriers to COD treatment should be alleviated. Such barriers listed included misdiagnosis of COD, lack of insurance coverage, lack of qualified professionals to assess COD accurately, and lack of bed space and funding for dual diagnoses programs. Additionally, participants mentioned that as barriers are addressed, attention to improvements to access COD programs was necessary.

Theme E: Evaluation of Outcomes.
The majority of participants noted that attention to program evaluation to include both process and outcome evaluation was a necessary ingredient to improve and expand upon quality services. Specifically, some mentioned the importance of conducting efficacy studies, comparing the impact of programs serving Native Hawaiian consumers using traditional cultural practices embedded in programming versus those programs using Western methods of treatment. Others mentioned the importance of measuring client outcomes as part of service delivery and, finally, the importance of implementing ongoing fidelity monitoring to oversee the adherence of implementation of evidence based practices.

Theme F: Service Delivery.

This theme encompassed the following four components: 1) Improving Assessment for COD; 2) Enhanced Case Management; 3) Increase Beds for COD treatment services; and, 4) Improve Transitioning services to community.

1) Improving Assessment for COD- Participants discussed the importance of adding to professionals' expertise (mental health, addiction, and criminal justice, medical) so that appropriate assessment for COD can be improved. Some participants noted it important to provide updated training to both mental health and substance abuse professionals to improve differential diagnoses skills in identifying those consumers with COD. Additionally, participants noted that access to more M.D.'s who are skilled in COD diagnoses would also be helpful in improving assessment services.

2) Enhanced Case Management- a number of participants mentioned the need for more case management services to reach COD consumers and the importance in providing training to case managers to increase skills in working with those with COD.

3) Increase Beds for COD treatment services- Some participants mentioned that there is a need for more specific residential beds to serve consumers with COD as current programs have waiting lists, leaving access difficult when consumers are motivated to obtain assistance.

4) Improve transitioning services to community- Several participants noted that transitioning services after completion of treatment was very important to support recovery efforts. These transition services are sometimes overlooked as a priority for recovery and that it important they be strengthened.

Theme G: Treatment Approaches.

This theme encompassed the following areas: 1) Evidence based practices (EBP's); 2) Holistic approach; 3) Stagewise Treatment; 4) Cognitive Behavioral therapy; 5) WRAP crises planning; 6) Therapeutic Alliance; 7) Multidisciplinary Team; 8) Increased availability of MD's.

1) Evidence Based Practices (EBP's) –Some participants mentioned the importance of supporting and implementing evidence based practices (EBP's) for addressing COD, and the need for support at the highest level of the system in order for EBP's to be effective and maintain fidelity to their models.

2) Holistic approach- A few participants accented the need for consumers to be seen as "whole persons" in need of treatment which provides holistic care.

3) Stagewise Treatment- Some participants noted the importance of assessing stage of change and providing appropriate stagewise treatment interventions for consumers with COD.

4) Cognitive Behavioral therapy- A few participants noted that the uses of cognitive behavioral interventions are imperative for successful treatment of COD.

5) WRAP crises planning- A number of participants noted that specific crises planning for consumers was a basic foundation of COD treatment.

6) Therapeutic Alliance- Participants noted the importance of portraying respect and building a trusting and safe relationship with COD consumers to promote recovery.

7) Multidisciplinary Team- Some participants noted the importance of providing teams of professionals working together to best assist consumers with COD.

8) Increased availability of MD's- A number of participants noted that more MD's are needed to serve consumers in Hawaii.

Theme H: Cultural Considerations.

This theme consisted of the following areas all focused on the importance of attention to cultural sensitivity and awareness in COD services: 1) Improve cultural competency; 2) Integrate cultural practices; and, 3) Hire diverse staff.

1) Improve Cultural Competency - All participants mentioned that it important to improve cultural sensitivity and competency in all levels of services provided to COD consumers. Participants discussed that the recognition and respect of a consumer's cultural background is paramount in providing the highest quality of care. Specific mention included becoming aware of community cultural resources, providing cultural competency training , culturally sound assessments, giving respect and understanding to the "host" culture, gaining knowledge of a variety of cultural groups' beliefs and traditions, and understanding that "culture" is defined as "beyond race and ethnicity" including other social groups and identifications.

2) Integrate cultural practices - Most participants mentioned the importance of integrating traditional cultural practices in service delivery, in addition to using Western approaches to COD treatment. Additionally, using efficacy studies to evaluate the effectiveness of integrating traditional Native Hawaiian practices into treatment services and funding cultural approaches to treatment were suggested.

3) Hire diverse staff – Most participants noted the importance of hiring and training a culturally diverse staff including "local" professionals to provide services to COD consumers. Notation was made that staff must understand the host culture and Hawaiian culture and traditions.

Theme I: Foundations for Recovery.

Theme I centered on important components necessary to support COD consumer's recovery and included: 1) Need for strong Support System; 2) Housing; 3) Self Help support; and, 4) Vocational Rehabilitation.

1) Need for strong Support System- A number of participants noted that COD consumers need assistance in developing a strong and coordinated support system to aid in recovery efforts, to include support of family, friends, and a team of multidisciplinary professionals.

2) Housing- Most participants noted that consumers with COD are in need of housing options and resources and those strategies to increase and improve housing options are a priority need.

3) Self Help support- There was some notation that more self help groups specifically focused to assist COD consumers were needed in many geographical areas.

4) Vocational Rehabilitation- A few participants noted the importance of assisting consumers in obtaining assistance in vocational rehabilitations services and locating employment to help find meaning and support in their lives.

Theme J: Resources.
This theme focused around training, consultation, and funding resources needed to support and improve services for COD consumers and included the following: 1) Training for professionals; 2) Technical assistance; and, 3) Increase funding for COD treatment services.

1) Training for professionals- A number of participants noted that a variety of training topics to improve professional knowledge and skills in working with COD consumers as imperative. Some of these topics included- differential diagnosis, de-escalation techniques, updates on COD, cultural issues, and crises planning.

2) Technical assistance- Some participants noted that assistance to agencies and staff in identifying and planning for treatment of COD would be welcomed as ways to assist programs in improving services.

3) Increase funding for COD treatment services- Most participants noted that increased funding is needed to provide more treatment beds, more COD programs and provide more case management services for consumers.

Theme K: Special Populations.
This final theme focused on the need to study, plan and improve services for COD consumers who are in need of housing or have been homeless for a number of years. Meeting the needs of this population was cited as essential in targeting many consumers who struggle with COD.

Phase III - Survey

Five hundred thirty-four females (56.7%), 388 males (41.2%), 10 transgender (1.1%) and 10 "prefer not to answer" (1.1%) completed the survey for a total of 942 respondents. Surveys were returned from every island in the state of Hawaii. Zip codes were used to identify the geographic home of survey respondents. Tables 5 to 9 below include totals and percentages of the demographic information from the State of Hawaii respondents and Table 9 also lists all 30 items in their ranked order.

For Table 4 below, "Responses by Island", the respondent's home island was identified through zip codes. Eighteen of the surveys had no zip code, and five survey zip codes could not be geographically identified. Additionally, other zip codes indicated that those respondents were from outside the state: three were from Washington State; and one each came from California, Missouri, Samoa and Pohnpei. As would be expected, respondents on the Island of Oahu completed the bulk of surveys, accounting for almost 74% of the total. Molokai and Lanai, the least populated islands, together returned 2.5 % of the surveys. Table 6 provides Island totals.

Table 4: Responses by Island

Island	Total	Percentage
Oahu	669	73.5
Hawaii	89	9.8
Maui	76	8.4

Kauai	53	5.8
Molokai	15	1.6
Lanai	8	0.9
Total	910	100.0

Respondents were represented across all of the affiliation categories designated in the survey. It should be noted that in Table 5 below the total number of categories endorsed by respondents exceeded 910 because respondents could check more than one affiliation category. Overall, "Service Providers" were the majority of respondents returning surveys for a total of 34.9%; with "Family/Loved One of a Service Receiver" the lowest number of respondents at 7.3% of the total surveys returned.

Table 5: Affiliation

Affiliation	Total	Percentage
Service Provider	394	34.9
Concerned Citizen	271	24.0
Receiver of Services	238	21.0
Administrator/Manager	144	12.8
Family/Loved One of a Service Receiver	82	7.3
Total	1129	100.0

The second step to designating affiliation was a request for administrator or manager respondents to choose the provider system with which they identified as indicated by the item that stated, "If you are an administrator/manager, check which system applies to you." Participants had three choices: Mental health, Substance abuse, or Criminal justice system. One hundred-forty-four respondents identified as "Administrator/Manager", yet responses for Mental health, Substance abuse, and Criminal justice system categories together totaled 237. The disparity between the two totals most likely indicated overlapping identification with one, two, or all three systems. Table 6 contains these totals.

Table 6: Provider System

Profession	Total	Percentage
Mental health	120	50.6
Substance abuse	89	37.6
Criminal justice	28	11.8
Total	237	100.0

The majority of respondents noted "Race/Ethnicity" as White, followed by Hawaiian, then Japanese. The totals are greater than 910 due to participants choosing more than one Race or Ethnicity. Those results are provided in Table 7.

Table 7: Totals by Race/Ethnicity

Race/Ethnicity	Total	Percentage
White	513	34.9
Hawaiian/Part-Hawaiian	217	14.8
Japanese	199	13.5

Chinese	146	10.0
Filipino	134	9.1
Hispanic/Latino	93	6.3
Pacific Islander	49	3.3
Black	47	3.2
Korean	27	1.8
Vietnamese	7	0.5
Asian Indian	5	0.4
Alaska Native	4	0.3
Unknown	7	0.5
Prefer Not To Answer	21	1.4
Total	1469	100.0

The heart of the survey instrument asked respondents to select which 10 of 30 items they thought were most important when considering the multiple needs of consumers who have co-occurring disorders. Those results are provided below rank ordered from 1 to 30 in Table 8.

Table 8: Item Rankings

Item No.	Rank	Statement	Total	Percent of All Respondents (n=942)
1	1	Focusing on the methamphetamine ("ice", "meth", or "crystal") drug problem.	650	69.0
9	2	More housing for people with CO-OCCURRING DISORDERS	509	54.0
2	3	Having substance abuse and mental health agencies work together better.	484	51.4
13	4	More money for programs already set up.	434	46.1
3	5	Helping persons with CO-OCCURRING DISORDERS get services faster.	411	43.6
18	6	More substance abuse treatment on our island.	398	42.3
26	7	Having the Adult Mental Health Division (AMHD) and Alcohol & Drug Abuse Division (ADAD) work together to help consumers.	383	40.7
5	8	Being able to get help from crisis services 24 hours a day.	371	39.4
17	9	Making outreach services better.	358	38.0
27	10	More services for families.	347	36.8
22	11	More residential co-occurring treatment programs.	337	35.8
6	12	More detoxification programs on our island.	335	35.6
29	13	More help with getting proper medications	332	35.2
15	14	Helping people with CO-OCCURRING DISORDERS find work.	320	34.0
4	15	Helping persons with CO-OCCURRING DISORDERS get or keep insurance coverage.	318	33.8
12	16	Smaller case loads for care providers.	303	32.2

Item No.	Rank	Statement	Total	Percent of All Respondents (n=942)
10	17	Training care providers on CO-OCCURRING DISORDERS.	301	32.0
8	18	Teaching families about CO-OCCURRING DISORDERS.	297	31.5
11	19	More certified substance abuse counselors.	283	30.0
7	20	More help from psychiatrists.	260	27.6
24	21	Making transportation services better.	260	27.6
21	22	More cultural activities in programs.	250	26.5
25	23	Making it easier to get co-occurring services.	250	26.5
19	24	Better assessment of persons with CO-OCCURRING DISORDERS.	249	26.4
23	25	More information about CO-OCCURRING DISORDERS for people in the community.	231	24.5
30	26	More self-help groups for people with CO-OCCURRING DISORDERS.	208	22.1
16	27	Helping people get in touch with friends, loved ones, or others in the community who can help them.	195	20.7
20	28	More help getting peer support or sponsors.	193	20.5
14	29	More information for care providers about different cultures.	185	19.6
28	30	More language interpreters.	123	13.1

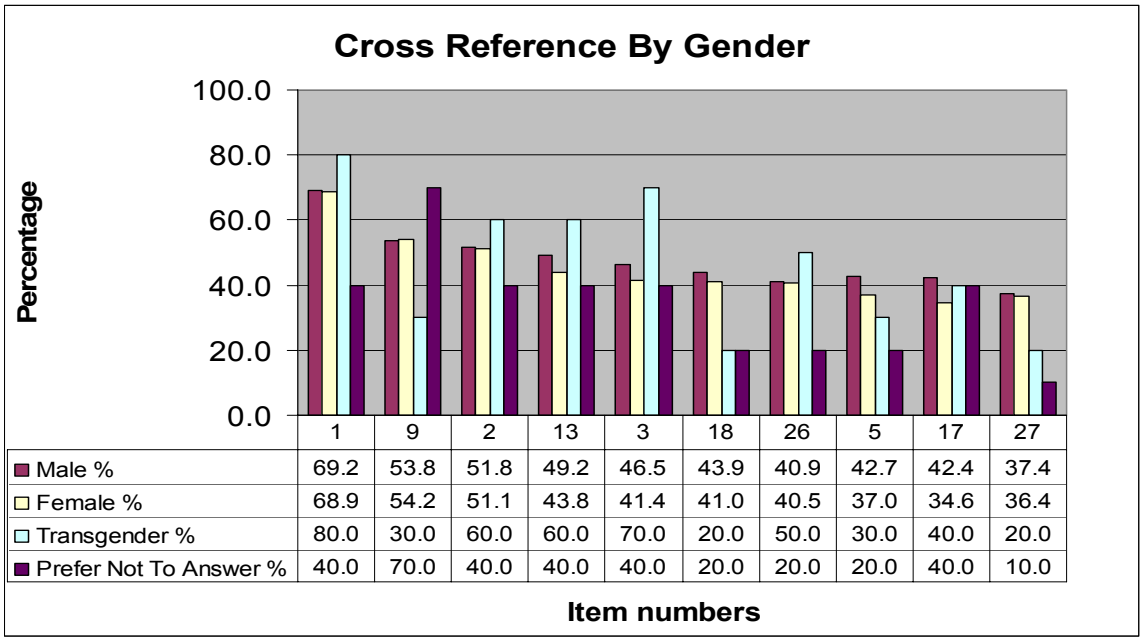
Respondents chose Item #1, the “Methamphetamine Drug problem”, as the #1 priority need to be addressed, with 69% of all respondents endorsing this item. The rest of the top 10 items were endorsed between 36.8% and 54.0% of all respondents. After the highest ranked item, the “Methamphetamine Drug problem”, three major themes emerged for ranked priorities 2 through 10: Outreach, Increase Current Services, and Collaboration.

First, the Outreach theme included items 3, 5 and 17, which all addressed in some way the need for outreach, improved accessibility, and crisis-related services to assist consumers with COD. The second theme, Increase Current Services (item 9, 13, 18 and 27) suggested that overall current mental health and substance abuse services needed continued and increased funding, expansion, and inclusion of more housing and family related services. The third theme focused on Collaboration (Item 2 and 26) between mental health and substance abuse programs and between the state level Adult Mental Health and Alcohol and Drug Abuse Divisions. Respondents indicated better collaboration is needed by both Divisions to work together to provide COD services to consumers.

The top 10 priority items were cross-referenced with the following demographic categories: gender, affiliation, race/ethnicity, and island to determine if there were any substantial differences across the demographic domains. Generally speaking, the top 10 priority items received strong endorsement from all the respondents’ demographic categories with all categories ranking Item 1, the “Methamphetamine (“ice”, “meth”, or “crystal”) drug problem” as the top priority. Additionally, almost every cross-referenced demographic category identified item 1 as the number one problem facing their communities. However, there were exceptions.

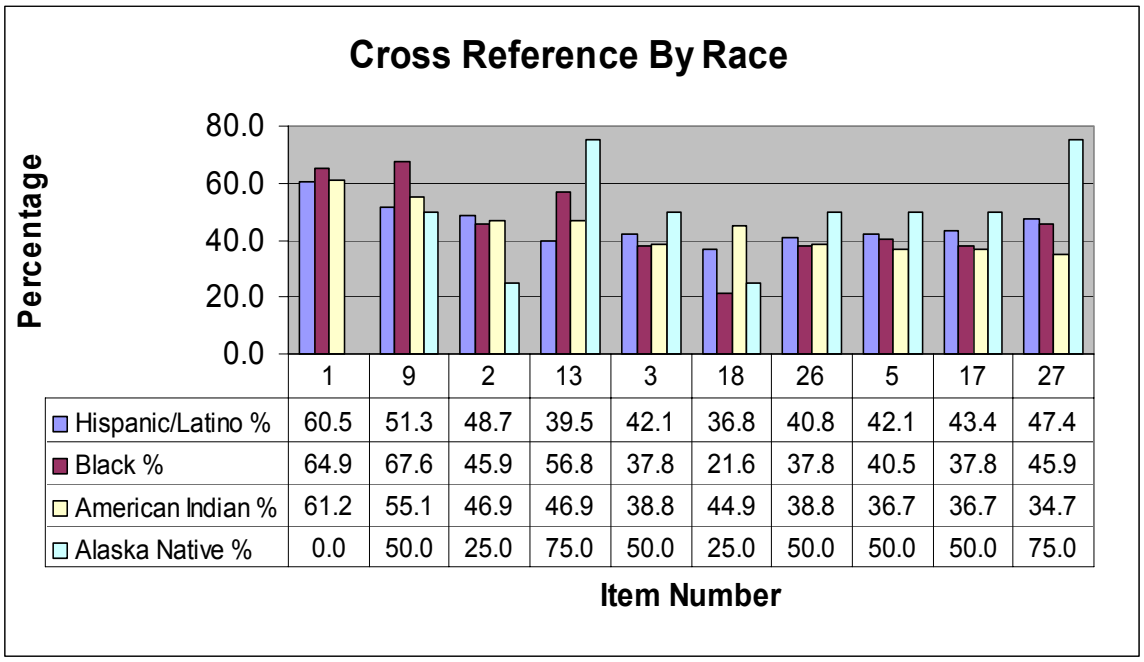
Certain demographic categories endorsed item 9, “More housing for people with co-occurring disorders” as the top priority. The following categories of respondents reported 9 as their top priority: “Receiver of services” (Affiliation), “Black or African American” (Race/Ethnicity), and Maui (Island). Of note, Item 2, “Have substance abuse and mental health agencies work together better” was consistently ranked third, with only two demographic categories ranking it second, Filipino (Race/Ethnicity) and Oahu (Island). The other seven items had no clear priority ranking. These above results are also reported as bar charts in Charts 1 to 4 in the following section for ease of observation and interpretation. The same results are also reported in table form in Appendix E, Cross-Reference Tables.

Chart 1: Top 10 Items by Gender

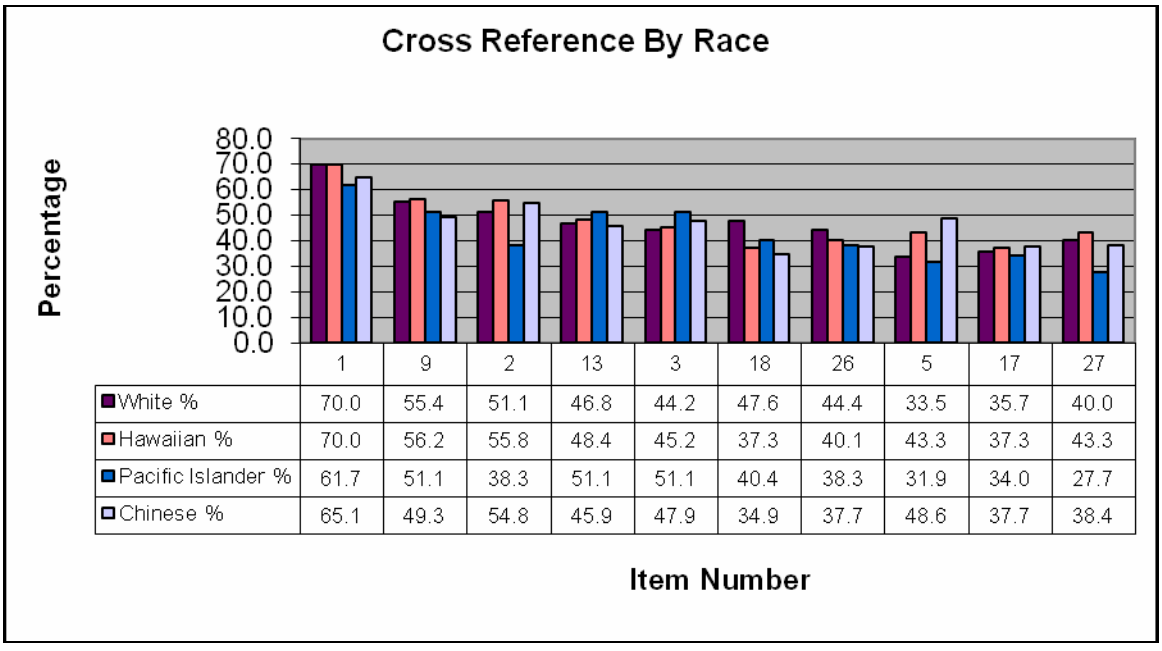


	1	9	2	13	3	18	26	5	17	27
Male %	69.2	53.8	51.8	49.2	46.5	43.9	40.9	42.7	42.4	37.4
Female %	68.9	54.2	51.1	43.8	41.4	41.0	40.5	37.0	34.6	36.4
Transgender %	80.0	30.0	60.0	60.0	70.0	20.0	50.0	30.0	40.0	20.0
Prefer Not To Answer %	40.0	70.0	40.0	40.0	40.0	20.0	20.0	20.0	40.0	10.0

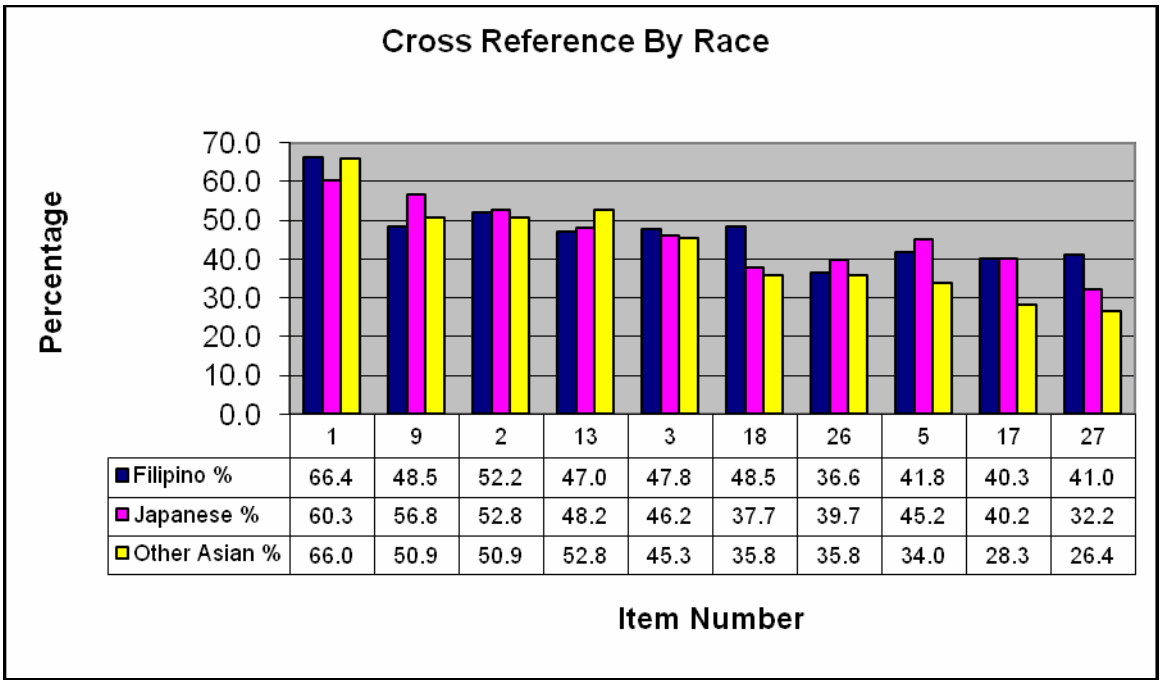
Chart 2: Top 10 Items by Race/Ethnicity



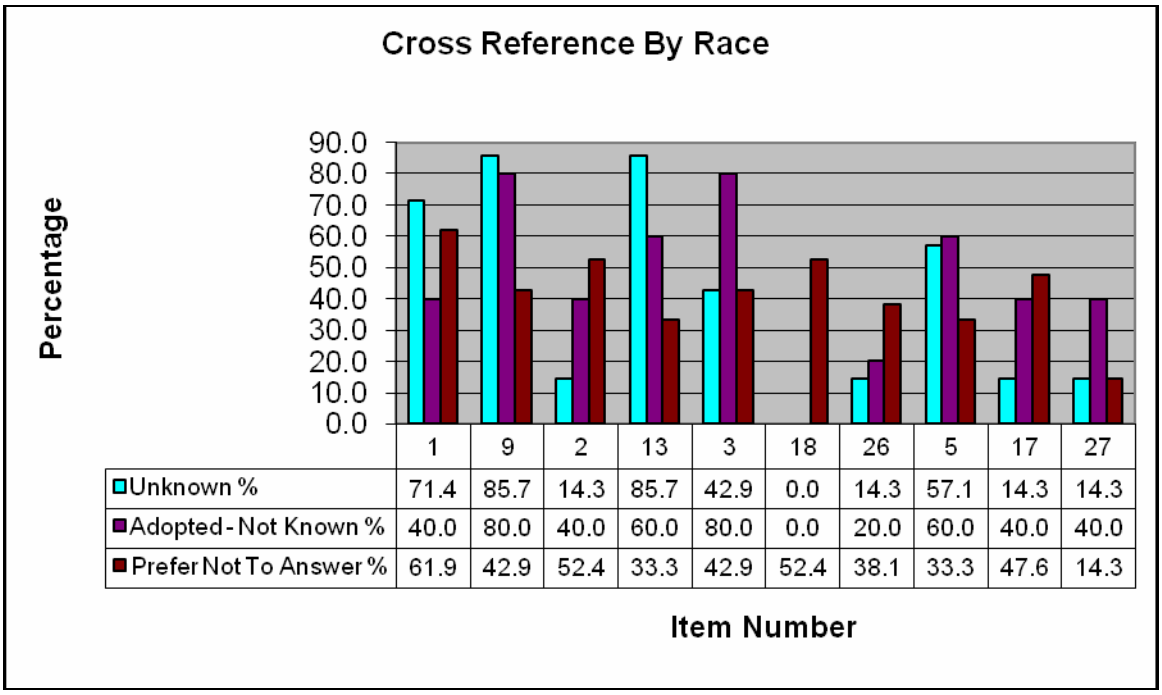
	1	9	2	13	3	18	26	5	17	27
Hispanic/Latino %	60.5	51.3	48.7	39.5	42.1	36.8	40.8	42.1	43.4	47.4
Black %	64.9	67.6	45.9	56.8	37.8	21.6	37.8	40.5	37.8	45.9
American Indian %	61.2	55.1	46.9	46.9	38.8	44.9	38.8	36.7	36.7	34.7
Alaska Native %	0.0	50.0	25.0	75.0	50.0	25.0	50.0	50.0	50.0	75.0



	1	9	2	13	3	18	26	5	17	27
White %	70.0	55.4	51.1	46.8	44.2	47.6	44.4	33.5	35.7	40.0
Hawaiian %	70.0	56.2	55.8	48.4	45.2	37.3	40.1	43.3	37.3	43.3
Pacific Islander %	61.7	51.1	38.3	51.1	51.1	40.4	38.3	31.9	34.0	27.7
Chinese %	65.1	49.3	54.8	45.9	47.9	34.9	37.7	48.6	37.7	38.4

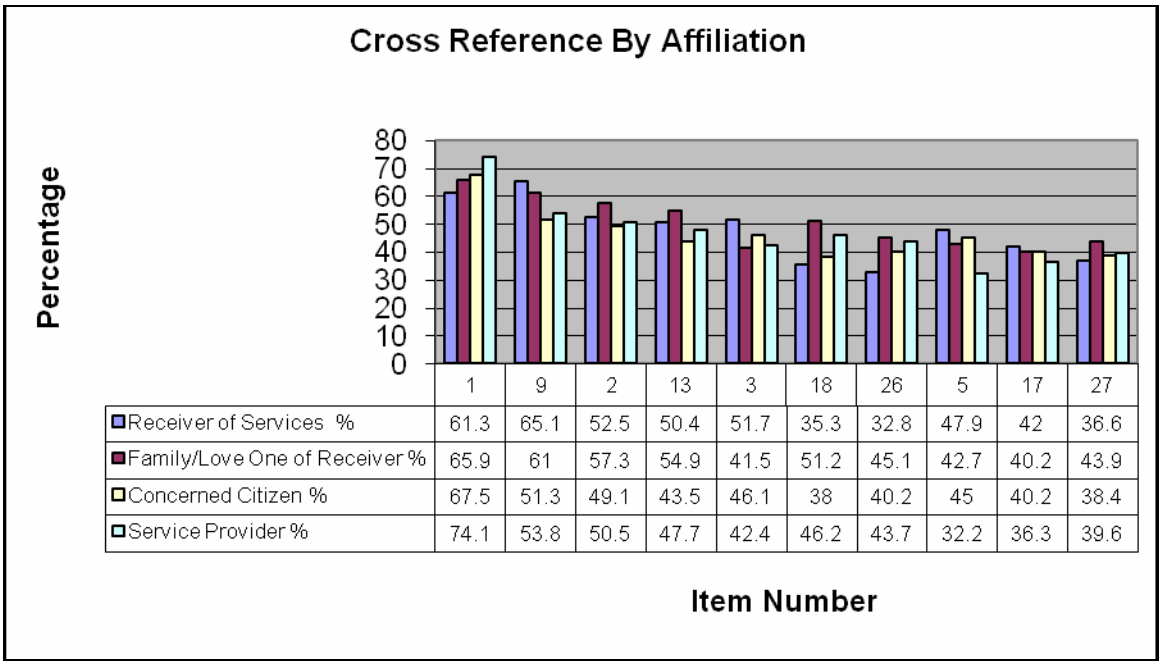


	1	9	2	13	3	18	26	5	17	27
Filipino %	66.4	48.5	52.2	47.0	47.8	48.5	36.6	41.8	40.3	41.0
Japanese %	60.3	56.8	52.8	48.2	46.2	37.7	39.7	45.2	40.2	32.2
Other Asian %	66.0	50.9	50.9	52.8	45.3	35.8	35.8	34.0	28.3	26.4

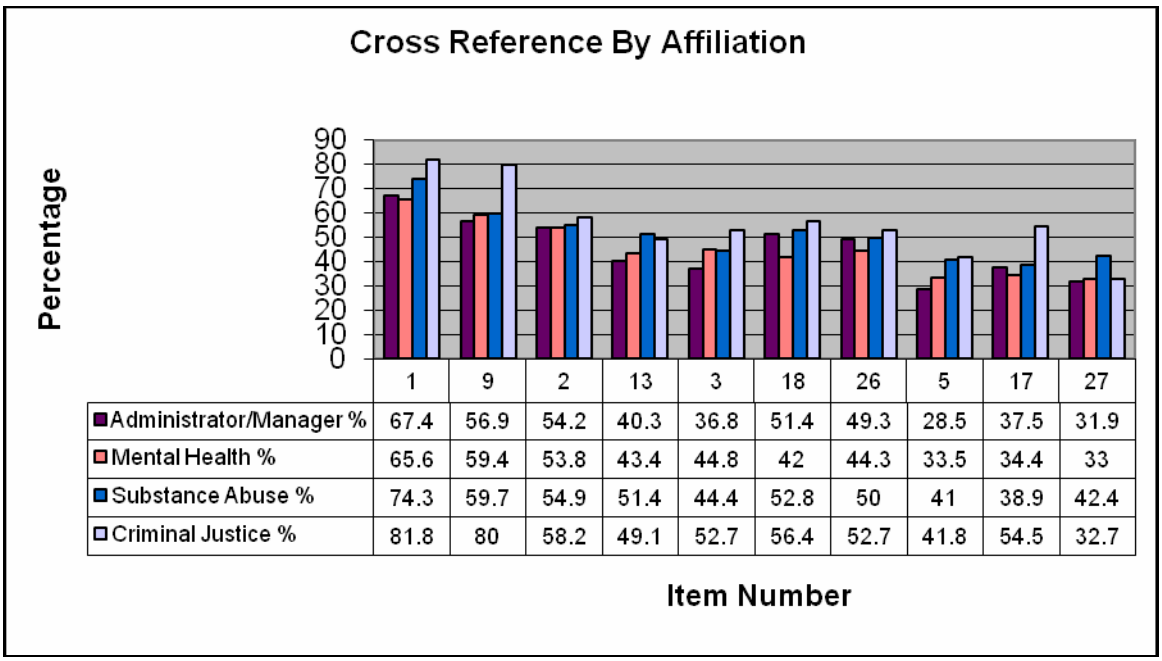


	1	9	2	13	3	18	26	5	17	27
Unknown %	71.4	85.7	14.3	85.7	42.9	0.0	14.3	57.1	14.3	14.3
Adopted - Not Known %	40.0	80.0	40.0	60.0	80.0	0.0	20.0	60.0	40.0	40.0
Prefer Not To Answer %	61.9	42.9	52.4	33.3	42.9	52.4	38.1	33.3	47.6	14.3

Chart 3: Top 10 Items by Affiliation

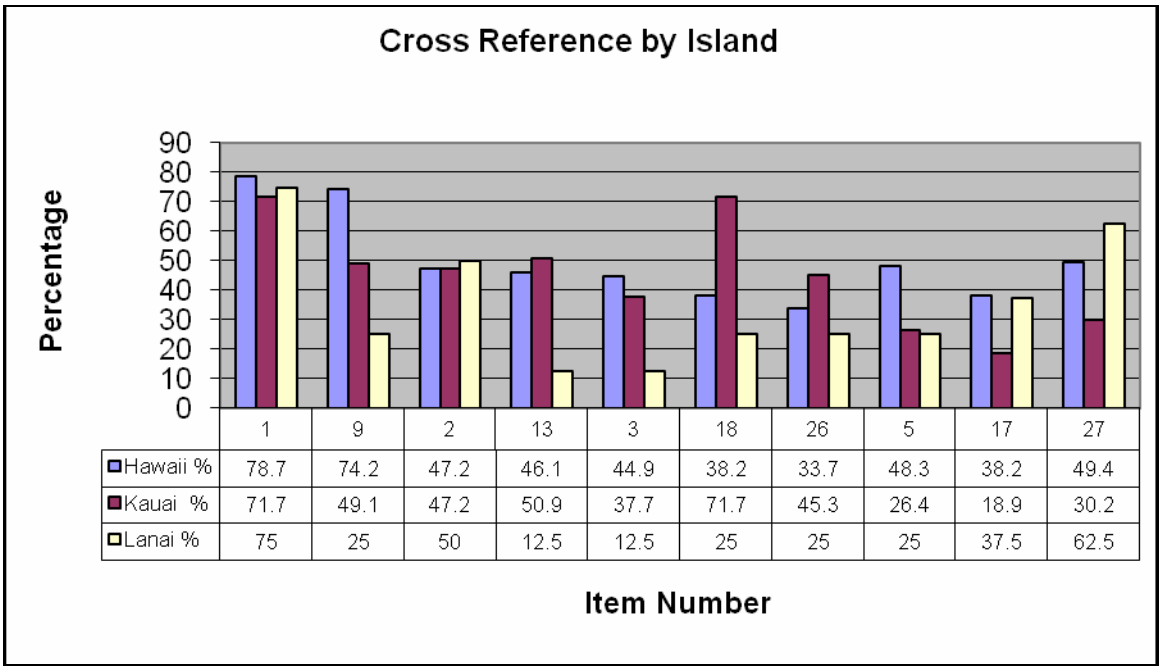


	1	9	2	13	3	18	26	5	17	27
Receiver of Services %	61.3	65.1	52.5	50.4	51.7	35.3	32.8	47.9	42	36.6
Family/Love One of Receiver %	65.9	61	57.3	54.9	41.5	51.2	45.1	42.7	40.2	43.9
Concerned Citizen %	67.5	51.3	49.1	43.5	46.1	38	40.2	45	40.2	38.4
Service Provider %	74.1	53.8	50.5	47.7	42.4	46.2	43.7	32.2	36.3	39.6

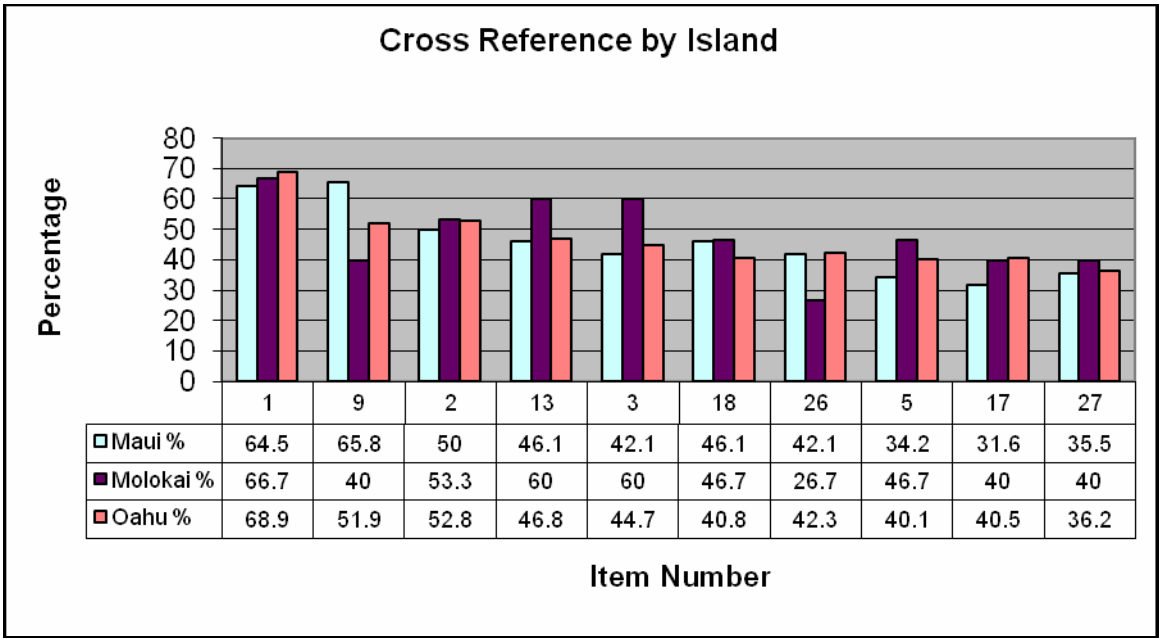


	1	9	2	13	3	18	26	5	17	27
Administrator/Manager %	67.4	56.9	54.2	40.3	36.8	51.4	49.3	28.5	37.5	31.9
Mental Health %	65.6	59.4	53.8	43.4	44.8	42	44.3	33.5	34.4	33
Substance Abuse %	74.3	59.7	54.9	51.4	44.4	52.8	50	41	38.9	42.4
Criminal Justice %	81.8	80	58.2	49.1	52.7	56.4	52.7	41.8	54.5	32.7

Chart 4: Top 10 Items by Island



	1	9	2	13	3	18	26	5	17	27
Hawaii %	78.7	74.2	47.2	46.1	44.9	38.2	33.7	48.3	38.2	49.4
Kauai %	71.7	49.1	47.2	50.9	37.7	71.7	45.3	26.4	18.9	30.2
Lanai %	75	25	50	12.5	12.5	25	25	25	37.5	62.5



	1	9	2	13	3	18	26	5	17	27
Maui %	64.5	65.8	50	46.1	42.1	46.1	42.1	34.2	31.6	35.5
Molokai %	66.7	40	53.3	60	60	46.7	26.7	46.7	40	40
Oahu %	68.9	51.9	52.8	46.8	44.7	40.8	42.3	40.1	40.5	36.2

Results of the Open Ended Question - Survey

Respondents were given an opportunity to list further priorities, needs, or provide general comments at the end of the survey through the following question. *(Please write down any suggestions you have that are not in the list above that **YOU BELIEVE** or **THINK** will make*

services for persons with co-occurring disorders better). The 538 written responses included the following 10 themes. **Appendix F** provides a complete list of the respondents' answers.

Theme 1: General Education and Training for Workforce Development.
This theme accented the need for the provision of general education about co-occurring disorders to families, the criminal justice system, and the community at large. Additionally, this theme included a mention of specific training topics needed for providers to develop and enhance skills in providing care to consumers with COD.

General Education.
"A better understanding of how the mental illness side of CODs plays into things is needed by both the public and providers. Many people use/abuse substances to control their mental health symptoms".
"Teaching families about COD"

Training.
"Require agencies to get training and treat CODs"
"People employed with these groups need to be adequately educated and trained to work with this population".
"Allow CMHC staff training days for CSAC and ADAD training programs"
"Better training for CSAC's including mental illness information".

Theme 2: Improved Service Delivery.
The second theme focused around a myriad of calls to improve current service delivery to COD consumers accenting such things as continuity of care, improved access to services, more staff, and improved quality of programs.

"More 1:1 case managers/MHTs"
"Longer treatment coverage. Not kicking someone out due to their medical running out".
"Quality control, better trained staff, peer advocacy services, dual dx treatment center minimum standards.
"Having Purchase of Service Contractors paid by AMHD deliver services in a more timely manner, don't let them slide for a year or two".
"There should be a seamless relationship between the aforementioned services so that those who are also in the hospital but need immediate transfer to other facility."

Theme 3: Collaboration.
Theme 3 centered on the need for agencies at all levels, as well as a variety of professionals, to improve coordination and collaboration across the system of care for COD consumers. Some of the following quotes accent the type of collaboration suggested by respondents.

"More communication between primary case managers, CH case managers and others involved in case".
"Help psychologists and psychiatrists work together."
"Help substance abuse and mental health agencies work together better."
"Better cooperation between Probation Officers and Case Managers/Treatment providers."
"It would be most helpful if state agencies were encouraged to work together to avoid the duplication of effort, so limited funds could be used for direct services and not to cover administrative costs."

***Theme 4: Increase Treatment Programs*.**
This theme described the need to increase or expand current programs serving consumers with COD as well as the development of new programs. This is demonstrated by a few of the respondents' quotes below.

"Increase in agencies with programs to support youth with substance abuse issues - in evenings."
"Continue needle exchange program to prevent spread of HIV & HCV."
"More detox programs."
"True dual diagnosis programs for the people that are dually diagnosed"

Theme 5: Support Services.
This theme focused on the need to provide information or enhance support services available for consumers with COD explained by respondents' comments below.

"More information about Alanon and AA meeting."
"COD recovery classes at night and which last longer, if consumer desires."
"More Dual Diagnosis meetings".
"Being able to get help from crisis services."

Theme 6: Housing.
Theme 6 focused on the need to provide and have more housing options available for consumers with COD as noted by the following respondents' examples.

"Need more structured residential facilities for clients who have decompensated and are not taking their meds but who may not need hospitalization."
"More homes shared living."
"Private housing for people with co-occurring disorders."
"Housing (affordable) or more long term (2 yr) transitional housing programs."

Theme 7: Legal.
Theme 7 centered on legal and other matters impacting the criminal justice system related to COD treatment services for consumers as noted by some of the following responses.

"Need to change conditional release law to remove probation from being mandated to supervise these clients. Because CR clients now have mental health agencies, case management programs and forensic coordinators (to assess risk), there is no need to duplicate roles."
"Assist co-occurring w/criminal justice issues (I.e. probation, parole, or work furlough)."
Properly detaining persons with co-occurring disorders to keep community safer.

Theme 8: Funding.
Theme 8 centered on the need for expanded funding for services. Some examples are noted below.

"More money to hire and expand existing services & facilities."
"Increase in DHS, SS, VA benefits."
"More money for programs already set up."
"Provide additional funding for state owned mental health centers."
"Explore and evaluate services that are not only Western based, but are best cultural practices. Make funding available for these services."

Theme 9: Psychiatric Services.
Theme 9 focused on the problem created by the shortage of services by qualified psychiatrists as noted by some of the following responses.

"The one psychiatrist that does work one day a week in Haleiwa like most if not all rural psychiatrist will not work with med-quest, Medicare or Medicaid."
"Rural psychiatrist does not serve the poor."
"Increase Medicaid coverage so that psychiatrists and MDs will see those with psychiatric needs."
"Provide a list of Medicaid accepting psychiatrists to consumers and providers."
"Assess the gaps in services for consumers trying to access psychiatrists."

Theme 10: Employment.
Theme 10 centered on the need for employment options for COD consumers as accented by the following response examples,

"Reward them and get them employed."
"Federal, State, City, County Jobs."
"Federal Employment for people with disorders."
"Providing customized employment increased GED program, basic skills training."
Perhaps incentives for employers."
"Creation of jobs that don't discriminate against the MISA patient."

Discussion

Phase I - Focus Groups
The results of Phase I focus groups provided 14 primary themes and sub-themes (see Table 2) from which to build upon in designing Phase II- Key Informant interview guides and construct the Phase III survey instrument to validate and prioritize the top ranked needs of COD consumers in the state of Hawaii. The 14 resulting themes identified a range of Hawaii's COD service system needs that ranged from the larger systems' needs, such as AMHD and ADAD's need to examine strategies for improvements in working together to better plan for and serve the COD consumer, to specific individual COD consumers' needs such as improving the availability of self-help groups and increasing employment opportunities to support recovery. Overall, Phase I results laid the groundwork for developing the Phase II and Phase III needs assessment methodologies thereby allowing the voices of COD consumers and service providers and administrators at the grassroots level to mold and guide further exploration for identifying and validating Hawaii's priority COD service needs.

The majority of the Phase I themes focused on infrastructure and capacity building to improve service delivery to COD consumers. Two exceptions to this focus were Theme I, which described the overall scope of the problem of COD, challenges in working with consumers, and addressed the concern of methamphetamine use among COD consumers, and Theme 12 which identified the need for a myriad of public educational interventions to inform the general community, policy makers, and family members better regarding the scope of the problem of COD, and the importance of supporting the recovery efforts of COD consumers for which to improve their quality of life.

Based on the results of Phase I, the COSIG PT was able to move forward in developing the foundations of the COSIG Strategic Plan, another major initiative to be achieved by the COSIG

PT. The 14 resulting themes identified from the 46 focus groups held statewide paved the way for the COSIG's Strategic Plan's subcommittees' (Infrastructure, Screening and Assessment, Treatment, and Workforce Development) initial work plans to target the unmet needs of COD consumers and to begin to develop strategies for improvements and changes in the infrastructure and capacity of the overall COD service system.

Phase II - Key Informant Interviews

Results of Phase II Key Informant interviews provided 11 primary themes described in Table (3) from which to validate the general categories uncovered by Phase I Focus group results. These key informant interviews assisted in designing the Phase III- Survey instrument to validate and prioritize the top ranked needs of COD consumers.

As one can note from Table 3, the 11 themes uncovered in the key informant interviews represented elements of all the major 14 themes from Phase I, with the exception of one theme, Theme 12 - Public Education & Public Perception of COD. For some reason, interview participants did not mention the need for public education efforts to assist the general community in increasing awareness and understanding of COD, although participants did echo the importance of providing mental health and substance abuse professionals' further training in assessing and treating COD among consumers.

Although some of the 11 resulting interview themes were labeled differently from the Phase I themes, there is no doubt that the components described in the key informant interview themes resonate with the majority of the Phase I themes. For the themes, which did emerge due to the individual interview format of the data methodology, participants were able to discuss in more detail the concerns at hand. For instance, when discussing Theme VIII- Cultural Considerations, participants were able to describe a variety of needs and strategies to improve cultural competency in service delivery.

The details uncovered in the key informant interviews were of assistance in deciding which survey items to accent and how to craft the language in each related item. Additionally, the key informant interviews called attention to the importance of adding an open-ended question at the end of the survey instrument so that respondents might include more detail and any suggested recommendations for improving the system of care for COD consumers.

Phase III - Survey

The third and final phase of COSIG's statewide needs assessment study was conducted over a six month period, concluding September 30, 2007, with a net accumulation of 942 respondents (534 females, 388 males, 10 transgender, and 10 "prefer not to answer").

Overall, 69.0% of respondents declared the "Methamphetamine Drug problem" as their number one concern. The ranked priorities 2 through 10 revealed three themes: Outreach services, Increase Current Services, and Collaboration. The top 10 priority items were then cross-referenced with the gender, affiliation, race/ethnicity, and island demographic categories. Almost every cross-referenced demographic variable identified survey item #1, the "Methamphetamine Drug problem" as the number one concern, however, there were exceptions. Certain demographic categories endorsed item 9, "More housing for people with co-occurring disorder" as the top priority need. Item 2, "Have substance abuse and mental health agencies work together better" was consistently ranked third, with only 2 demographic categories ranking it second. This indicates general consistency of ranking across the 3 r items, #1, #2, and #9. The other seven items had no clear priority ranking, unlike the above three items.

Ten themes emerged from comments gleaned from responses to the open ended question at the end of the survey asking respondents to note other priorities or make general comments. These 10 themes supported the survey results as they accented such matters as the need for more education and training on COD, improved collaboration across services and professionals, more housing options, more programs and improved quality of current services.

In summary, survey respondents described Hawaii's top three co-occurring needs as the following:

- The "Methamphetamine drug problem."
- The "Need for more housing for people with COD."
- The "Need to have substance abuse and mental health agencies work together better" to improve Hawaii's COD system of care for consumers.

Moreover, these top 3 priorities were consistently echoed across all demographic domains in survey results and were also voiced as significant needs by participants in both Phase I and Phase II of the needs assessment.

Integrated Results: Phase I, II & III

Now, that all three phases of the statewide needs assessment have been completed, data results from all phases have been integrated and are presented below. First, in terms of overall demographic information obtained from Phase I Focus group participants and Phase III Survey respondents the following **Table 9** provides information regarding participants' representation from all the Hawaiian Islands.

Table 9: Comparison of Phase I - Focus Groups and Phase III - Survey Participants, by Island

Phase I Focus Group			Phase III Survey		
Island	**Total**	**Percent**	**Island**	**Total**	**Percent**
Oahu	162	48.4	Oahu	669	73.5
Hawaii	88	26.3	Hawaii	89	9.8
Maui	40	11.9	Maui	76	8.4
Kauai	25	7.5	Kauai	53	5.8
Molokai	20	6.0	Molokai	15	1.6
Lanai	0	0.0	Lanai	8	0.9
Totals	**335**	**100.0**		**910**	**100.0**

As would be expected, overall, Oahu had the majority of needs assessment participants, although the Phase I- Focus Group percentage for Oahu is 48.4% compared to the Phase III- Survey percentage of 73.5%. This is because the COSIG staff made concerted efforts to recruit a proportionate number of focus group participants from all the neighbor islands, including scheduling extra focus groups on neighbor islands where more diverse cultural and rural representation was needed. While the same attempt was made for distribution of the survey, a proportionate number of participants from the neighbor islands could not be guaranteed to respond.

(Note: Table 9- Phase II- Key Informant interviews were all held on the island of Oahu and are not included above).

Table 10 below provides information about both Phase I Focus group and Phase III Survey participants' affiliations.

Table 10: Comparison of Phase I - Focus Group and Phase III - Survey Participants, by Affiliation.

Phase I Focus Group			Phase III Survey		
Affiliation	**Total**	**Percent**	**Affiliation**	**Total**	**Percent**
Service Provider	127	37.9	Service Provider	394	45.9
Administrator/ Manager	79	23.6	Administrator/ Manager	144	16.8
Consumer/ Family Member	129	38.5	Consumer/ Family Member	320	37.3
Totals	**335**	**100.0**		**858**	**100.0**

The three affiliation categories represented across both the Phase I Focus groups and the Phase III Survey respondents are fairly similar, especially the Consumer/Family Member category. The COSIG staff recognized the importance of collecting a proportional set of data that was representative of each category when conducting focus groups, hence extra efforts were made to recruit focus group participants who would represent a wide variety of affiliations. Collecting a proportional set of representative data from the survey was more complicated due to survey distribution and administration factors.

Note: Table 10

a) **Phase II interviewee's affiliations are not included in the above Table 10, but consisted of 1 consumer and 5 administrators.**

b) **Phase III Survey respondents could check more than one category of affiliation.**

c) **The total number of Phase III survey respondents in Table 10 does not reflect the total (N=942) survey respondents due to respondents having other choices to indicate additional affiliations not included in Table 11 (e.g. Concerned Citizen).**

The Phase I Focus group and Phase III Survey participants' comparison by gender reveals similar distribution for males and females noted in Table 11 below.

Table 11: Comparison of Phase I - Focus Group and Phase III - Survey Participants, by Gender.

Phase I Focus Group			Phase III Survey		
Gender	**Total**	**Percent**	**Island**	**Total**	**Percent**
Female	158	55.6	Female	524	56.5
Male	126	44.4	Male	366	40.2
Transgender	0	0.0	Transgender	10	1.1
Prefer Not To Answer	0	0.0	Prefer Not To Answer	10	1.1
Totals	**284**	**100.0**		**910**	**100.0**

Note: Table 11

a) **Focus Group demographic information did not include the Transgender category and not all participants noted their gender.**
b) **Some survey respondents did not indicate a gender preference.**
c) **Phase II Key Informant interviewee's gender representation is not noted in Table 11 but consisted of 2 men and 4 women**.

Table 13 (See Appendix H) provides a comprehensive overview of all the Phase I- Focus group, Phase II- Key informant interviews, and Phase III- Survey results (all 30 ranked items). As one can see all original Phase I Focus group categories are addressed by either the Phase II Key Informant Interview or Phase III –Survey results

As one can note, Phase I, II and III- provided a cross validation across three different methodologies of the gaps, priorities, and identified needs to improve the COD service system. Specifically, Phase III Survey results (top 10 ranked items) created a cluster of priorities (which had also been identified in Phase I- Focus groups and Phase II Key Informant interviews) to be addressed for which to improve services to COD consumers across the state of Hawaii. These priorities include the following:

a) **The need to address the scope of the methamphetamine problem among COD consumers;**

b) **Improved integration and state level coordination between Hawaii's Adult Mental Health Division and the Alcohol and Drug Division and improved collaboration between substance abuse and mental health providers to serve COD consumers better;**

c) **Addressing the need for more housing for COD consumers;**

d) **Improving access to COD services including timeliness of crises services and enhanced outreach services;**

e) **Providing more funding to programs already reaching COD consumers and increasing substance abuse services on neighbor islands;**

f) **Providing services to families of COD consumers.**

Now, that all three phases of the COSIG statewide needs assessment have been completed, these data will continue to be integrated into the final COSIG PT's work. Results will also be shared with other pertinent planning groups (e.g. State of Hawaii Mental Health Transformation Grant initiative) so that ongoing infrastructure and capacity building strategies and plans can be further developed and implemented for actions to improve Hawaii's public mental health and substance abuse system and services for COD consumers.

It can be safely concluded that the respondents to this multi-phased needs assessment saw the methamphetamine problem as the most pressing concern of the COD system of care. Further study should be made of what are the current resources available to address this problem and what steps need to be taken to enhance them.

Service system integration emerged as another key need. The progress toward integration of care already made through the COSIG project and related efforts by ADAD and AMHD for those

people who have co-occurring substance use and mental disorders should be sustained and built upon.

Finally, respondents noted that expanding the array of available services and improving access to them throughout the State of Hawaii should be another goal for the COD system of care. This expansion should also include improved outreach both to service recipients as well as their families and other loved ones.

Appendix A
Opening Statement

Welcome to this morning's (afternoon's) discussion group. This group is a part of the State of Hawaii's Co-Occurring Disorder State Infrastructure Grant, or COSIG for short. Through this COSIG grant, we are trying to make changes and improvements in the ways that the substance abuse and mental health care systems provide care for people who have co-occurring substance use and mental disorders. Please understand that systems change takes a long time and may occur over several months and years.

We have invited you to participate in this group as a first step in our trying to identify what works and doesn't work in the way the State now offers care to people who have co-occurring disorders. XXX, the group assistant, and I (the group leader) will be taking notes about what is discussed during the group. Your responses to the questions we ask will be completely anonymous; we will not record the names of any of the group's participants. After the group meeting XXX and I will meet and tabulate what was discussed by identifying statements about what's working and statements about what's not working. These statements will then be used to construct a paper and pencil type survey. The results of this survey will then be used to help set the agenda for changing the ways in which we provide care for people who have co-occurring substance use and mental disorders.

I'm now going to ask the group a series of questions about what happens to people who have co-occurring substance use and mental disorders. Before we begin we'd like to tell you the three rules that we'll observe for the rest of this group. First, everyone's voice has the right to be heard. We would like to hear the opinions of every group member. So, sometimes I might call on someone who's been quiet. Second, everyone in this group has the right to remain silent. We don't mean that you're under arrest but rather that you also have the right to just sit back and listen to what others are saying and that you don't have to say anything yourself. Third, we're here to talk about opinions and experiences, so there is no right or wrong answers to any of the questions. No one should criticize anyone else for something that they say. The one exception to this is that I'll also be making sure that we stay on task by letting people know when they might have strayed too far from the original question. The last point is that we have XX people here to answer 5 questions. Sometimes I may have to stop the discussion of a question so that we can move on to the next one. So, are there any questions before we begin?

Ok, here is the first question. …

Appendix B
Focus Group Interview Guide

Questions for consumers and family members

1. What's been your experience in getting care for your mental health and substance abuse needs?
2. What has been helpful?
3. What hasn't been helpful?
4. Were there any services that you (or your loved one) felt you wanted or needed but didn't get?
5. How might the system better incorporate cultural issues into treatment for people with co-occurring disorders?
6. Is there anything else we haven't covered that you feel is important or were hoping to talk about today?

Questions for providers

1. What's been your experience in providing care for people who have co-occurring substance use and mental disorders?
2. What are the things that you've done that work in helping people who have co-occurring substance use and mental disorders?
3. What might help you work more effectively with people who have co-occurring substance use and mental disorders?
4. What are some specific training, resources, or technical assistance that might help you work more effectively with people who have co-occurring substance use and mental disorders?
5. How might the system better incorporate cultural issues into treatment for people with co-occurring disorders?
6. Is there anything else we haven't covered that you feel is important or were hoping to talk about today?

Questions for administrators

1. What's been your experience in developing programs for people who have co-occurring substance use and mental disorders?
2. How does the current system support your efforts?
3. How does the current system hinder your efforts?
4. What are some specific system changes you see are necessary for improving the treatment of people who have co-occurring substance use and mental disorders?
5. How might the system better incorporate cultural issues into treatment for people with co-occurring disorders?
6. Is there anything else we haven't covered that you feel is important or were hoping to talk about today?

Appendix C
Key Informant Semi-Structured Interview Guide

Questions for administrators.

1. What's been your experience in developing programs for people who have co-occurring substance use and mental disorders?
2. How does the current system support your efforts?
3. How does the current system hinder your efforts?
4. What are some specific system changes you see are necessary for improving the treatment of people who have co-occurring substance use and mental disorders?
5. How might the system better incorporate cultural issues into treatment for people with co-occurring disorders?
6. Is there anything else we haven't covered that you feel is important or were hoping to talk about today?

Questions for consumers.

1. What's been your experience in getting care for your mental health and substance abuse needs?
2. What has been helpful?
3. What hasn't been helpful?
4. Were there any services that you (or your loved one) felt you wanted or needed but didn't get?
5. How might the system better incorporate cultural issues into treatment for people with co-occurring disorders?
6. Is there anything else we haven't covered that you feel is important or were hoping to talk about today?

Appendix D
Survey

Co-occurring State Incentive Grant (COSIG) Needs Assessment Survey

COSIG Project

Please take a few minutes and fill out this survey to help the Hawaii Co-occurring State Incentive Grant (COSIG) Project! The goal of the COSIG project is to make plans to improve services in Hawaii for people who have dual disorders (co-occurring disorders).

Definitions

Co-occurring disorder or dual disorder- People with co-occurring disorders or dual disorders have one mental health disorder and a substance disorder. Both are considered primary disorders. Dual disorders are common**.**

Consumer- Person needing services for a co-occurring disorder.

Interested persons- Anyone who would like to participate in filling out the survey.

Purpose of Survey

The purpose of this survey is to get information from interested persons in identifying the needs for individuals with co-occurring disorders. Interested persons can include consumers, family members, and providers of care, criminal justice professionals, administrators and concerned citizens. Results from this survey will help the COSIG project's leaders and "policy makers" in making plans and taking actions to improve services.

Voluntary and Confidential

Your participation in this survey is voluntary! There are no negative consequences if you choose not to participate. You are free to stop anytime while taking the survey. Your answers will not be shared with anyone other than the researchers and there is no way you can be identified.

Please help us make services for consumers and families struggling with co-occurring disorders better!

Instructions:

There are two parts to this survey:

Part I: Information about you.

Part II: Please choose 10 items **YOU BELIEVE** are most important for making services for persons with co-occurring disorders better.

PART 1

Please complete the following information about yourself.

1. What is your home zip code? _____

2. Please mark which role best describes you (mark all that apply):

☐ Receiver of services
☐ Family or loved one of someone who receives services
☐ Concerned citizen
☐ Provider of services
☐ Administrator or manager

If you are an administrator of manager, check which system applies:
☐ Mental health
☐ Substance Abuse
☐ Criminal Justice

3. What is your gender?

☐ Female
☐ Male
☐ Transgender
☐ Prefer not to answer
☐ Other (please specify)
_____

4. Are you Hispanic or Latino? ☐ Yes ☐ No

Mark all that apply:

☐ Cuban ☐ Mexican ☐ Puerto Rican
☐ Other Hispanic or Latino (please specify) _____

5. What is your race/ethnicity? Mark all that apply.

☐ Black or African American ☐ American Indian ☐ Alaska Native ☐ Portuguese ☐ White or Caucasian

☐ Hawaiian/Part Hawaiian ☐ Guamanian/ Chamorro ☐ Micronesian ☐ Samoan
☐ Other Pacific Islander (please specify) _____

☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (please specify) _____

Unknown
☐ Adopted –don't know ☐ Unknown ☐ Prefer not to answer

If none of the groups above describe you the best, please list how you self-identify here:

_____

Which group do you prefer to identify with?

_____

PART 2

Please tell us the **10** items **YOU BELIEVE** or **THINK most important in your community** to help improve services for persons with co-occurring disorders. Do this by placing a check in the box before each item. Not checking an item does not mean it will be thrown out.

	ITEMS
☐	1. Focusing on the methamphetamine ("ice", "meth", or "crystal") drug problem.
☐	2. Having substance abuse and mental health agencies work together better.
☐	3. Helping persons with CO-OCCURRING DISORDERS get services faster.
☐	4. Helping persons with CO-OCCURRING DISORDERS get or keep insurance coverage.
☐	5. Being able to get help from crisis services 24 hours a day.
☐	6. More detox programs on our island.
☐	7. More help from psychiatrists.
☐	8. Teaching families about CO-OCCURRING DISORDERS.
☐	9. More housing for people with CO-OCCURRING DISORDERS.
☐	10. Training care providers on CO-OCCURRING DISORDERS.
☐	11. More certified substance abuse counselors.
☐	12. Smaller case loads for care providers.
☐	13. More money for programs already set up.
☐	14. More information for care providers about different cultures.
☐	15. Helping people with CO-OCCURRING DISORDERS find work.
☐	16. Helping people get in touch with friends, loved ones, or others in the community who can help them.
☐	17. Making outreach services better.
☐	18. More substance abuse treatment on our island.
☐	19. Better assessment of persons with CO-OCCURRING DISORDERS.
☐	20. More help getting peer support or sponsors.
☐	21. More cultural activities in programs.
☐	22. More residential co-occurring treatment programs.
☐	23. More information about CO-OCCURRING DISORDERS for people in the community.
☐	24. Making transportation services better.
☐	25. Making it easier to get co-occurring services.
☐	26. Having the Adult Mental Health Division (AMHD) and Alcohol & Drug Abuse Division (ADAD) work together to help consumers.
☐	27. More services for families.
☐	28. More language interpreters.
☐	29. More help with getting the proper medication(s).
☐	30. More self-help groups for people with CO-OCCURRING DISORDERS.

Please write down any suggestions you have that are not in the list above that **YOU BELIEVE** or **THINK** will make services for persons with co-occurring disorders better.

1._____

2._____

3._____

4._____

5._____

MAHALO FOR YOUR HELP!

Appendix E
Cross-Reference Tables

Table 6: Gender Cross-Reference

Item #	Male		Female		Transgender		Prefer Not To Answer	
	Total	Percent	Total	Percent	Total	Percent	Total	Percent
1	274	69.2	376	68.9	8	80.0	4	40.0
9	213	53.8	296	54.2	3	30.0	7	70.0
2	205	51.8	279	51.1	6	60.0	4	40.0
13	195	49.2	239	43.8	6	60.0	4	40.0
3	184	46.5	226	41.4	7	70.0	4	40.0
18	174	43.9	224	41.0	2	20.0	2	20.0
26	162	40.9	221	40.5	5	50.0	2	20.0
5	169	42.7	202	37.0	3	30.0	2	20.0
17	168	42.4	189	34.6	4	40.0	4	40.0
27	148	37.4	199	36.4	2	20.0	1	10.0

Table 7: Affiliation Cross-Reference

Item #	Receiver of Services		Family/Love One of Receiver		Concerned Citizen		Service Provider	
	Total	Percent	Total	Percent	Total	Percent	Total	Percent
1	146	61.3	54	65.9	183	67.5	292	74.1
9	155	65.1	50	61.0	139	51.3	212	53.8
2	125	52.5	47	57.3	133	49.1	199	50.5
13	120	50.4	45	54.9	118	43.5	188	47.7
3	123	51.7	34	41.5	125	46.1	167	42.4
18	84	35.3	42	51.2	103	38.0	182	46.2
26	78	32.8	37	45.1	109	40.2	172	43.7
5	114	47.9	35	42.7	122	45.0	127	32.2
17	100	42.0	33	40.2	109	40.2	143	36.3
27	87	36.6	36	43.9	104	38.4	156	39.6
Item #	**Administrator / Manager**		**Mental Health**		**Substance Abuse**		**Criminal Justice**	
	Total	Percent	Total	Percent	Total	Percent	Total	Percent
1	97	67.4	139	65.6	107	74.3	45	81.8
9	82	56.9	126	59.4	86	59.7	44	80.0
2	78	54.2	114	53.8	79	54.9	32	58.2
13	58	40.3	92	43.4	74	51.4	27	49.1
3	53	36.8	95	44.8	64	44.4	29	52.7
18	74	51.4	89	42.0	76	52.8	31	56.4
26	71	49.3	94	44.3	72	50.0	29	52.7
5	41	28.5	71	33.5	59	41.0	23	41.8
17	54	37.5	73	34.4	56	38.9	30	54.5
27	46	31.9	70	33.0	61	42.4	18	32.7

Table 8: Race/Ethnicity Cross-Reference

Item #	Hispanic / Latino		Black or African American		American Indian		Alaska Native	
	Total	Percent	Total	Percent	Total	Percent	Total	Percent
1	46	60.5	24	64.9	30	61.2	0	0.0
9	39	51.3	25	67.6	27	55.1	2	50.0
2	37	48.7	17	45.9	23	46.9	1	25.0
13	30	39.5	21	56.8	23	46.9	3	75.0
3	32	42.1	14	37.8	19	38.8	2	50.0
18	28	36.8	8	21.6	22	44.9	1	25.0
26	31	40.8	14	37.8	19	38.8	2	50.0
5	32	42.1	15	40.5	18	36.7	2	50.0
17	33	43.4	14	37.8	18	36.7	2	50.0
27	36	47.4	17	45.9	17	34.7	3	75.0
Item #	**White / Caucasian**		**Hawaiian / Part-Hawaiian**		**Pacific Islander**		**Chinese**	
	Total	Percent	Total	Percent	Total	Percent	Total	Percent
1	359	70.0	152	70.0	29	61.7	95	65.1
9	284	55.4	122	56.2	24	51.1	72	49.3
2	262	51.1	121	55.8	18	38.3	80	54.8
13	240	46.8	105	48.4	24	51.1	67	45.9
3	227	44.2	98	45.2	24	51.1	70	47.9
18	244	47.6	81	37.3	19	40.4	51	34.9
26	228	44.4	87	40.1	18	38.3	55	37.7
5	172	33.5	94	43.3	15	31.9	71	48.6
17	183	35.7	81	37.3	16	34.0	55	37.7
27	205	40.0	94	43.3	13	27.7	56	38.4
Item #	**Filipino**		**Japanese**		**Other Asian**		**Unknown**	
	Total	Percent	Total	Percent	Total	Percent	Total	Percent
1	89	66.4	120	60.3	35	66.0	5	71.4
9	65	48.5	113	56.8	27	50.9	6	85.7
2	70	52.2	105	52.8	27	50.9	1	14.3
13	63	47.0	96	48.2	28	52.8	6	85.7
3	64	47.8	92	46.224	24	45.3	3	42.9
18	65	48.5	75	37.7	19	35.8	0	0.0
26	49	36.6	79	39.7	19	35.8	1	14.3
5	56	41.8	90	45.2	18	34.0	4	57.1
17	54	40.3	80	40.2	15	28.3	1	14.3
27	55	41.0	64	32.2	14	26.4	1	14.3
Item #	**Adopted – Do Not Know**		**Prefer Not To Answer**					
	Total	Percent	Total	Percent				
1	2	40.0	13	61.9				
9	4	80.0	9	42.9				
2	2	40.0	11	52.4				
13	3	60.0	7	33.3				

3	4	80.0	9	42.9
18	0	0.0	11	52.4
26	1	20.0	8	38.1
5	3	60.0	7	33.3
17	2	40.0	10	47.6
27	2	40.0	3	14.3

Table 9: Island Cross-Reference

Item #	Oahu		Hawaii		Maui		Kauai	
	Total	Percent	Total	Percent	Total	Percent	Total	Percent
1	461	68.9	70	78.7	49	64.5	38	71.7
9	347	51.9	66	74.2	50	65.8	26	49.1
2	353	52.8	42	47.2	38	50.0	25	47.2
13	313	46.8	41	46.1	35	46.1	27	50.9
3	299	44.7	40	44.9	32	42.1	20	37.7
18	273	40.8	34	38.2	35	46.1	38	71.7
26	283	42.3	30	33.7	32	42.1	24	45.3
5	268	40.1	43	48.3	26	34.2	14	26.4
17	271	40.5	34	38.2	24	31.6	10	18.9
27	242	36.2	44	49.4	27	35.5	16	30.2

Item #	Molokai		Lanai	
	Total	Percent	Total	Percent
1	10	66.7	6	75.0
9	6	40.0	2	25.0
2	8	53.3	4	50.0
13	9	60.0	1	12.5
3	9	60.0	1	12.5
18	7	46.7	2	25.0
26	4	26.7	2	25.0
5	7	46.7	2	25.0
17	6	40.0	3	37.5
27	6	40.0	5	62.5

Appendix F
Phase III Survey Open Ended Question - 10 Themes and Responses

Theme 1 - General Education & Training for Workforce Development.

General Education

Education that most alcoholics and addicts are dually diagnosed.
Helping people w/out CODs not be afraid of people with CODs
More psychoeducation for consumers (a more informed consumer is better than uninformed consumer)
A better understanding of how the mental illness side of CODs plays into things is needed by both the public and providers. Many people use/abuse substances to control their mental health symptoms.
Teaching families about COD
Do more to inform community and business owners about people w/COD
Eliminate ICE w/focus on education
Prevention, prevention education geared toward youth. Inform them of the detriment of drugs, especially crystal meth - Mandate drug education classes - scare them from ever taking drugs
Educate those of us with co-occurring disorders about ourselves. Give us more information about our illnesses, our addiction and show us a plan on how to recover. Give us more role models...
I think an ongoing (daily) column in the newspapers educating and informing the community.
ACTIVE EDUCATION (not just information) for people in the community.
More educational programs for families and community about co-occurring disorders.
Education re: prescription drug abuse
Education for AA about mental illness.
More outreach for people who are still minors, more on educating them.
Educate judges on mental illness, and suffering of patients to paranoid and mentally unstable to take medication
Community needs more education on mental illness and to be more aware of what they can provide and do.
The judicial system (judges, attorneys, etc.) need to be educated on mental disorders- They lack an understanding of what types of tx consumers' need, which affects their decisions about placements.
Outreach to 12 step meetings and sponsors to educate them about the needs of DDX folks that attend such meetings.
Educate law makers on mental disorders and types of efficacious treatment programs that need to be created out in the community.
Classes that teach people and families the symptoms of co-occurring disorders
The more information- knowledge- education, the better- understanding is the key
Educate people
Better education for families or care givers about COD
Community education
Removing the stigma
Interaction with community to bring awareness
Educating the general public about basic statistics regarding people with COD's
Make sure substance abuse educations programs for kids in schools are effective best practice models.
The education systems need to be completely revamped due to this issue alone, so much is lost and never to be recovered.

Start with school programs (8-18)
Make it easier for co-occurring disorder people to take self-esteem, and any other beneficial class for their well being and benefit.
Educate community how to challenge co-occurring disorder people into crises services when they “flip out”.
Education for family members for people w/co-occurring disorders
Educating clients on co-occurring disorders and effects
Education into one’s particular illness
Education on how to abstain from substances while on medications
Organize small and large business- educate owners

Training
More ADAD trainings for CEU’s.
Require agencies to get training and treat CODs
Addiction treatment training for all the staff, family members, professionals - anyone contact
People employed with these groups need to be adequately educated and trained to work with this population.
Train care providers at DD residential facilities about mental health
Allow CMHC staff training days for CSAC and ADAD training programs
Better training for CSAC's including mental illness information.
Training of mental health case managers in managing people with dual disorder problems
Training sessions to include both providers and MISA consumers together to help providers implement IDDT.
Improve the skill level of providers at existing treatment programs (Po'ailani, Hina Mauka) in working with people with SPMI and SUD. Currently they're not great at working with more difficult pts.
Training on how to 1. involve family members in COD interventions and 2. how to do COD interventions in the absence of family (common in Hawaii)
Training with emphasis on actual skills and recovery planning assoc. with early stages of change, contingency management, for all providers
Hands on training
Doctors who are educated about addiction and how medications effect those with substance dependency
Formal training for physical abuse awareness- and referral process
More intense teaching of co-occurring disorders
Educate drug counselors about COD. They don’t know.
Provider training on “harm reduction” practices
There should be educational training for people with co-occurring disorder
More training and workshops provided for staff on COD and Dual disorder
More school classes for disorders
Education for doctors and clients that they can’t rely on medication only for recovery: best results they need to address their physical, spiritual and emotional health too.
Educate COD staff about disorders (psyche) and medications. They don’t know.
More use and education on “harm reduction theory”
Teach programs how to evaluate outcomes.
More training for staff/workers
Increase training to mental health providers about COD’s and treatment
More education for providers on how the drugs affect their medical condition
Make college degree a requirement for CSAC
Case managers with master’s degrees in social work, abnormal psych, or counseling.

Theme 2 - Improved Service Delivery.

Continuity of care (have psychologist case worker (all in different agencies).
Interpreters for language speakers.
Flex hours for MH staff for more coverage.
More 1:1 case managers/MHTs
More emphasis on sex abuse treatment and the effects of sexual abuse on substance abuse
Quality control, better trained staff, peer advocacy services, dual dx treatment center minimum standards
There are not enough of us treating, and not enough services in general.
Hiring professionals that would do a good job. SW and CM's who actually care to do their job.
Current SW and CM's don't have empathy for the SMI population.
Incentives to draw qualified workers into the field
Able to identify and refer at earlier in the disease
More counselors
Services provided by well trained and paid professionals
Services that emphasis family assistance
Put individuals into programs and monitor them
Accessibility to programs after consumer is detoxed or released from detox to continue tx immediately instead of releasing to community and waiting for programs
Better help for others
Provide more cultural services for SA & MH w/Kupuna guidance
Dropping of Felix decree, referral system for adolescents not working
Increased supervision for mental health providers
More providers
More effective counselors to provide effective services
Tracking co-occurring patients thru out the system for continuity of care
Assist with avoiding staff burnout
Hawaii's care providers are too "shame based" and functioning under an old outdated approach to addiction treatment
More incorporation of Native Hawaiian cultural practices from Native Hawaiian plants on the groups of facilities to working with community. Organizations that care for loi, or fishpond, even reforestation/conservation techniques
Need more interpreters or Micronesian speaking counselors/Dr's.
Not pushing placement of people who are co-occurring into facilities that are not co-occurring facilities
AMHD should hot require ICM casemanagers to go to the consumer. The consumer should be required to come to the office if they are serious about wanting help. Driving to the consumer's homes is not paid activity, so ICM case managers waste much of their time driving. This leads to longer working hours which results in burn out, which results in high turnover and lack of continuity.
All agencies agree to treat/heal
More 1:1 casemanagers/consumers
More help for people who don't fit in
Support for consumers by casemanagers is very lacking
Rehabilitation for family of mentally ill who's living independently
Please do not always have persons with COD services to be located on church, on church grounds, or associated with churches.
Consult UH Social Work program on implementing strength-based case management services.
Treatment must be available at the moment clients are ready for it- no 1 week or 2 months later- the "window of willingness" often dissipates and by the time beds are available, clients are often MIA in jail, using again, etc.

CBT – individuals must know they are primarily responsible for their reactions (emotional)
Provide us with staff who truly care and believe in us- that we can recover. Help us.
Provide better qualified case managers and social workers in the state owned mental health centers.
Having Purchase of Service Contractors paid by AMHD deliver services in a more timely manner, don't let them slide for a year or two.
There should be a seamless relationship between the aforementioned services so that the those who are also in the hospital but need immediate transfer to other facility
Speed up AMHDs eligibility determination
Better transition from HSH to community with a semi-permeable step-down of care.
Decrease recreational activities and focus more on treatment, so substance abuse criminals aren't tempted to abuse mental health system
Increase transitional services between inpatient and outpatient treatment
Drug and Mental Health Court w/trained advocates and Public Defenders.
Early and accurate assessment of co-occurring disorders
Increase case managers
Making services more accessible
More personal treatment for people with co-occurring disorders
Provide treatment/supportive services for both mental health and substance abuse while “ruling out” drug induced psychosis.
Make sure substance abuse education programs in schools for kids are effective best practice models.
Better food
Psychologists on site at the schools
Help them break their addiction and provide counseling for these individuals
Quicker and more lively ED’s so that CT can be assessed earlier and transferred to permanent case management sooner
Better qualified direct care staff.
Consumers rarely see CMS’ it is very difficult to get CM’s to respond to consumers’ need- please do something
More use and education on “harm reduction theory”
Friends to receive treatment to rehabilitation of services provided w/in community
Teach programs to evaluate outcomes
Develop culturally appropriate methods for integrating patients into the community
Activity on weekends and holidays
Helping people/staff w/out COD’s better related to people w/COD’s.
Counseling services are needed (knowledgeable)
They must take responsibility and learn to reframe thinking. This will lead to better mood regulation and less need to take illegal drugs.
Do not force medication, “It does not solve the problem more effective doctor will provide effective services”
Free up providers from paperwork
Smaller caseloads
Casemanagers with caseloads for dual diagnosis patients
Mental Health system needs to improve
Mandated treatment or terminate all benefits until person willing to comply (accountability- no cash for cigarettes etc.)
Re-occurring disorder individuals need to be more responsible. Limit their re-occurring use, have harder consequences.

Theme 3 – Collaboration.

Develop partnerships with the faith community
More communication between primary case managers, CH case managers and others involved in case.
Help psychologists and psychiatrists work together
Help substance abuse and mental health agencies work together better.
Better cooperation between Probation Officers and Case Managers/Treatment providers
It would be most helpful if state agencies were encouraged to work together to avoid the duplication of effort, so limited funds could be used for direct services and not to cover administrative costs
The justice system, public safety, police, and mental health division should work closely together so that appropriate patients can receive mental health care and unnecessary hospitalization can be
AMHD and ADAD both need to work more closely with primary care providers, especially community health centers that see low income, homeless, immigrants, Hawaiians, and other underserved groups.
State agencies should work closely in conjunction with community groups, especially community health clinics, providers, other health groups that know their communities.
Have an agreement by several state agencies to share information about co-occurring disorders and services throughout state system
Facilitation of team building among providers in various geographical areas (by island? sections of islands?)
Dept. of Ed and Dept. of Health need to work better together
Better communication between providers
Have case managers work better with Probation officers
Provide forums for DOH employees to get to know each other & services
Better/closer cooperation between probation officers and case managers
Work together to find a cure for mental illness
Better coordination of co-occurring disorder services
Services are uncoordinated/fragmented/duplicated and shortsighted.
DOE not referring children to treatment
Reduce DOH “silos’ (i.e. increase inter-agency networking and collaboration and how does it work.
Closer cooperation b/w psychiatrist and casemanagers and substance abuse providers
I believe our #1 need is vision and coordination.
It is also problematic and potentially dangerous to clients to have 2 separate branches of government (Judiciary and Mental health (state, Executive branch) sharing supervision responsibility - ultimately, these are mental health clients, they have not been convicted of crimes and the Mental Health system is the gatekeeper to determine who is clinically appropriate to hospitalize.
Better response from DHS workers several times they did not return phone calls, ever!
These are not isolated problems, but occur as a result of cultural trauma/socioeconomic stress as well as individual maladaptive behaviors. We need a broader vision of “treatment” which includes primary/secondary/tertiary prevention thru partnership with Mental Health, Criminal Justice, Clinical Medicine, Education, Public Health, Housing, Welfare, Community Leaders to address all factors related to substance abuse.

Theme 4 - Increase Treatment Programs.

Increase in agencies with programs to support youth with substance abuse issues - in evenings
Continue needle exchange program to prevent spread of HIV & HCV

More detox programs
Include families in helping - make them part of the treatment team
Program Mentoring; More assistance/oversight to service providers in the actual implementation of best practices/info. received in training sessions.
True dual diagnosis programs for the people that are dually diagnosed. Poailani's program is not really designed for the dually diagnosed. They focus on substance abuse mainly.
Help us to help ourselves. Give us access to more programs that specialize in treating those of us with co-occurring disorders. Educate us about stigmas. Some of us are ashamed of our illness
Trauma center for women w/sexual abuse, DV, rape, tailored to this population
More substance abuse treatment centers on Maui, live in programs in Kikei, there are none-Wailuku or Kahului
A detox facility at hospital not needing to go thru ER to get in and not on med surg unit- a specialized detox area
More faith-based therapeutic living programs
Detox program with longer duration are needed or step-down programs with longer durations
Prevention programs
Case management services
Need substance treatment programs designated specifically for the dual diagnosis program.
Mental health services for people with DD and S/A
Outreach providers are excellent, we just need more.
More outreach a lot of homeless are mentally ill
Co-occurring disorder treatment for professionals
More dual diagnosis programs
More resources/services for teens with co-occurring disorders
Services that emphasis family assistance
Accessibility to programs after consumer is detoxed or released from detox to continue tx immediately instead of releasing to community and waiting for programs.
Support line (phone center etc.)
Need more care homes that are willing to take mental health and medical issues with consumers
More care home providers that will keep consumers in their home or track down their consumers and bring them back to care home facility.
More residential treatment programs
More counseling/therapy services (i.e. weekly, long term)
Rehab for people on pain medications (chronic)
More help for people that don't' fit in
Homeless drop in center where people can be evaluated
Someone other than Aloha House for treatment
Short-term shelters that will accept dual diagnosed folk's w/positive drug screen and despite symptoms currently only place is hospital or LCRS
Rehabilitation for family members' w/COD to recover and to heal
Counseling provided within the community
Better community outreach
There needs to be a residential substance abuse treatment center on Kauai (pertains to #18 & 22) Asking people to leave their family and friends when they need the most help is not giving them the best opportunity to succeed.
Treatment must be available at the moment clients are ready for it- no 1 week or 2 months later- the "window of willingness" often dissipates and by the time beds are available clients are often MIA, in jail using again etc.
More outer island services, especially residential treatment

More options in Kihei please (southside)
More substance abuse programs on neighbor islands
Have separate services for dual diagnosis program
Secured facility treatment, a "captive audience" increases likelihood of completing treatment
New more structured residential programs for clients who are non-compliant w/mental health and or S/A Tx
Services for gap group- non SMI's are needed
Programs that help youth and adult to re-learn basic life skills (balancing a checking acct, job hunting, cooking, cleaning, house, etc.)
More residential tx programs
Residential substance abuse
More bed space for consumers
More intensive after-care programs
More inpatient beds for adolescents who are seeking voluntary treatment- when they are ready- there is not space available to them.
SA/DD programs in jail (where people are abstinent for long periods and have time and motivation for treatment w/out temptations and distractions)
More services for parents of children, adolescents, and 18-21 yr olds who have COD's.
Expand drug court and jail diversion programs for COD patients
Intervention programs to decrease the number of re-occurrences. Work together with City, State and County to ensure services, money etc. are in place to handle the increasing number of inflicted people.
Being able to get help from crisis services
Support or services for children of mental disorder parent

Theme 5 - Support Services.
More information about Alanon and AA meeting
COD recovery classes at night and which last longer, if consumer desires.
Help for suicide aspect of it.
Area counselors in ___ area of Oahu for phone callers to call
More Dual Diagnosis meetings.
Educational services (help people get GED)
Educate cleanliness, hygiene, to take care of health and body.
Join a clubhouse
Additional childcare services
Belonging to a club to get one foot ahead of the other
Support groups
Comprehensive support group lists (current)
More DDA groups and more DDA-friendly meeting places. Let DDA pay a token rent (they insist on this), but not market rent.
More opportunities to become self-sufficient and independent contributors to the community via work, helping others with similar problems through volunteering and developing a solid social foundation.
Patient managed co-occurring residences w/ supervision and AA/NA
Support the DDA program to get off its feet.
Childcare services for people while in treatment
More camping trips for TCP (good healing)
Better transportation for co-occurring disorder patients
Better transportation for other handy van, truck running better
Transportation for my home care operator to get my medication on time.
Get food for those with mental illness

Belly dance class
More meetings on recovery, dual diagnosis
Bible discussions featuring how Jehovah God's Holy Spirit can help me cope with disorders and hope that someday people will not have any witness in Revelation 21:4.
Better smoking cessation resources
Offer DDA /DDR groups in Kona
Support services for co-occurring geriatrics
More support
Availability/access of meetings (i.e. - group settings (12 step programs) support groups, topic based meeting formats, in address of substance abuse/personal issues (let's talk about it) recovery based, address methods, open/honest format.
Sports leadership to teach
Free food for clubhouse members
Faster mail service with a messenger
Having a list of day and night ER numbers
Make it easier for co-occurring people to take self- esteem, and any other beneficial class for their well being and benefit.
There should be educational training for people with co-occurring disorder.
More overnight group outings
More support services (counseling) for families'
Better food
Community neighborhood meetings for group homes
Transportation
Transportation for me to go to drug programs
Have exercise programs/ sports for mentally ill
Once a week someone w/a dog should visit CARE Hawaii
Tai Chi Chuan
Activity on weekends and holidays
More allowance money
More transportation service people
Phone numbers of crises team and crises number
Activity on weekend and holidays
We need front line help, not more studies.

Theme 6 – Housing.
Need more structured residential facilities for clients who have decompensated and are not taking their meds but who may not need hospitalization
More homes shared living
Private housing for people with co-occurring disorders
Housing (affordable) or more long term (2 yr) transitional housing programs
Affordable rent for consumers in group homes, and more group homes.
Much more specialized housing needs to be available for people with co-occurring disorders, including more houses.
Co-occurring disorders housing so clients can live separate from those that still choose to use substances and enablers, and learn how to live without abusing.
Affordable housing for families
AMHD must either make/create the infrastructure to provide housing for patients; this goes for not only Dual Dx. pts but others as well.
There should be appropriate placements in the community for patients that are ready to be discharged.

Existing housing programs for all patients, are too particular about who they accept. This is altogether discriminatory.
Because there are limited places only for patients outside of the hospital, they decompensate.
Transitions places for different levels of patient functioning should be developed and established.
There is a real need for supervised safe housing for consumers
More supported housing for persons with co-occurring disorders- with case management support
Our housing problem must be addressed as state and community.
Affordable rentals and rent subsidy programs
More housing
Improved access to housing
Low income housing in less heavy drug areas
Housing- homeless outreach
Getting cheap housing
Housing for family of mentally ill who's living independently
People who are homeless get help
More low cost housing and supplements for them
Housing is always a problem more so with mentally ill
Need more housing affordable for consumers
Housing
Housing that is culturally sensitive
More interim housing programs for SA consumers in transition

Theme 7 – Legal.
Need to change conditional release law to remove probation from being mandated to supervise these clients. Because CR clients now have mental health agencies, case management programs and forensic coordinators (to assess risk), there is no need to duplicate roles.
Assist co-occurring w/criminal justice issues (I.e. probation, parole, or work furlough)
Properly detaining persons with co-occurring disorders to keep community safer.
Stiff penalties for ice use
Stop enabling substance abusers who break laws as a result of their substance use. They need to be punished to the point where using substances is too painful and inconvenient for them.
Mandatory community service for convicted drugees (illegal users or sellers)
Mandatory sentences for repeat offenders
More treatment inside the prisons. Make rewards really good and punishments really painful.
Change Hawaii laws to decriminalize mental illness, allow more civil commit; need dedicated mental health court; pts w/ co-occur disorders w/ drug violations referred to MH court should be referred
People receiving services (welfare) shall pass drug test (urine test).
Mandatory sentences for drug dealers
Prosecute substance abuse criminals for malingering @ psych institutions for malingering or make restitution payments for services provided
There are too many people that fall through the cracks of the system. HSH will release CR cases if they are doing well there but these people cannot function on the outside, no matter what. There should be an in-between program before release to the community and if CR case cannot make it return to HSH w/o 72 hr. hearing.
Let AMHD and HSH handle conditional release cases and not involve probation.

Theme 8 – Funding.
More money to hire and expand existing svcs & facilities

Increase in DHS, SS, and VA benefits
More money for programs already set up.
Provide additional funding for state owned mental health centers.
Explore and evaluate services that are not only Western based, but are best cultural practices. Make funding available for these services.
Better management of the disparity between paying rent and a disabled person's quality of life
Let public know how monies spent by ADAD, AMHD and other state agencies are effective in helping person to recovery
Funding support for _____, a clean and sober housing program, would be very beneficial.
The State needs to allocate more money for Mental Health Services. The Government of HI has one of the worst Mental Health Care Systems in the country.
Access to medical services that aren't covered under health plans
More funding for Maui Drug Court (Molokai)
More funding for the clubhouse that is in Wailuku
More pay for mental health workers
Better salaries for professional/masters level direct service providers
Insurance coverage critical
Increase funding so that providers can make a living
More federal or state funded facilities island-wide.
Emergency funds for homeless
Higher insurance reimbursement for provider (i.e. psychologist) in working w SA and MH dx for individual/group
Speed up receipt of benefits from DHS- especially for clients discharged from hospitals (private and HSH).
Insurance to cover more per year to attend due to relapse being part of recovery process/be eligible for residential tx facilities.
Work with health insurances to cover services for people with COD
Limited insurance coverage
We need more ideas and financial services
Dental insurance coverage for people with mental illness and COD
Help or financial aid to get meds not covered by insurance
Making more funding available to treat people through mental health and substance abuse agencies.
Consumer groups are underfunded- you've paid United Self Help $40k for support- yes and nothing for Bridges classes, 4th Friday. No increase on Warm Line, $31, 320 you need to pay your bills on time, make RFP;s more profitable so the good providers take them.
Less money and staff for surveys and training. Unit to expand residential treatment services and follow-up.
Drug coverage for suboxone consumers guaranteed
Insurances should allow for longer coverage for co-occurring disorders
Benefit increase
More allowance money
Financial budgeting for operating Clubhouses in Hawaii
More cashing checks with case manager
Keeping money after Tx programs to save for housing that is not a group home.
I have never had a client whose benefits have started before 30 days (all required info in to DHS)
Longer treatment coverage. Not kicking someone out due to their medical running out.
Maintaining medical benefits when the disabled person's SSDI is too high that they no longer qualify for Medicaid
Pay for counselors is like that for teachers very very very inadequate

Higher pay for people/staff in field
For youth, more money to provide experiential learning. Being in this field for some years now, it is clear that youth do not learn well sitting in a circle and talking! They need to get out and learn!

Theme 9 - Psychiatric Services.
The one psychiatrist that does work one day a week in Haleiwa like most if not all rural psychiatrist will not work with med-quest, Medicare or Medicaid.
Psychiatrists treat "whole person" rather than just symptoms with meds.
Rural psychiatrist does not serve the poor.
Increase Medicaid coverage so that psychiatrists and MDs will see those with psychiatric needs.
Provide a list of Medicaid accepting psychiatrists to consumers and providers.
Assess the gaps in services for consumers trying to access psychiatrists.
More psychiatrists in rural areas
It is time that the power in government realize that rural areas do not have access to psychiatry
The truth is no psychiatrist serves the North Shore of Oahu

Theme 10 – Employment.
Reward them and get them employed
Federal, State, City, County Jobs
Federal Employment for people with disorders
Providing customized employment increased GED program, basic skills training
Education on the Trends in business that need to employ disabled people
Reference # 15- More supported employment needed. Perhaps incentives for employers.
Creation of jobs that don't discriminate against the MISA pt.
How to dress, job preparation- working with employers to hire co-occurring disorders
Vocational services
Provide work sponsored programs to teach co-occurring participants a life skill.

Miscellaneous.
I feel good with the services offered to me at this time. Excellent!
I think all of the above is important
Before more treatment slots are authorized, there needs to be serious work done on building infrastructure- qualified and capable workers-adequate housing clients can transition to and from.
Having a cell phone for work purposes only
Counselors having access to equipment (cell phone)
Better help for others
The above list says it all.
All good above the ones I checked.
Stop crimes
More computers at CMHC’s
Move away from “drug problem” and look at substance abuse as “addiction problem”
Our cultural for the island of Hawaii.

Appendix G

Table 12- Results of Phase I, Phase II, and Phase III- Cross Referencing Top 10 Phase III Survey Priorities.

Theme	Phase I Focus Group Themes	Phase II Key Informant Interview Themes	Rank Item	Phase III Survey- Top 10 Ranked Items
I	Scope of Co-Occurring Disorders • Sub-Theme 1: Methamphetamine	A. Scope of Drug Problem	**1**	Focusing on the methamphetamine (“ice”, “meth”, or “crystal” drug problem
II	Systems Issues • Sub-Theme 1: Bureaucracy as a barrier • Sub-Theme 2: Paperwork requirements	B. Service System Issues 1. Multifaceted system needs		
III	Integration Issues • Sub-Theme 1: Lack of integration • Sub-Theme 2: Positives and why integration is important	2. Systems Level coordination	**7**	Having the Adult Mental Health Division (AMHD) and Alcohol & Drug Abuse Division (ADAD) work together to help consumers
IV	Interagency Collaboration • Sub-Theme 1: Lack of integration • Sub-Theme 2: Communication issues • Sub-Theme 3: Referrals	C. Service Level Coordination	**3**	Having substance abuse and mental health agencies work together better
V	Access • Sub-Theme 1: Access Issues (+/-) • Sub-Theme 2: Eligibility Criteria • Sub-Theme 3: Insurance and Reimbursement • Sub-Theme 4: Timely Access	D. Barriers to Treatment	**5**	Helping person with co-occurring disorders get services faster
VI	Quality of Care (+/-)	E. Evaluation of Outcomes		

Theme	**Phase I** **Focus Group Themes**	**Phase II** **Key Informant Interview Themes**	**Rank Item**	**Phase III** **Survey- Top 10 Ranked Items**
VII	Continuum of Care • Sub-Theme 1: Screening and assessment • Sub-Theme 2: Outreach and Crisis Management • Sub-Theme 3: Level of Care • Sub-Theme 4: More Programs	F. Service Delivery 1. Improved Assessment 2. Enhanced Case Management 3. Increase Beds for COD 4. Improved Transitioning to Community	**9** **8** **4** **6**	Making outreach services better Being able to get help from crisis services 24 hours a day More money for programs already set up More substance abuse treatment on our island
VIII	Treatment Approaches • Sub-Theme 1: Comprehensive, holistic • Sub-Theme 2: Multidisciplinary • Sub-Theme 3: Staged/motivational • Sub-Theme 4: Recovery orientation	G. Treatment Approaches 1. Evidence Based Practices 2. Holistic 3. Stagewise Tx 4. CBT Approaches 5. WRAP Crises Planning 6. Therapeutic Alliance 7. Multidisciplinary Team		
IX	Treatment Modalities • Sub-Theme 1: Psychiatry and medication • Sub-Theme 2: Psychology and individual counseling • Sub-Theme 3: Group therapy • Sub-Theme 4: Psychoeducation and skills training • Sub-Theme 5: Clubhouse	8. Increased Availability of MD's.		
X	Cultural Considerations • Sub-Theme 1: Lack of interpreters,	H. Cultural Considerations 1. Improve		

Theme	Phase I Focus Group Themes	Phase II Key Informant Interview Themes	Rank Item	Phase III Survey- Top 10 Ranked Items
	bilingual resources • Sub-Theme 2: Need for more programs incorporating cultural healing practices (primarily Hawaiian) • Sub-Theme 3: Need for adaptation of Western EBP's for culturally competent application • Sub-Theme 4: Lack of funding for cultural services • Sub-Theme 5: Access community cultural events to disseminate COD information • Sub-Theme 6: Need for cultural competency professional training • Sub-Theme 7: Need for culturally competent providers and ethnically diverse staff (e.g. include cultural practitioners as recognized staff) • Sub-Theme 8: Need for understanding of "local culture"	Cultural Competency 2. Integrate Cultural Practices 3. Hire Diverse Staff		
XI	Living in Recovery • Sub-Theme 1: Meaningful structured activities • Sub-Theme 2: Spirituality • Sub-Theme 3: Social support/relationships • Sub-Theme 4: Families • Sub-Theme 5: Housing • Sub-Theme 6:	I. Foundations for Recovery 1. Need for Strong Support System 2. Housing 3. Self Help Support	**10** **2**	More services for families More housing for people with

Theme	Phase I Focus Group Themes	Phase II Key Informant Interview Themes	Rank Item	Phase III Survey- Top 10 Ranked Items
	Employment • Sub-Theme 7: Self-help	4. Vocational Rehab.		co-occurring disorders
XII	Public Education & Public Perception of COD • Sub-Theme 1: Stigma-general • Sub-Theme 2: Stigma-professional and relational • Sub-Theme 3: Stigma-community and culture • Sub-Theme 4: Stigma as a barrier • Sub-Theme 5: Stigma-families • Sub-Theme 6: Community education to reduce stigma • Sub-Theme 7: Community education about MI and SUD to increase awareness • Sub-Theme 8: Raising community involvement and support • Sub-Theme 9: Misperceptions of programs			
XIII	Resources – (e.g. human, financial, physical) • Sub-Theme 1: Human resources • Sub-Theme 2: Financial resources • Sub-Theme 3: Physical resources • Sub-Theme 4: Consumer resources • Sub-Theme 5: Treatment resources	J. Resources 1. Training for Professionals 2. Technical Assistance 3. Increase Funding For COD programs		

Theme	**Phase I** **Focus Group Themes**	**Phase II** **Key Informant Interview Themes**	**Rank Item**	**Phase III** **Survey- Top 10 Ranked Items**
XIV	Special Populations • Sub-Theme 1: Homeless • Sub-Theme 2: Children and teens • Sub-Theme 3: Forensic • Sub-Theme 4: Women and Children	K. Special Populations 1. Improve Services Homeless COD		

Appendix H

Table 13: Results of Phase I- Focus Group, Phase II- Key Informant, and Phase III- Survey Items: Cross-Referencing ALL Themes and ALL 30 Rated Survey Items

Theme	**Phase I** **Focus Group Themes**	**Phase II** **Key Informant Interview Themes**	**Rank Item**	**Phase III** **Survey - All 30 Ranked Items.**
I	Scope of Co-Occurring Disorders • Sub-Theme 1: Methamphetamine	A. Scope of Drug Problem	**1**	Focusing on the methamphetamine ("ice", "meth", or "crystal" drug problem
II	Systems Issues • Sub-Theme 1: Bureaucracy as a barrier • Sub-Theme 2: Paperwork requirements	B. Service System Issues 1. Multifaceted system needs		
III	Integration Issues • Sub-Theme 1: Lack of integration • Sub-Theme 2: Positives and why integration is important	2. Systems Level coordination	**7**	Having the Adult Mental Health Division (AMHD) and Alcohol & Drug Abuse Division (ADAD) work together to help consumers
IV	Interagency Collaboration • Sub-Theme 1: Lack of integration • Sub-Theme 2: Communication issues • Sub-Theme 3: Referrals	C. Service Level Coordination	**3**	Having substance abuse and mental health agencies work together better
V	Access • Sub-Theme 1: Access Issues (+/-) • Sub-Theme 2: Eligibility Criteria • Sub-Theme 3: Insurance and Reimbursement • Sub-Theme 4: Timely Access	D. Barriers to Treatment	**22** **15** **5**	Making it easier to get co-occurring services Helping people with co-occurring disorders get or keep insurance coverage Helping person with co-occurring disorders get services faster

Theme	**Phase I** **Focus Group Themes**	**Phase II** **Key Informant Interview Themes**	**Rank Item**	**Phase III** **Survey - All 30 Ranked Items.**
VI	Quality of Care (+/-)	E. Evaluation of Outcomes	**16**	Smaller case loads for care providers.
VII	Continuum of Care • Sub-Theme 1: Screening and assessment • Sub-Theme 2: Outreach and Crisis Management • Sub-Theme 3: Level of Care • Sub-Theme 4: More Programs	F. Service Delivery 1. Improved Assessment 2. Enhanced Case Management 3. Increase Beds for COD 4. Improved Transitioning to Community	**24** **9** **8** **4** **6** **11** **12**	Better assessment of persons with co-occurring disorders Making outreach services better Being able to get help from crisis services 24 hours a day More money for programs already set up More substance abuse treatment on our island More residential co-occurring treatment programs More detoxification programs on our island
VIII	Treatment Approaches • Sub-Theme 1: Comprehensive, holistic • Sub-Theme 2: Multidisciplinary • Sub-Theme 3: Staged/motivational • Sub-Theme 4: Recovery orientation	G. Treatment Approaches 1. Evidence Based Practices 2. Holistic 3. Stagewise Tx 4. CBT Approaches 5. WRAP Crises Planning 6. Therapeutic Alliance 7. Multidisciplinary		
IX	Treatment Modalities • Sub-Theme 1: Psychiatry and medication • Sub-Theme 2: Psychology and individual counseling • Sub-Theme 3: Group therapy • Sub-Theme 4:	8. Increased Availability of MD's.	**13** **20**	More help with getting proper medications More help from psychiatrists

Theme	Phase I Focus Group Themes	Phase II Key Informant Interview Themes	Rank Item	Phase III Survey - All 30 Ranked Items.
	Psychoeducation and skills training • Sub-Theme 5: Clubhouse			
X	Cultural Considerations • Sub-Theme 1: Lack of interpreters, bilingual resources • Sub-Theme 2: Need for more programs incorporating cultural healing practices (primarily Hawaiian) • Sub-Theme 3: Need for adaptation of Western EBP's for culturally competent application • Sub-Theme 4: Lack of funding for cultural services • Sub-Theme 5: Access community cultural events to disseminate COD information • Sub-Theme 6: Need for cultural competency professional training • Sub-Theme 7: Need for culturally competent providers and ethnically diverse staff (e.g. include cultural practitioners as recognized staff) • Sub-Theme 8: Need for understanding of "local culture"	H. Cultural Considerations 1. Improve Cultural Competency 2. Integrate Cultural Practices 3. Hire Diverse Staff	**30** **22** **29**	More language interpreters. More cultural activities in programs More information for care providers about different cultures.
XI	Living in Recovery • Sub-Theme 1: Meaningful structured activities • Sub-Theme 2: Spirituality • Sub-Theme 3: Social	I. Foundations for Recovery 1. Need for Strong Support System 2. Housing	**27** **10**	Helping people get in touch with friends, loved ones, or others in the community who can help them. More services for families

Theme	Phase I Focus Group Themes	Phase II Key Informant Interview Themes	Rank Item	Phase III Survey - All 30 Ranked Items.
	support/relationships • Sub-Theme 4: Families • Sub-Theme 5: Housing • Sub-Theme 6: Employment • Sub-Theme 7: Self-help	3. Self Help Support 4. Vocational Rehab	**2** **14** **26** **28**	More housing for people with co-occurring disorders Helping people with co-occurring disorders find work More self-help groups for people with co-occurring disorders More help getting peer support or sponsors
XII	Public Education & Public Perception of COD • Sub-Theme 1: Stigma-general • Sub-Theme 2: Stigma-professional and relational • Sub-Theme 3: Stigma-community and culture • Sub-Theme 4: Stigma as a barrier • Sub-Theme 5: Stigma-families • Sub-Theme 6: Community education to reduce stigma • Sub-Theme 7: Community education about MI and SUD to increase awareness • Sub-Theme 8: Raising community involvement and support • Sub-Theme 9: Misperceptions of programs		**18** **25**	Teaching families about co-occurring disorders More information about people with co-occurring disorders for people in the community
XIII	Resources – (e.g. human, financial, physical)	J. Resources 1. Training for Professionals		

Theme	**Phase I** **Focus Group Themes**	**Phase II** **Key Informant Interview Themes**	**Rank Item**	**Phase III** **Survey - All 30 Ranked Items.**
	• Sub-Theme 1: Human resources • Sub-Theme 2: Financial resources • Sub-Theme 3: Physical resources • Sub-Theme 4: Consumer resources • Sub-Theme 5: Treatment resources	2. Technical Assistance 3. Increase Funding for COD programs	**17** **19** **20**	Training care providers on co-occurring disorders More certified substance abuse counselors Making transportation services better
XIV	Special Populations • Sub-Theme 1: Homeless • Sub-Theme 2: Children and teens • Sub-Theme 3: Forensic • Sub-Theme 4: Women and Children	K. Special Populations 1. Improve Services Homeless COD		

Appendix I
Literature Citations

1. Bean-Bayog M: Inpatient treatment of the psychiatric patient with alcoholism. General Hospital Psychiatry 9:203-209, 1987
2. Hellerstein DJ, Meechan B: Outpatient group therapy for schizophrenic substance abusers. American Journal of Psychiatry 144:1337-1339, 1987
3. Drake RE, Wallach MA: Substance abuse among the chronic mentally ill. Hospital and Community Psychiatry 40:1041-1045, 1989
4. Drake RE, Osher FC, Wallach MA: Alcohol use and abuse in schizophrenia: a prospective community study. Journal of Nervous and Mental Disease 177:408-414, 1989
5. Test MA, Wallisch LS, Allness DJ, et al: Substance use in young adults with schizophrenic disorders. Schizophrenia Bulletin 15:465-476, 1989
6. Turner WM, Tsuang MT: Schizophrenia Bulletin 16:87-95, 1990
7. Mueser KT, Drake RE, Miles KM: The course and treatment of substance use disorder in persons with severe mental illness, in Treatment of Drug-Dependent Individuals with Comorbid Disorders. Edited by Onken LS, Blaine JD, Genser S, et al. Rockville, MD, National Institute on Drug Abuse, 1997
8. Drake RE, Wallach MA: Dual diagnosis: 15 years of progress. Psychiatric Services 51:1126-1129, 2000
9. Baker FM, Haning WF: Substance abuse and dependence in a public hospital: Hawaii. Hawaii Medical Journal 60:35-38, 2001
10. Powell BJ, Penick EC, Nickel EJ, et al: Outcomes of co-morbid alcoholic men: a 1-year follow-up. Alcoholism Clinical and Experimental Research 16:131-138, 1992
11. Brown RA, Evans DM, Miller IW, et al: Cognitive behavioral treatment for depression in alcoholism. Journal of Consulting and Clinical Psychology 65:715-726, 1997
12. Maisto SA, Carey KB, Carey MP, et al: Methods of changing patterns of substance use among individuals with co-occurring schizophrenia and substance use disorder. Journal of Substance Abuse Treatment 17:221-227, 1999
13. Kamerow DB, Pincus HA, MacDonald DI: Alcohol abuse, other drugs and mental disorders in medical practice: prevalence, costs, recognition and treatment. JAMA 255:2054-2057, 1986
14. Wyshak G, Modest GA: Violence, mental health and substance abuse in patients who are seen in primary care settings. Archives of Family Medicine 5:441-447, 1995
15. Mueser KT, Bellack AS, Blanchard JJ: Comorbidity of schizophrenia and substance abuse: implications for treatment. Journal of Consulting and Clinical Psychology 60:845-856, 1992
16. Bartels ST, Drake RE, Wallach MA: Long-term course of substance use disorders among patients with severe mental illness. Psychiatric Services 46:248-258, 1995
17. Drake RE, Mueser KT, Clark RE, et al: The course, treatment and outcome of substance disorders in persons with severe mental illness. American Journal of Orthopsychiatry 66:42-49, 1996
18. Carey KB: Treatment of the mentally ill chemical abuser: description of the Hutching's day treatment program. Psychiatric Quarterly 60:303-316, 1989
19. Results from the 2001 National Household Survey on Drug Abuse: Volume I: Summary of National Findings. Rockville, Md, Substance Abuse and Mental Health Services Administration, 2002

20. Carey KB, Carey MP: Enhancing the treatment attendance of mentally ill chemical abusers. Journal of Behavior Therapy and Experimental Psychiatry 21:205-209, 1990
21. Bartels SJ, Teague GB, Drake RE, et al: Substance abuse in schizophrenia: service utilization and costs. Journal of Nervous and Mental Disease 181:227-232, 1993
22. Jerrell JM, Hu TW, Ridgely MS: Cost-effectiveness of substance disorder interventions for people with severe mental illness. Journal of Mental Health Administration 21:283-297, 1994
23. Dickey B, Azeni H: Persons with dual diagnoses of substance abuse and major mental illness: their excess costs of psychiatric care. American Journal of Public Health 86:973-977, 1996
24. Clark RE, Teague GB, Ricketts SK, et al: Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders. Health Services Research 33:1285-1308, 1998
25. Drake RE, Noordsy DL: Case management for people with coexisting severe mental disorder and substance use disorder. Psychiatric Annals, 24:427-431, 1994
26. Jarrell JM, Ridgely MS: Comparative effectiveness of three approaches to serving people with severe mental illness and substance use disorders. Journal of Nervous and Mental Disease 183: 566-576, 1995
27. Osher FC: A vision for the future: toward a service system responsive to those with co-occurring addictive and mental disorders. American Journal of Orthopsychiatry 66:71-76, 1996
28. Drake RE, McHugo GJ, Becker DR, et al: The New Hampshire study of supported employment for people with severe mental illness. Journal of Consulting and Clinical Psychology 64:391-399, 1996
29. Ho AP, Tsuang JW, Liberman RP, et al: Achieving effective treatment of patients with chronic psychotic illness and comorbid substance dependence. American Journal of Psychiatry 156:1765-1769, 1999