

Source/Topic: Motivational Interviewing in July, for the School Mental Health Workforce

Information:

Workshop 1: Cognitive Behavioral Therapy (CBT) & Motivational Interviewing as School Mental Providers

Thinking Through How to Integrate Interventions

Monday, July 24, 2023 • 3:00pm - 5:00pm

Motivational interviewing and standard versions of Cognitive Behavioral Therapy are powerful and effective strategies to help students and their families realize change. Although both are very effective, practitioners are often challenged by the decision to use one intervention for a variety of school-based social and emotional issues. In this session, we will consider when to use common MI and CBT interventions based on the stages of change being experienced by the student. We will also explore which MI and CBT interventions overlap, which have specific applications, and which MI and CBT interventions we can apply flexibly to a number of common school-based challenges.

After attending this workshop, school mental health providers and professionals will be able to:

- Identify at least four common factors shared between motivational interviewing and cognitive behavioral therapy.
- Create a collaborative treatment/change plan with students and parents that contains at least three change targets that can be addressed using motivational interviewing or cognitive behavioral therapy.
- Practice applying at least three motivational interviewing and/or cognitive behavioral interventions based on a student's or parent's identified concerns and stage of change for each concern.
- Construct a plan to use integrated motivational interviewing and cognitive behavioral interventions for at least one student/parent.

Workshop 2: Developmentally Responsive Motivational Interviewing for School Based Providers

Having Strategic Conversations About Change with Young People and their Caregivers

Wednesday, July 26, 2023 • 3:00pm - 5:00pm

Motivational interviewing (MI) is a well-researched and broadly applied practice that enables us to have conversations about change with diverse individuals. Practitioners use MI with adolescents, young adults, and parents to successfully support their values and guide them toward their own desired change targets. In this session, we will discuss research-based MI interventions for youth and specific strategies to reduce resistance and engage young people in conversations about and movement toward personally meaningful change.

After attending this workshop, school mental health providers and professionals will be able to:

- Determine the at least one type of motivation-based intervention appropriate for children, adolescents/young adults, and parents.
- Construct at least one values-based intervention to help guide adolescent and young adults toward change targets.
- Practice two interventions to reduce resistance and support autonomy of youth engaged in conversations about change.
- Design one conversation about change intended to support and guide parents of youth involved in change.

Contact Us

- NETWORKOFFICE@MHTTCNETWORK.ORG
- 650-721-8692

Get Help

- [988 Suicide and Crisis Lifeline](#)
- [Early Serious Mental Illness Treatment Locator](#)
- [FindTreatment.gov](#)
- [SAMHSA's National Helpline – 1-800-662-HELP \(4357\)](#)
- [SAMHSA's Disaster Distress Helpline - 1-800-985-5990 or text TalkWithUs to 66746](#)

Source/Topic: Destigmatizing Mental Health in Asian American and Pacific Islander Communities

Information: Date: May 22, 2019

Category: [Mental Health](#)

By: [Victoria Chau, Ph.D., M.P.H., Public Health Analyst](#) and [Roslyn Holliday-Moore, M.S., Public Health Analyst](#)

Asian Americans and Pacific Islanders are the fastest growing population in the United States, representing numerous cultures, histories, languages and socio-demographic characteristics. While recognizably diverse, Asian and Pacific Islanders are not so different when it comes to

their attitudes about mental health. Stigma associated with mental health problems is common in Asian and Pacific Islander communities. Shaming related to mental health problems is a cultural norm in some Asian communities, leading many who have mental health problems to avoid seeking help despite the need.

May is [Asian American Pacific Islander Heritage Month](#)

and during this national observance SAMHSA is highlighting two groups that have successfully engaged Asian American and Pacific Islander communities to learn about mental health—The Asian Pacific American Officers Committee of the U.S. Public Health Service and the Cambodian Family organization, a member organization of the SAMHSA [National Network to Eliminate Disparities in Behavioral Health \(NNED\)](#)

).

Suicide is the leading cause of death for Asian American and Pacific Islander youth aged 12-19 years old. In light of this issue, the Asian Pacific American Officers Committee launched the [Healthy Mind Initiative](#)

, in January 2018. The goal of the Initiative is to raise awareness about mental health among adolescents. This [collaborative effort](#) focuses on increasing mental health literacy among Asian American and Pacific Islander adolescents and parents by providing culturally and linguistically appropriate education. Since October 2018, the Committee has reached over 1100 individuals in underserved Asian American and Pacific Islander communities through the Initiative events and trainings. Additionally, the Montgomery County Council in Maryland recognized the Healthy Minds Initiative in May 2019 with a [proclamation](#)

for their commitment to raising awareness about mental health and efforts among Asian American and Pacific Islander communities.

The Cambodian Family has developed capacity to implement to promote healing from trauma and build resilience in their community. As the result of The Cambodian Family's participation in SAMHSA's NNEDLearn trainings, the organization was able to expand and sustain mental health services for refugee and immigrant families. Furthermore, The Cambodian Family was awarded approximately \$500,000 from the [Well Being Trust](#)

to implement the Body, Mind, and Spiritual Wellness program and approximately \$37,000 from the County of Orange Health Care Agency to support the implementation of Early Intervention Services for Older Adults.

Asian Pacific American Officers Committee and The Cambodian Family have led the way in starting an important and needed conversation in Asian and Pacific Islander communities about mental health. By lifting up the culture and language that is innate in many Asian and Pacific Islander and immigrant communities, both groups shine a light onto a potential pathway to destigmatizing mental health.

5600 Fishers Lane, Rockville, MD 20857

1-877-SAMHSA-7 (1-877-726-4727)

Topic/Source: Fighting the Stigma: Mental Health among Asian Americans and Pacific Islanders

Information: Although the US has made progress in [raising awareness of mental health](#) and normalizing conversations about the topic, a great deal of stigma remains around mental illness and poor mental health, and many still face barriers to accessing services and supports.

Among Asian American and Pacific Islander (AAPI) communities, these issues are often shrouded by silence and shame, allowing misconceptions and minimization of mental health concerns to thrive.

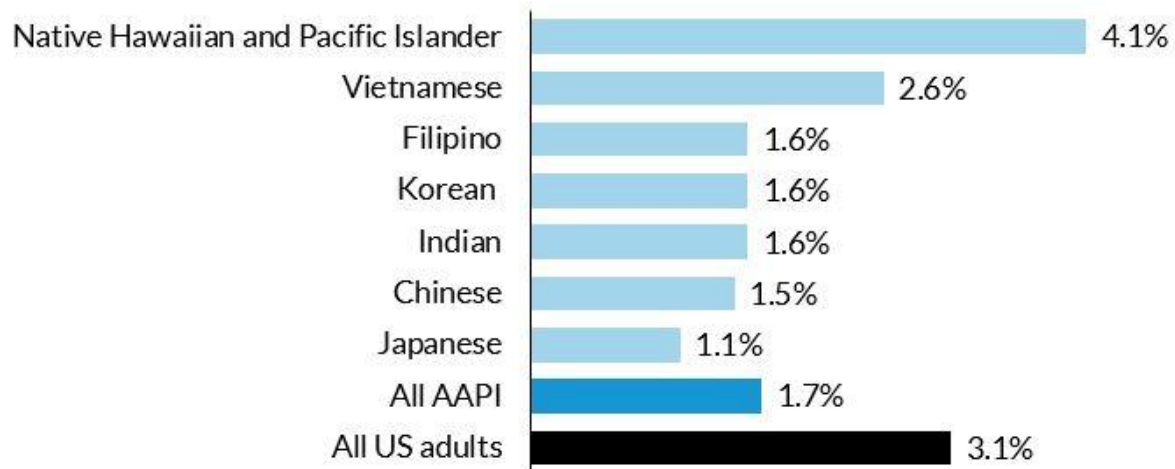
But [AAPIs are not a monolith](#). Our understanding of their mental health needs—and how we respond—should reflect the [diversity of experiences within the AAPI community](#). Here's what you should know about this important topic and underserved population this [Mental Health Awareness Month](#) and [Asian Pacific American Heritage Month](#).

AAPIs are the least likely of any racial or ethnic group to report mental health issues and to seek mental health services

According to the National Survey on Drug Use and Health, [AAPI adults report serious psychological distress at about half the rate of the US average](#)—but there is wide variation between AAPI ethnic subgroups. Vietnamese Americans, Native Hawaiians, and Pacific Islanders report poor mental health at rates closer to the US average than to their AAPI counterparts.

There are also notable [differences in mental health across immigration-related factors](#). Second-generation AAPIs were almost twice as likely to report a mental health disorder in the past year than first-generation immigrants.

Share of US Adults Reporting Serious Psychological Distress in the Past 30 Days



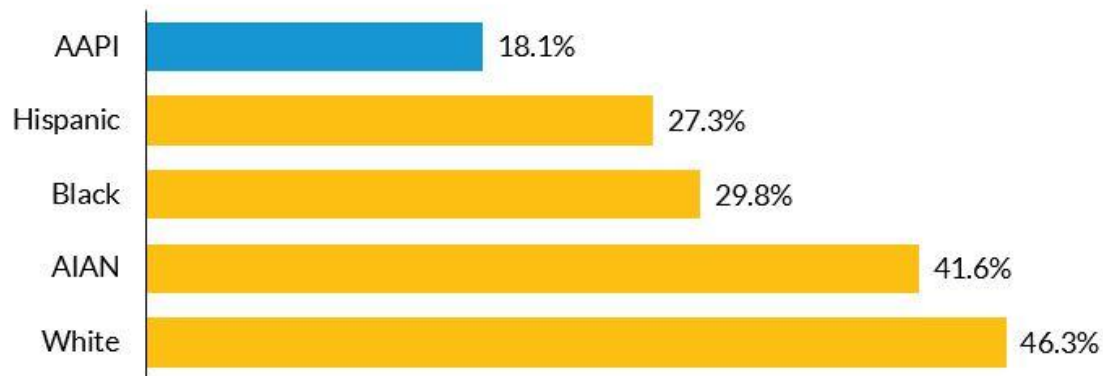
Source: CDC National Health Interview Survey, 2010–2014.

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Notes: Serious psychological distress includes mental health problems severe enough to cause moderate to serious impairment in social, occupational, or school functioning and to require treatment; AAPI = Asian American and Pacific Islanders.

But even after controlling for prevalence of mental illness, AAPI adults [seek mental health services less](#) than any other group. They are almost three times less likely than white adults to seek mental health services for unmet needs.

Use of Mental Health Services in the Past Year among US Adults with Any Mental Illness



Source: SAMHSA National Survey on Drug Use and Health, 2008–2012.

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Note: AIAN = American Indian and Alaskan Native; AAPI = Asian American and Pacific Islander.

A 2015 Substance Abuse and Mental Health Services Administration study found AAPIs were [more likely than people of other racial or ethnic identities](#) to cite “low perceived need,” “structural barriers,” and “not thinking services would help” as reasons for not using mental health services.

AAPIs face cultural and structural barriers to accessing mental health services

Although there are deep-rooted systemic [challenges with the American mental health care system](#) as a whole—such as inadequate funding and support, uneven geographic distribution of services, and fragmented and uncoordinated service providers—certain cultural and structural barriers also affect service provision and quality of care for AAPI communities more specifically.

Culturally specific attitudes among AAPIs that stigmatize help-seeking include the following:

- **The model minority myth.** The assumption that all AAPIs experience [educational success and economic stability](#) can place immense pressure on people to meet these societal and familial expectations, often at the cost of their mental well-being.
- **Generational experiences of hardship.** Many first-generation AAPIs experienced trauma as immigrants or refugees adapting to life in a foreign land. As a result, [younger generations often feel guilty](#) about sharing their mental health struggles, fearing they may seem insignificant when compared with their parents’ and grandparents’ hardships.
- **Lack of understanding about mental health.** AAPIs, particularly first-generation immigrants, may not understand that mental health is part of a person’s overall well-being and can be treated just like other medical concerns. As a result, many older AAPIs [deny or neglect mental health issues, explain symptoms in physical terms rather](#)

[than psychological ones, or rely on social networks for support](#) rather than seek professional services.

But even those who want to access mental health care may not be able to because of structural barriers:

- **Low cultural competency among service providers.** Service providers are not always trained to understand and address culturally specific mental health issues. This lack of competency has historically led to [misdiagnosis and underdiagnosis](#) of mental illness for AAPIs.
- **Insufficient multilingual services.** More than a third of AAPIs have [limited English proficiency](#), and over 30 languages are spoken across AAPI communities. Nearly half of AAPIs will have [difficulty accessing mental health treatment](#) because they cannot find services that meet their language needs.
- **Challenges with health care and insurance.** [Immigration status, financial obstacles, and high rates of uninsurance and underinsurance](#) are also barriers to accessing affordable mental health services among AAPIs, as well as immigrants more broadly.

Culturally sensitive research can inform advocacy, legislation, and practice

Although there are clear limitations to current knowledge about AAPI mental health, as well as gaps in services, efforts are underway to advance AAPI mental health and well-being through [advocacy](#), [legislation](#), and [research-informed practice](#).

As researchers, we should strive to gather [meaningful and disaggregated data on AAPIs](#) to understand the range of lived experiences and internalized beliefs that may undermine mental health or treatment and recovery from mental illness.

Thoughtful research that illuminates the scope and nature of mental health issues among AAPIs can inform culturally responsive policies and practices that reduce stigma and bridge the gap between AAPIs and mental health service providers.

NAMI HelpLine is available M-F 10 am – 10 pm, ET.

Connect by phone 800-950-6264 or text "Helpline"

to 62640, or [chat](#). In a crisis call or text 988.

Topic/Source: Hawaii Health Data

Information: **Welcome to your one-stop source for Hawai'i health data. We provide essential information for researchers, planners, policy makers, community members and students. Click [here](#) for more information on how to use this website.**

The [Holoi ā nalo Wāhine 'Ōiwi: Missing and Murdered Native Hawaiian Women and Girls Task Force Report \(Part 1\)](#) presents the scope of Native Hawaiian Women and Girls who are murdered and missing and identifies possible solutions.

[Find out more](#)

[2.5](#)

[Per 100,000 population](#)

[Homicide Death Rate](#)



[Adult Intimate Partner Violence- Sexual](#)

[\(Compared to Median Value for States and Territories\)](#)

[5.9%](#)

[Intimate Partner Violence Among Teens](#)



[Teens Who Ever Used illicit drugs](#)

[\(Compared to U.S. Value\)](#)

State: Hawaii

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Topic/Source: Health Care Disparities Among Asian, Native Hawaiian, and Other Pacific Islander (NHOPI) People

Information:

Health Care Disparities Among Asian, Native Hawaiian, and Other Pacific Islander (NHOPI) People

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May 24, 2023

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Asian, Native Hawaiian, and Other Pacific Islander (NHOPI) people are a diverse and growing population in the U.S. (Figure 1). Asian people are the fastest-growing racial or ethnic group in the United States, [almost doubling](#) from 10.5 million to almost 20 million between 2000 and 2020. In addition, there are nearly 700,000 people in the country who identify as NHOPI. In this data note, we use 2021 American Community Survey (ACS) data to examine how demographic characteristics as well as measures of health coverage and other social and economic factors that drive health and health care vary for Asian and NHOPI people overall and by subgroups. We include data for smaller subgroups wherever available. Instances in which the unweighted sample size for a subgroup is less than 50 – which are smaller than what we would typically include in analysis like this — are noted in the figures, and confidence intervals for those measures are included in the [Appendix](#). Although these small sample sizes may impact the reliability, [validity](#), and reproducibility of data, they are important to include because they point to potential underlying disparities that are hidden without disaggregated data, further [exacerbating health inequities](#).

Examining experiences among Asian and NHOPI people is important since [broad data](#) for Asian people often mask underlying disparities among subgroups of the population and disaggregated data are often not available or reported for NHOPI people. Understanding the experiences of Asian and NHOPI people is particularly important at this time given growing concerns about [mental health](#) and well-being amid a [significant uptick](#) in anti-Asian hate incidents since the pandemic, an increased focus on advancing [health equity](#) and addressing racism, and ongoing efforts to improve [data collection](#) and reporting, particularly for [smaller population groups and subgroups](#) of the broader racial and ethnic categories.

Figure 1

Asian and Native Hawaiian and Other Pacific Islander People (NHOPI) in the U.S., 2021

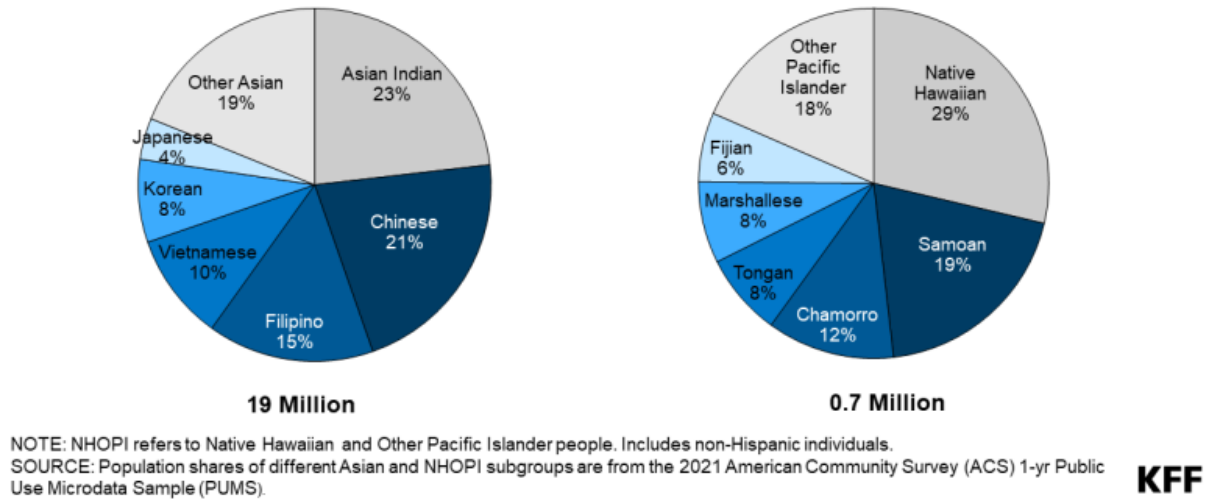


Figure 1: Asian and Native Hawaiian and Other Pacific Islander People (NHOPI) in the U.S., 2021

Demographics

The majority of Asian and NHOPI people in the U.S. are citizens, adults, and many are parents or living in multigenerational households (Figure 2). Asian and NHOPI people included larger shares of noncitizens relative to White people (25% and 14% vs. 1%). One in five Asian (20%) and 19% White people were children, while more than one in four (26%) NHOPI people were children. Larger shares of Asian people lived in households comprised of parents with children or multigenerational households as compared to White people (42% vs. 33%).

Citizenship and household status varied among Asian and NHOPI subgroups: For example, the share of Asian people who are noncitizens ranged from 5% among Hmong people to 55% among Mongolian people. Among NHOPI people, Native Hawaiian and Chamorro people were significantly less likely than NHOPI people overall to be noncitizens (at less than 1%). In contrast, Marshallese people were more likely to be noncitizens (54%). This variation reflects differences in birth citizenship rights across locations to which NHOPI people trace their origins. Specifically, people born in Hawaii and Guam (Chamorro people) are U.S. citizens by birth, while other Pacific Islander people, including those born in the Marshall Islands, which is part of the [Compact of Free Association \(COFA\)](#) with the U.S. are not conferred U.S. citizenship at birth. The share of these groups who are children also ranged widely, from 9% of Japanese people to 36% of Hmong people among Asian subgroups and from 17% of Fijian people to 43% of Marshallese people among NHOPI subgroups. Household composition also

varied by subgroup. Among Asian subgroups, the share who were parents or living in multigenerational households ranged from 27% for Japanese people to 68% for Bhutanese people. Among NHOPI subgroups, Native Hawaiian people (27%) were less likely than the group overall to be in a multigenerational household, while Marshallese people were more likely (48%).

Health Coverage

As of 2021, among the nonelderly population, 6% of Asian people and 11% of NHOPI people were uninsured (Figure 3). The uninsured rate for Asian people was slightly lower than the rate for White people (7%), while the rate for NHOPI people was higher. Across both groups, uninsured rates were lower for children compared to nonelderly adults. The shares of Asian people covered by private coverage were higher than the shares for White people and the shares covered by Medicaid were lower. In contrast, NHOPI people were less likely to have private coverage and more likely to be covered by Medicaid, with over half (52%) of NHOPI children being covered by Medicaid or the Children's Health Insurance Program (CHIP).

There are wide variations in uninsured rates among Asian and NHOPI subgroups (Figure 4). As of 2021, among nonelderly Asian people, uninsured rates ranged from 4% for Asian Indian and Taiwanese people to 28% for Mongolian people. Among NHOPI people, uninsured rates ranged from 5% for Chamorro people to 24% for Marshallese people, although uninsured rates for other NHOPI subgroups were not statistically significantly different from nonelderly NHOPI people overall. Uninsured rates further varied by citizenship status, with higher uninsured rates for noncitizens across most groups. Among nonelderly Asian noncitizens, uninsured rates varied from 5% for Japanese people to 38% for Mongolian people. There were no statistically significant differences in uninsured rates among nonelderly NHOPI noncitizens. Of note, the sample sizes for some noncitizen subgroups were small (<50), which can lead to a higher degree of uncertainty, i.e., larger confidence intervals for their measures. Confidence intervals for each subgroup measure in Figure 4 can be found in the [Appendix](#).

Socioeconomic Differences

A variety of social and economic factors influence individuals' access to health coverage, their ability to access health care, and their overall well-being. While as a broad group Asian people often fare [similar to or better](#) than White people across many of these measures, some

subgroups fare worse. On the other hand, NHOPI people generally fare worse than their White counterparts across a range of social and economic measures.

Data show variations in socioeconomic measures among nonelderly Asian and NHOPI subgroups, which may contribute to the differences in health coverage (Figure 5). Among Asian subgroups, there was an almost five-fold difference in the share of people who have received a bachelor's degree or higher, with 18% of Laotian people having a bachelor's degree or higher as compared to 87% of Taiwanese people. Overall educational attainment is lower among NHOPI people, with a lower share of Marshallese people (6%) having a bachelor's degree or higher compared to nonelderly NHOPI overall, and a higher of Chamorro people (28%) having at least a college degree. The share of Asian households with at least one full-time worker also varied by subgroup, ranging from 66% among nonelderly Mongolian people to 91% among nonelderly Asian Indian people. Among NHOPI people, Fijian and Samoan people were slightly more likely than the overall group to have at least one full-time worker. Similarly, household income among Asian subgroups varied widely with the share of nonelderly people who lived in a low-income household (below 200% of the federal poverty level or \$43,920 for a family of 3 in 2021) ranging from 12% among Asian Indian people to 55% among Mongolian people and 52% among Burmese people. Some of these differences are likely driven by differences in citizenship and visa status. For example, those entering the U.S. with work visas likely have higher median household incomes compared to those that entered as asylees and/or refugees. Many Burmese people immigrate to the U.S. as [refugees](#) fleeing war in their home country, which could contribute towards their lower household incomes. On the other hand, higher earning groups such as Taiwanese people and Asian Indian people usually immigrate through [work visas](#). Despite eight in ten nonelderly Marshallese people living in a household with at least one full-time worker, 63% lived in a low-income household, while only 27% of Chamorro and Fijian people were low-income. Lower educational attainment as well as higher shares of noncitizens may in part explain the higher shares of Marshallese people living in low-income households.

Key Issues Looking Ahead

Understanding the experiences of Asian and NHOPI people is of particular importance at this time given growing concerns about mental health and well-being amid a [significant uptick](#) in anti-Asian hate incidents. The COVID-19 pandemic and underlying racism and discrimination have contributed to a [significant rise](#) in hate crimes against Asian people in the United States, which have contributed to deteriorating mental health among Asian people. In a 2021 survey, [a majority](#) of Asian Americans cited COVID cases being first reported in China and President Trump as major reasons for discrimination against the Asian and Pacific Islander community. Against the backdrop of these anti-Asian sentiments and actions, two tragic mass shootings occurred around this past Lunar New Year, of whom many of the victims were Asian. These tragic events and their devastating impacts on the community have highlighted the importance of understanding and addressing [mental health needs](#) among Asian and NHOPI

people. Although overall rates of mental illness are generally lower among Asian people compared to White people, this finding may reflect [underdiagnosis](#) and [underreporting](#). It also may mask variations in mental health among subgroups of the population. Among people with mental illness, Asian people are [less likely](#) to utilize mental health services compared to other racial and ethnic groups. In 2021, among adults with any mental illness in the past year, only 25% of Asian adults reported receiving mental health services compared to 52% of White adults (Figure 6). Data on utilization were not available for NHOPI people. Moreover, data show rising rates of suicide death among Asian and Pacific Islander adolescents (ages 12-17). Although they have lower rates of suicide deaths compared to their White peers, suicides were the [leading cause of death](#) among Asian and Pacific Islander children ages 10-14 and the second leading cause among those between the ages of 15 and 35 in 2020, and [suicide death rates](#) more than doubled among this population from 2010 (2.2 per 100,000) to 2020 (5.0 per 100,000).

In the wake of the COVID-19 pandemic, there has been a heightened awareness and focus on addressing health disparities, including recognizing the ongoing impacts of historic actions and policies on health disparities today. Anti-Asian racism [is not new](#) within the United States. Anti-Asian sentiments and related Sinophobia are embedded in U.S. history, as evidenced by the implementation of the [Chinese Exclusion Acts](#) in the late 1800s and the [incarceration](#) of Japanese Americans in the twentieth century. Historical actions have also contributed to ongoing [trauma](#) and negative health outcomes for NHOPI people. In the 19th century, the U.S. began [substantial expansion](#) across the Pacific Ocean which included the colonization of many of the Pacific Islands, and the overthrow of the Hawaiian monarchy. Since occupation, the United States' colonial, post-colonial, and military actions in the region have resulted in adverse [socioeconomic](#), [health](#), and [environmental pollution](#)-related legacies among local and Indigenous populations. In addition to these historic actions and their aftermath, Asian and NHOPI people have faced ongoing stresses associated with the [perpetual foreigner](#) and [model minority](#) stereotypes, and [acculturation](#).

The federal government has taken several actions focused on advancing health equity broadly and in response to the rise in Asian hate and anti-Asian violence, specifically. Early in his presidency, President Biden issued a series of executive orders focused on advancing health equity, including orders that outlined [equity as a priority](#) for the federal government broadly and as part of the [pandemic response and recovery efforts](#). Federal agencies were directed with developing [Equity Action Plans](#) that outlined concrete strategies and commitments to addressing systemic barriers across the federal government. In 2021, Congress enacted the [COVID-19 Hate Crimes Act](#) in response to the increase in anti-Asian violence during the pandemic. During that time, [the Biden Administration](#) also released Executive Order 14031 “Advancing Equity, Justice, and Opportunity for Asian Americans, Native Hawaiians, and Pacific Islanders,” which established the White House Initiative on Asian Americans, Native Hawaiians, and Pacific Islanders (WHIAANHPI). [The WHIAANHPI](#) is committed to advancing equity for Asian Americans, Native Hawaiians, and Pacific Islanders

(AANHPI) by investing in AANHPI communities and responding to the spikes in anti-Asian violence. In January 2023, the White House announced its [National Strategy to Advance Equity, Justice, and Opportunity for Asian American, Native Hawaiian, and Pacific Islander \(AA and NHPI\) Communities](#).

As part of efforts to address disparities and advance health equity, there are efforts underway to expand and improve availability of disaggregated data, including for Asian and NHPI people. As shown in this analysis, Asian and NHPI people have diverse characteristics and experiences that influence their health and health care. These differences point to the importance of having disaggregated data for Asian and NHPI groups to identify disparities and direct efforts to [address them](#). The Biden Administration has [charged the government](#) with addressing the systemic lack of disaggregated AANHPI data in federal statistical systems. The [Interagency Working Group on Equitable Data](#) in collaboration with the WHIANHPI is also working to improve research on policy and program outcomes for AANHPI communities. In April 2022, the working group released its [Equitable Data Working Group Report](#), which highlighted the need to generate disaggregated data, increase access to disaggregated data, conduct equity assessments of federal programs, and emphasize accountability to communities in the United States. The Office of Management and Budget released proposals in January 2023 to update the [minimum standards](#) for collecting and presenting data on race and ethnicity for all federal reporting, including providing a separate racial category for people who identify as Middle Eastern or North African and moving to collect race and ethnicity through a combined single question instead of asking about Hispanic or Latino ethnicity in a separate question from race.

Appendix

Figure 4a: Share of All Nonelderly Uninsured Asian People, 2021

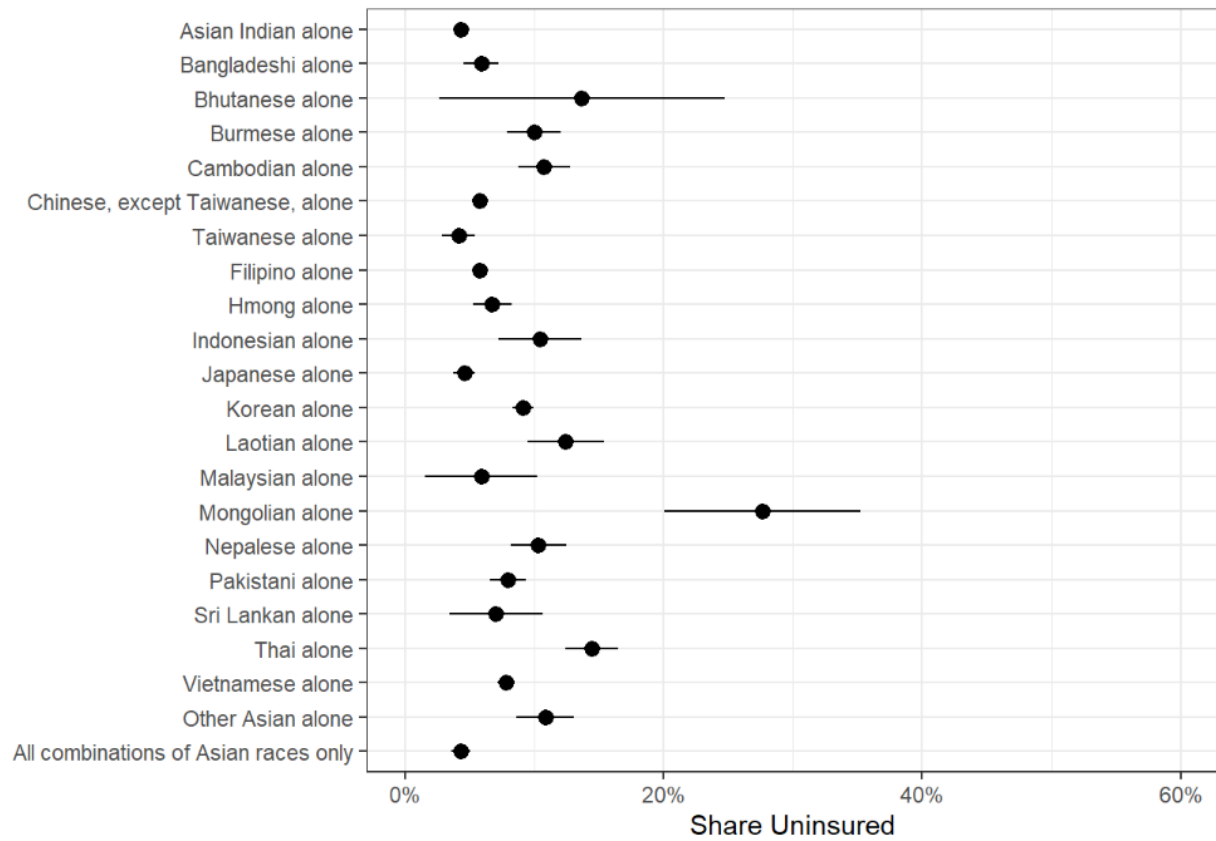


Figure 4a: Share of All Nonelderly Uninsured Asian People, 2021

Figure 4b: Share of Nonelderly Uninsured Asian Citizens, 2021

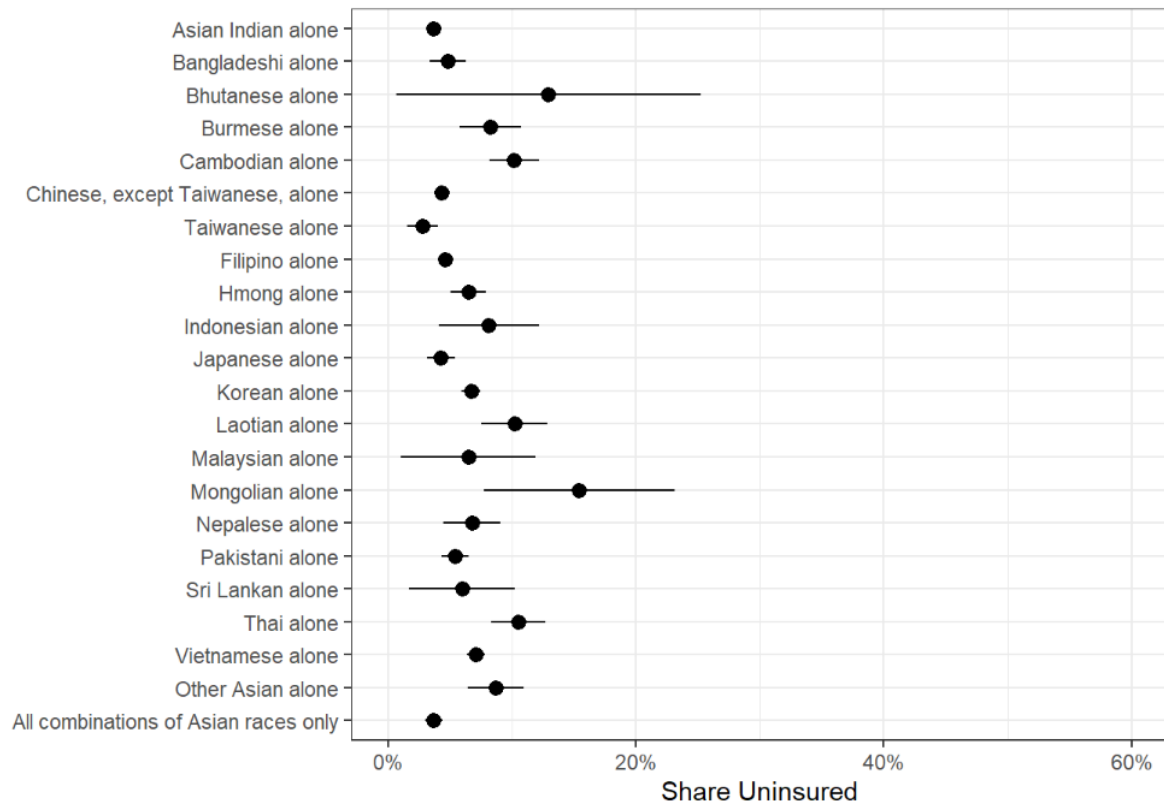


Figure 4b: Share of Nonelderly Uninsured Asian Citizens, 2021

Figure 4c: Share of Nonelderly Uninsured Asian Noncitizens, 2021

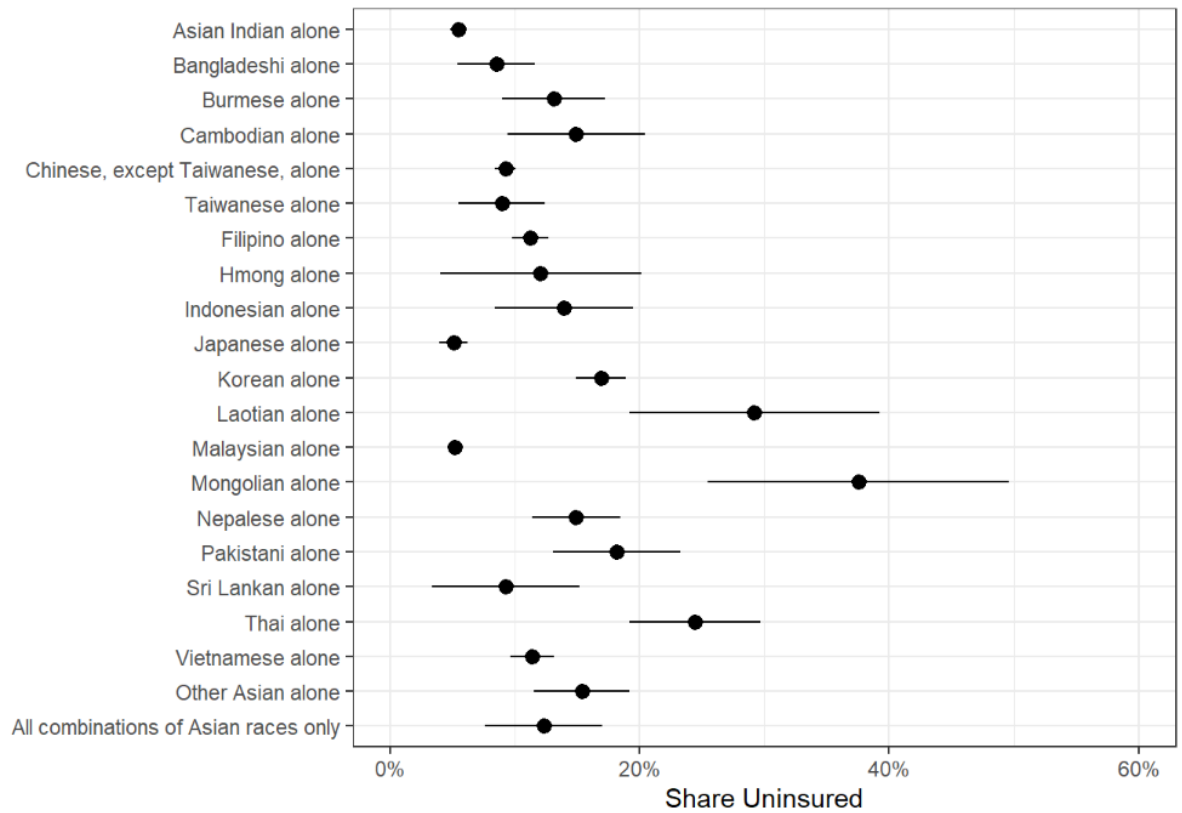


Figure 4c: Share of Nonelderly Uninsured Asian Noncitizens, 2021

Figure 4d: Share of All Nonelderly Uninsured NHOPI People, 2021

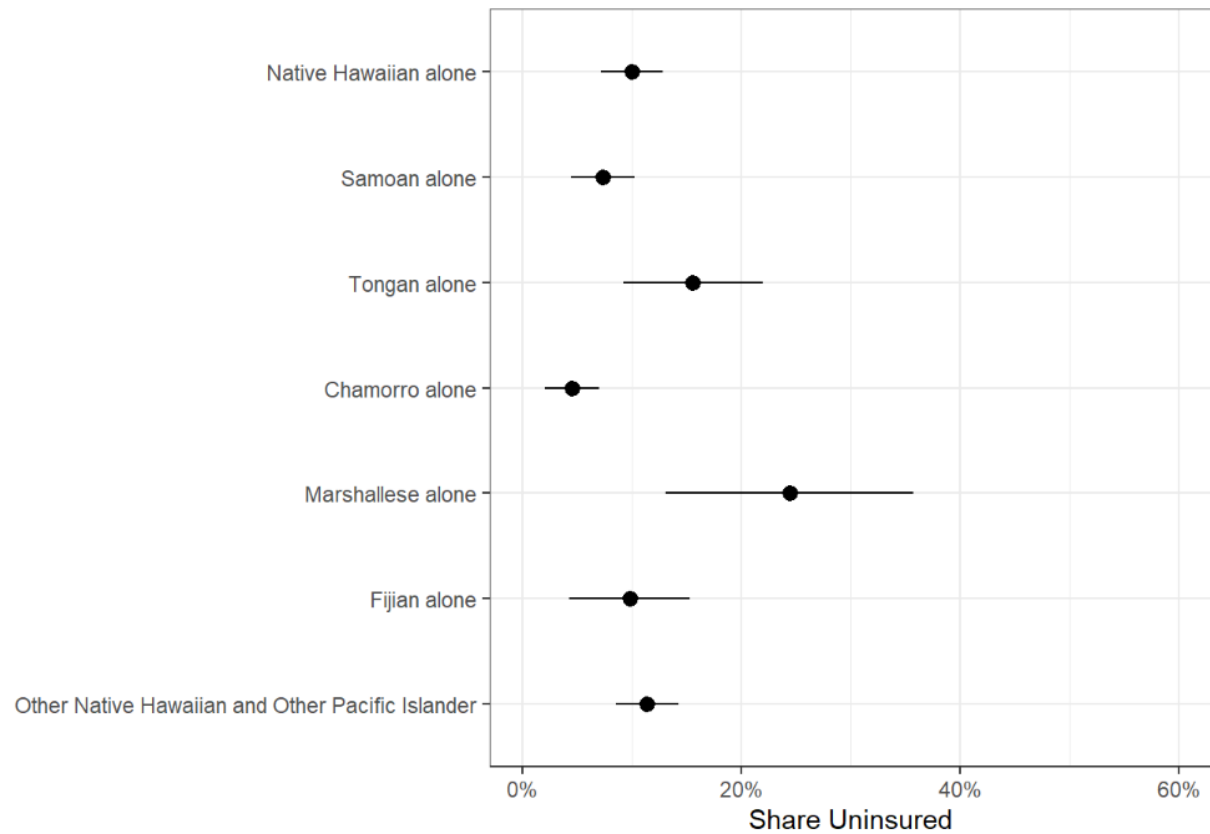


Figure 4d: Share of All Nonelderly Uninsured NHOPI People, 2021

Figure 4e: Share of Nonelderly Uninsured NHOPI Citizens, 2021

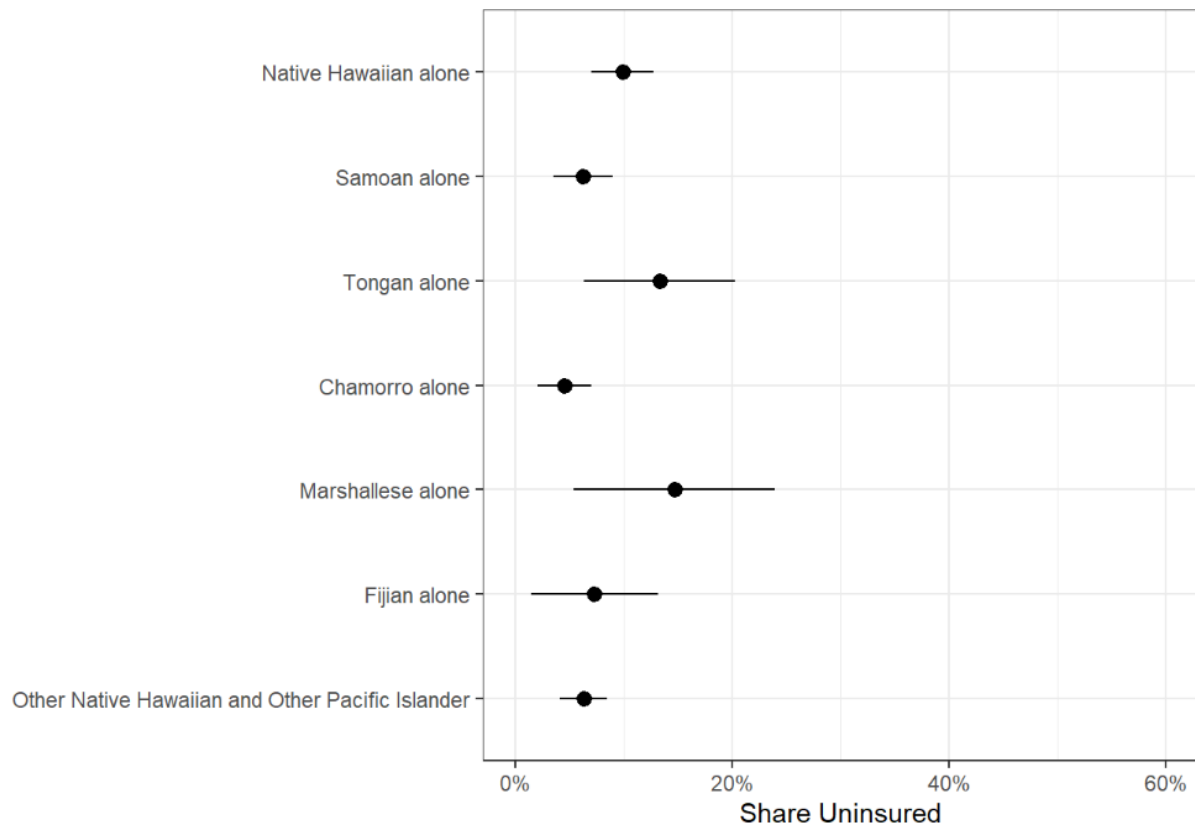


Figure 4e: Share of Nonelderly Uninsured NHOPI Citizens, 2021

Figure 4f: Share of Nonelderly Uninsured NHOPI Noncitizens, 2021

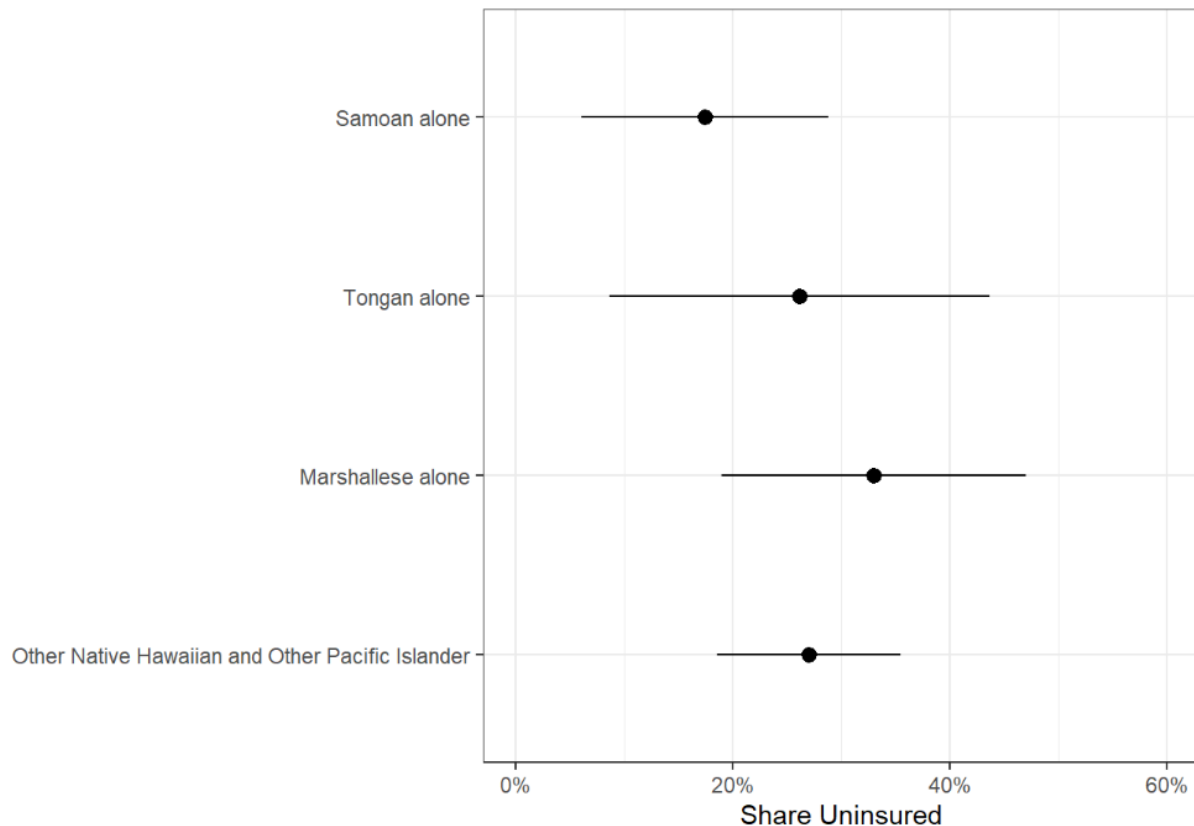


Figure 4f: Share of Nonelderly Uninsured NHOPI Noncitizens, 2021

Topic/Source: Asian American and Pacific Islander

Information: Asian Americans and Pacific Islanders (AAPI) are an integral part of the American cultural mosaic, encompassing a wide range of diversity. AAPI communities consist of approximately 50 distinct ethnic groups speaking over 100 languages, with connections to Chinese, Indian, Japanese, Filipino, Vietnamese, Korean, Hawaiian, and other Asian and Pacific Islander ancestries.

[As of the 2020 Census](#), 24 million people identified as Asian and 1.6 million identified as Native Hawaiian and Other Pacific Islander, either as their only identity or in combination with another identity.

Ethnic and communal identity is considered a notable protective mental health factor for many AAPIs. The sense of communal identity, connections, belonging and family bonds is a strong predictor of resilience while facing life's challenges. Studies have shown that a strong sense of ethnic identity is linked to [lower suicide risks and predicts higher resilience](#) in the face of racial discrimination, which is, unfortunately, an issue for many in this population.

On the other hand, second-generation AAPI immigrants may face challenges in their cultural identity, struggling to balance their familial ties to traditional cultural values with the pressure to

assimilate to mainstream American society. Additionally, an emphasis on community identity can create a strong burden of expectations, which may increase stigma and shame if a person doesn't meet those expectations.

Barriers to Mental Health Care

Compared to those of other racial/ethnic backgrounds, Asian Americans are least likely to receive mental health treatment - only [20.8%](#) of Asian adults with a mental illness received treatment in 2020. There are many systemic barriers to accessing mental health care and quality treatment for Asian Americans, which are exacerbated by stigma and a lack of culturally relevant and integrated care. These disparities can lead to worsened symptoms and poorer quality of life if treatment is unavailable or delayed.

Language Barriers

As immigration is a primary driver of AAPI population growth within the United States, many AAPI do not speak English as their primary language. [30.9%](#) of Asian Americans do not consider themselves fluent in English, and rates of English language proficiency vary depending on nation of origin. Additionally, [60%](#) of AAPIs aged 65 years and older have limited English proficiency. Language barriers and [limited availability](#) of culturally appropriate mental health service providers may prevent people from getting the care they need.

Stigma and Shame

Compared to those with other racial/ethnic identities, AAPIs are [more likely](#) to report that they did not receive mental health treatment because they:

- Didn't want others to find out
- Feared their neighbors' negative opinions

Lack of understanding about mental illness and stigma associated with mental health issues can lead to denial or neglect of mental health problems, especially among first-generation AAPI immigrants. The notions of shame and "loss of face" is an important factor in understanding low use of services among AAPI people.

Mental illness has often been considered a weakness or a sign of poor parenting, and a source of shame not only to the individual, but also to the entire household. The desire to protect the family's reputation can often discourage help-seeking until there is a crisis.

The Model Minority Myth

Asian American communities are burdened with the "model minority" stereotype, a prevalent and misleading assumption that depicts AAPIs as uniformly well-adjusted, attaining more

socioeconomic success than other minority groups through strong work ethic, conforming to social norms and excelling academically. The fact is the AAPI community is highly diverse across subgroups in rates of socioeconomic, health and mental health challenges. The social and familial pressure created by this deceptive [stereotype](#) can prevent community members from seeking mental health care.

Insufficient Health Insurance Coverage

Concerns over the high cost of mental health care also lead to lower rates in help-seeking and treatment adherence. Some groups within the AAPI community face disparities in coverage — Native Hawaiian or Other Pacific Islander (NHOPI) populations have a higher uninsured rate of [13.0%](#) , compared to [7.0%](#) for Asian American communities in 2019.

Immigration Status

Some AAPI immigrants may not seek necessary mental health care due to fears of jeopardizing their immigration status or citizenship application process.

Faith and Spirituality

Faith and spirituality have important influences on mental health, especially for the AAPI community where [religious diversity](#) is a distinct characteristic, and more people identify as Buddhists, Hindus, Muslims or other religious affiliations compared to the U.S. average.

Faith communities often offer a built-in social support system. However, religious communities may perpetuate stigma around mental illness that can delay treatment. For example, characterizing mental illness as divine punishment, bad karma, disturbed flow of life energy or imbalance of basic elements inside the body. This is especially true for AAPI families who turn to their religious leaders first for mental health support.

Alternatives to Treatment

[Traditional medicine or indigenous healing practices](#), which often emphasize the integration of mind and body in maintaining health and promoting healing, remain popular forms of mental health intervention in some AAPI communities. These practices include, but are not limited to:

- Traditional Chinese medicine
- Ayurveda (the traditional medicine of India)
- Kampo - Japanese herbal medicine
- gSo-ba Rigpa - Tibetan medicine
- Acupuncture
- Massage therapy
- Folk nutritional therapy
- Energy healing exercises (ex: tai chi, qi gong)
- Guided meditation
- Spiritual healing

Some AAPIs, especially first-generation immigrants, consider traditional/non-western medicine their primary treatment rather than a complementary treatment. This can result in delaying or refraining from seeking mental health care.

Challenges in Research

Insufficient research on AAPI communities often leads to an inaccurate picture of the experience and needs of these communities. Due to the broad diversity of the community overall, and the relatively small population size of specific cultural subgroups, it can be challenging to obtain adequate samples or to generalize the needs of this population.

Despite these challenges, researchers and clinicians have made [progress](#) recently in bridging the gap of quality treatment by exploring culturally relevant interventions for AAPI people. An example is the first NIH-funded [study](#) that tested a form of cognitive-behavioral therapy (CBT) adapted for recent Asian American immigrants seeking psychotherapy.

How to Seek Culturally Competent Care

Culturally competent providers understand each person's values, experiences and personal beliefs, and strive to provide services that support their goals and are aligned with their cultural values. When a person is struggling with their mental health, it is essential to receive quality and culturally competent care in order to improve outcomes.

Given the vast diversity of AAPI groups, culturally competent providers for these communities often show a strong desire to establish a trust-based therapeutic relationship with the individuals they are treating through effective listening and willingness to learn. They may understand and work with individuals to address concerns over medication, such as fear of side effects. A culturally competent provider may also demonstrate knowledge and acknowledgement of "[cultural bound syndromes](#)," such as:

- "Hwa-byung" – Korean syndrome similar to DSM-5 major depression
- "Taijin kyofusho" – Japanese disorder similar to DSM-5 social phobia
- "Shenjingshuairuo" – Chinese term for [neurasthenia](#)

While we recommend seeking help from a mental health professional, a primary care professional can be a great place to start for an initial assessment or to get a referral for a recommended mental health professional.

When meeting with a provider, ask questions to get a sense of their level of cultural sensitivity. Providers expect and welcome questions from their patients since this helps them better understand what is important in their treatment. Here are some questions to ask:

- Have you treated other AAPI people?
- Have you received training in cultural competence or on AAPI mental health?

- How do you see our cultural backgrounds influencing our communication and my treatment?

Whether you seek help from a primary care professional or a mental health professional, you should finish your sessions with health professionals feeling heard and respected. You may want to ask yourself:

- Did my provider communicate effectively with me?
- Is my provider willing to integrate my beliefs, practices, identity and cultural background into my treatment plan?
- Did I feel like I was treated with respect and dignity?
- Do I feel like my provider understands and relates well with me?

The relationship and communication between a person and their mental health provider is a key aspect of treatment. It's very important that a person feels their identity is understood by their provider to receive the best possible support and care.

More Information

- If finances are preventing you from finding help, contact a local health or mental health clinic or your local government to see what services you qualify for. You can find contact information online at findtreatment.samhsa.gov or by calling the National Treatment Referral Helpline at 800-662-HELP (4357).
- If you or your loved one does not speak English, or are not fluent, you have the right to receive language-access services at institutions that receive funding from the federal government as well as the right to request a trained interpreter and to receive information in your language.

Resources

[NAMI Family & Friends](#)

A free 90-minute or four-hour seminar, with an e-book available in three Asian languages: Chinese, Korean and Vietnamese.

[NAMI In Our Own Voice](#)

A stigma-busting presentation providing a model that facilitates highly individualized accounts of lived experience of mental health conditions. This video features program leaders from various racial and ethnic backgrounds.

[NAMI Family-to-Family](#)

An 8-week psychoeducation program for families and friends. A Chinese translation with

cultural adaptations will be available in 2021, with online classes offered by NAMI Affiliates in a limited number of states, including California and New Jersey.

[NAMI Support Groups](#)

Peer-led and offers participants an opportunity to share their experiences and gain support from other attendees. Culturally sensitive groups are offered by NAMI Affiliates in a limited number of states, including California and New Jersey.

[NAMI Blog — AAPI related posts](#)

Where voices from diverse communities are heard on various topics.

Please note: The resources included here are not endorsed by NAMI, and NAMI is not responsible for the content of or service provided by any of these resources.

[Anxiety and Depression Association of America \(ADAA\) — Asian Americans/Pacific Islanders](#)

ADAA is an international nonprofit organization dedicated to the prevention, treatment, and cure of anxiety, depression, OCD, PTSD, and co-occurring disorders through education, practice and research. It has a dedicated webpage on AAPI resources and research information.

[Asian American Health Initiative \(AAHI\)](#)

AAHI is a health and wellness initiative of Maryland's Montgomery County Department of Health and Human Services. Its website is available in four Asian languages: Traditional Chinese, Hindi, Korean and Vietnamese.

[Asian American Psychological Association \(AAPA\)](#)

AAPA is a San Francisco-based non-profit organization of Asian American mental health professionals, with the mission of advancing the mental health and well-being of Asian American communities through research, professional practice, education and policy.

[Asian Mental Health Collective](#)

A new global non-profit organization with the mission of normalizing and de-stigmatizing mental health within the Asian community through projects such as Facebook group, resource library, video web-series and meet-up groups.

[Asian & Pacific Islander American Health Forum \(APIAHF\)](#)

Founded in 1986, APIAHF influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians and Pacific Islanders.

[Asian Pride Project](#)

Asian Pride Project is a nonprofit organization that celebrates the journeys, triumphs and struggles of LGBTQ individuals and Asian and Pacific Islander (API) families and communities through the use of arts — film, video, photography and the written word — as a medium for social justice and advocacy.

[Chinese-American Family Alliance for Mental Health \(CAFAMH\)](#)

CAFAMH is a NYC-based nonprofit organization that seeks to promote self-empowerment and mutual support among Chinese-American caregivers of individuals with mental illness by providing a safe space for family support group meetings.

[Chinese-American Sunshine House](#)

A non-profit organization based in Brooklyn that provides awareness programming and education workshops to Chinese-American families.

[Chinese for Affirmative Action \(CAA\)](#)

CAA advocates for systemic change that protects immigrant rights, promotes language diversity, and remedies racial and social injustice.

[Each Mind Matters](#)

Mental health support guide for Chinese-American communities.

[GAPIMNY](#)

Empowering queer and trans Asian Pacific Islanders.

[Mental Health America](#)

Asian American/Pacific Islander communities and mental health.

[Mental Health Association for Chinese Communities \(MHACC\)](#)

MHACC is a California-based nonprofit organization with a mission of raising awareness of mental health within the Chinese community through advocacy, education, research and support.

[MedlinePlus](#)

MedlinePlus is a free service provided by the National Library of Medicine of the National Institutes of Health which presents high-quality, relevant health and wellness information in multiple languages, including about 20 AAPI languages.

[National Asian American Pacific Islander Mental Health Association \(NAAPIMHA\)](#)

NAAPIMHA is a nonprofit organization with the mission of promoting the mental health and wellbeing of Asian American and Pacific Islander communities.

[National Queer Asian Pacific Islander Alliance \(NQAPIA\)](#)

NQAPIA is a federation of lesbian, gay, bisexual and transgender Asian American, South Asian, Southeast Asian and Pacific Islander (AAPI) organizations

[Psychology Today](#)

Psychology Today's directory provides a comprehensive and searchable directory of therapists, psychiatrists and treatment facilities across the U.S. and includes a directory of Asian therapists.

[Viet-Care](#)

A California-based nonprofit organization providing mental health education, support and

advocacy to Vietnamese-American families.

[Letters to Strangers](#)

A global youth-run 501(c)(3) nonprofit seeking to destigmatize mental illness and increase access to affordable, quality treatment for youth aged 13 to 24. Its founder, Diana Chao, and her team of youth advocate leaders represent diverse communities and contribute to the awareness of and advocacy for Asian American youth mental health. Download their [Youth-for-Youth Mental Health Guidebook](#) (free digital B&W version) for more in-depth statistics and narratives on AAPI communities.

Topic/Source: Implications of Two Conflicting Federal Court Rulings on the Availability of Medication Abortion and the FDA's Authority to Regulate Drugs

Information:

On April 7, 2023, two conflicting rulings on the provision of mifepristone, the drug used for medication abortion, were issued by two separate federal court judges, one in Texas and one in Washington State. Judge Mathew Kacsmaryk, the judge in the US District Court for the Northern District of Texas Amarillo Division, issued a preliminary injunction in the case, *Alliance for Hippocratic Medicine v. FDA*, blocking the FDA's approval of mifepristone dating back to 2000. The judge has stayed his decision for seven days to give the FDA time to appeal, but the ruling effectively impacts the entire nation and would effectively revoke the FDA approval granted to mifepristone in 2000.

On the same afternoon, Judge Thomas O. Rice from the United States District Court in the Eastern District of Washington ruled in a case that was filed by the Oregon and Washington Attorneys General joined by 16 other Attorneys General. The AGs are [challenging](#) the FDA's decision to impose restrictions on prescribing and dispensing mifepristone through the Risk Evaluation and Mitigation System (REMS), claiming the restrictions on the dispensing of the drug imposed by the FDA are unnecessary and limit its availability. This ruling orders the FDA to maintain the current availability of mifepristone in the 17 states and DC, the plaintiffs in this case.

As a result, the FDA has conflicting orders: to suspend its approval mifepristone on one hand and not to alter its approval effective January 2023, on the other. Because these two federal court rulings conflict, the Supreme Court could be called upon to resolve this conflict and decide the merits of both cases. This Q&A summarizes some of the key issues related to these rulings.

Who are the plaintiffs that are suing to block medication abortion?

The plaintiffs in the Texas case, Alliance for Hippocratic Medicine (a newly formed anti-abortion advocacy coalition); the American Association of Pro-Life Obstetricians and Gynecologists; the American College of Pediatricians; and the Christian Medical and Dental Associations, as well

as three individual doctors challenged the FDA's approval of mifepristone, one of the drugs used in medication abortion. The plaintiffs are [challenging](#) the FDA's approval process and subsequent modifications of the conditions for dispensing mifepristone (known as REMS) as being beyond the FDA's authority. The plaintiffs also contend that an 1873 anti-obscenity law, the Comstock Act, prohibits the mailing of any medication used for abortion (for details on the case see: [Legal Challenges to the FDA Approval of Medication Abortion Pills](#)). The Judge's ruling in this case directs the FDA to suspend its approval of the mifepristone while the litigation continues, but gives the FDA seven days to appeal the case to the 5th Circuit before the order takes effect. This ruling would block the sale and distribution of mifepristone in the entire country, and would also block access to the drug in states where abortion is legal and protected.

What is the lawsuit filed by Democratic State Attorneys General?

The Oregon and Washington Attorneys General joined by 16 other Attorneys General are also [challenging](#) the FDA's decision-making about mifepristone, but rather than challenging the FDA approval process, the plaintiffs are calling into question the FDA's decision to impose restrictions on prescribing and dispensing mifepristone through the Risk Evaluation and Mitigation System (REMS). As of January 3, 2023, mifepristone can only be prescribed by a certified provider and the drug can only be provided by a certified pharmacy or clinician. The judge in this case has issued a preliminary injunction blocking the FDA from changing any rules that would impact the availability of mifepristone in states bringing the lawsuit (WA, OR, CO, CT, IL, NV, AZ, RI, OR, DE, MI, NM, VT, HA, MD, ME, MN, PA, and DC).

What is medication abortion?

The most common [medication abortion](#) regimen in the United States involves the use of two different medications: mifepristone and misoprostol, which are FDA approved. Mifepristone, also known as the abortion pill, or RU-486 is sold under the brand name Mifeprex and through a generic manufactured by GenBioPro in the United States. The FDA has found that medication abortion is a safe and highly effective method of pregnancy termination. When taken up to 70 days of pregnancy, the medication abortion regimen successfully terminates the pregnancy [99.6%](#) of the time, with a [0.4%](#) risk of major complications, and an associated [mortality rate](#) of less than 0.001 percent (0.00064%). Mifepristone was first approved by the FDA in 2000, and by 2021, over [half](#) of abortions in the US were medication abortions. Despite being available for medication abortion for over two decades, there is still considerable confusion about the drug in this country. A KFF [poll](#) conducted in January 2023 found that about half of the public was unsure as to whether medication abortion is legal in their state, including four in ten (41%) women ages 18 to 49 and half of women living in states where abortion is legal.

A little-known fact is that mifepristone, under the brand name Korlym, was also FDA-approved in 2012 without any REMS to manage blood sugar levels (hyperglycemia) in adults with

endogenous Cushing's syndrome. Korlym is a higher dose of mifepristone than Mifeprex and is taken daily.

There is also a different medication abortion protocol using misoprostol alone that is more commonly used internationally. Misoprostol is frequently used in obstetrics and gynecology for procedures like the medical management of miscarriage, induction of labor, cervical ripening before surgical procedures, and the treatment of postpartum hemorrhage. While misoprostol is FDA approved for many medical uses, it has not been FDA approved for abortions, meaning it is used "off label" for this purpose in the US. The regimen is also recommended for up to 70 days (10 weeks) of pregnancy. Research has shown the misoprostol-only regimen to be a [safe and highly effective](#) method of pregnancy termination, however it may result in a [higher incidence](#) of side effects. Some U.S. [telehealth organizations](#) have been providing the misoprostol-only regimen as an option for medication abortion for several years.

Will medication abortion continue to be available?

It is too soon to tell what the impact will be on the availability of medication abortion. It's not known how the FDA will act in response to the two conflicting rulings. The FDA approves drugs for the whole country and does not vary its approval by state. If the FDA is forced to suspend its approval of mifepristone, some clinics may respond to this ruling by switching from the mifepristone/misoprostol regimen to using a higher dose of misoprostol alone.

What is the next step in the litigation?

Hours after Judge Kacsmaryk's ruling, the FDA filed a notice of appeal to the US Court of Appeals for the 5th Circuit and [Attorney General Merrick Garland](#) said the government would request a stay to block this ruling while the appeal is considered. If the 5th Circuit does not grant this request, the FDA is likely to appeal immediately to the Supreme Court of the United States to block the ruling during the appeal process. If the case is appealed but the courts do not provide a stay, then the distribution of mifepristone could be halted across the nation pending the final outcome of the case.

The FDA may not appeal Judge Rice's decision as it directs the FDA to keep the status quo. The Attorneys General who brought the case may appeal the decision to the 9th Circuit to seek an injunction to block the enforcement of the REMS approved in January 2023.

As both of these cases involve the FDA approval and provision of mifepristone, it is likely that if they reach the Supreme Court, it will review the cases together.

Are there other lawsuits that involve mifepristone?

Some are questioning how the new state authority to regulate or ban abortion intersects with the Federal FDA's authority to regulate drugs. There are currently two cases in federal court

challenging state abortion prohibitions and restrictions on federal preemption grounds. The maker of a generic mifepristone medication, [GenBioPro, Inc.](#), is challenging West Virginia's [total abortion ban](#), and an ob-gyn, [Dr. Amy Bryant](#), is challenging the abortion restrictions in North Carolina, which include requirements that mifepristone be dispensed [in person](#) by a physician following a state-mandated counseling session and a [72-hour waiting period](#). In both cases, plaintiffs argue that the FDA's authorization and regulation of mifepristone preempt state law banning the use of the medication or regulating its use more strictly, and given this, enforcement of the state laws should be blocked. If these lawsuits are successful, people living in states where abortion is banned could access medication abortion.

What impact do these rulings have on the FDA's approval of other drugs?

These rulings will likely have implications far beyond abortion, though it is still too soon to tell. Court challenges such as these could open the door for other actors to potentially sue to block the approval of existing or new drugs that may be considered controversial, such as vaccines or treatments for conditions that are at the crosshairs of so-called "culture wars." Manufacturers may be reluctant to bring to market certain new drugs or treatments if they are concerned that a court ruling could block their approval in the future.

Topic/Source: Asian American / Pacific Islander Communities and Mental Health

Information: It's important to recognize that the term "AAPI" (Asian American / Pacific Islander) encompasses a wide range of countries, ethnicities, nationalities, and identities. Many different communities within AAPI label face their own unique challenges: from the trauma faced by those who survived wars in Laos, Cambodia, and Vietnam; Japanese Americans who remember the internment camps of the WW2 era; or the anxiety felt by the children of first-generation immigrants to reconcile their cultural heritage with American life. The struggles faced by Filipinx Americans vary from the experiences of Indian Americans (not to be confused with Native Americans). Additionally, Native Hawaiians, who are grouped into the category of AAPI as Pacific Islanders, still experience generations of historical trauma from the colonialization of the islands of Hawaii.

AAPI communities in the United States (U.S.) have had to struggle to reconcile their identities and challenges while recognizing the privilege that comes with the "model minority" myth. The "model minority" myth is a microaggression known as "ascription of intelligence," where one assigns intelligence to a person of color on the basis of their race. It's important to recognize how the "model minority" myth plays into complex systems that hold up white supremacy by allowing Asian Americans to benefit from systems of power at the expense of the wellbeing of Black people.

Other race-based issues that impact the mental health of AAPIs include but are not limited to:

The Perpetual Foreigner stereotype: This occurs when someone is assumed to be foreign-born or doesn't speak English. Some questions that perpetuate this stereotype include "Where are you from?" "Where are you really from?" and "How do you say (or write) _____ in your language?" This increases feelings of isolation and loneliness by being presumed as an outsider based on your race.

Trauma: First-generation immigrants - particularly from conflict areas – may experience trauma. This trauma can be passed down to their children and subsequent generations. AAPIs with a long family history in the US may have compounded trauma due to racial discrimination.

Stigma: Asian Americans are the least likely racial group to take actions on their mental health and are [more likely to reach out to friends and family](#). However, not all AAPIs have a strong support system and can have difficulty expressing their challenges due to guilt, shame, or even not being able to speak the same language.

Expectations: Criticizing appearance, comparing successes, not being _____ enough. Children of first-generation immigrants are particularly expected to serve as cultural and linguistic liaisons for older family members in addition to serving as a caregiver for younger children and attending school.

Religious intolerance: Religious minorities, for example Muslims and Sikhs, are often discriminated against for their appearance and beliefs, bearing the brunt of racial profiling due to Islamophobia (It's important to note that Sikhism is not the same as Islam). There is also the assumption of criminal status where someone is presumed to be dangerous, criminal, or deviant based on their race.

Demographics/Societal Issues

- There are over [20 million people in the United States who identify as Asian/Pacific Islander](#) (6.1 percent of the overall population).
- [As of 2018 there were 5.2 million people of Chinese descent, 4.5 million of \(Asian\) Indian descent, and 4.1 million of Filipino descent, followed by 2.2 million of Vietnamese descent, 1.9 million of Korean descent, and 1.5 million of Japanese descent.](#)
- Over [420,000 \(2.5 percent\) of Asian Americans](#) and more than [76,000 \(7.6 percent\) Native Hawaiian and Pacific Islanders](#) are veterans.
- Nearly [54 percent of Asian Americans](#) and [24.4 percent of Native Hawaiian and Pacific Islanders](#) have at a bachelor's degree or higher.
- In 2018, [10.8 percent of Asian Americans lived at or below poverty level, and 6.2 percent were without health insurance.](#) Hawaiian Natives and Pacific Islanders fared slightly worse with [14.8 percent at or below poverty level, and 8.6 percent without health insurance.](#)

Attitudes

Knowledge of the mental health needs and attitudes of Asian Americans/Pacific Islanders regarding mental illness is limited. Few epidemiological studies have included Asian Americans or people whose English is limited.

The National Asian Women's Health Organization (NAWHO) sponsored a study, [Breaking the Silence: A Study of Depression Among Asian American Women](#), that found:

- Conflicting cultural values are impacting Asian-American women's sense of control over their life decisions
- Feeling responsible, yet unable to meet biased and unrealistic standards set by families and society, contributes to low self-esteem among Asian-American women
- Asian-American women witness depression in their families, but have learned from their Asian cultures to maintain silence on the subject
- Asian-American women fear stigma for themselves, but more so for their families

Prevalence

According to [SAMHSA's National Survey on Drug Use and Health](#), mental health issues are on the rise for Asian American/Pacific Islander/Native Hawaiian young adults.

- Serious mental illness (SMI) rose from 2.9 percent (47,000) to 5.6 percent (136,000) in AAPI people ages 18-25 between 2008 and 2018.
- Major depressive episodes increased from 10 percent-13.6 percent in AAPI youth ages 12-17, 8.9 percent to 10.1 percent in young adults 18-25, and 3.2 percent to 5 percent in the 26-49 age range between 2015 and 2018.
- Suicidal thoughts, plans, and attempts are also rising among AAPI young adults. While still lower than the overall U.S. population aged 18-25, 8.1 percent (196,000) of AAPI 18-25 year-olds had serious thoughts of suicide in 2018, compared to 7.7 percent (122,000) in 2008. 2.2 percent (52,000) made a plan in 2018, compared to 1.8 percent (29,000) in 2008, and 7,000 more AAPI young adults made an attempt in 2018, compared to 2008.
- Binge drinking, smoking (cigarettes and marijuana), illicit drug use and prescription pain reliever misuse are more frequent among AAPI adults with mental illnesses.

Treatment Issues

- Language barriers make it difficult for Asian Americans to access mental health services. Discussing mental health concerns is considered taboo in many Asian cultures. Because of this, [Asian Americans tend to dismiss, deny, or neglect their symptoms](#).
- Lack of awareness of the resources and services that are available, as well as the stigma surrounding mental health issues, are the [biggest deterrents in seeking professional help](#).

- Most young Asian Americans tend to seek out support from personal networks such as close friends, family members, and religious community members [rather than seek professional help for their mental health concerns](#).

Access/Insurance

- Historically, AAPIs have had challenges in accessing health care and insurance.
- 7.4 percent of Asian Americans and 9.4 percent of Pacific Islanders [do not have health insurance](#).
- Language barriers may contribute to difficulty finding healthcare and other services. Overall, 32.6 percent of Asian Americans [do not speak English fluently](#).
- AAPIs adults are the racial group [least likely to seek mental health services](#) - 3 times less likely than their white counterparts.
- Of AAPI adults with a mental illness, [73.1 percent did not receive treatment](#) compared to 56.7 percent of the overall population.

Mental Health Resources for Asian American and Pacific Islander Communities

- [Asian American Psychological Association \(AAPA\)](#): dedicated to advancing the mental health and wellbeing of Asian American communities through research, professional practice, education, and policy
 - [Fact Sheets](#)
 - [Bullying Awareness Campaign](#)
 - [LGBTQ+ Resources](#)
- [Asian & Pacific Islander American Health Forum](#): focused on improving the health of Asian Americans, Native Hawaiians, and Pacific Islanders
 - [Community Care Package](#): COVID focused weekly digital “community care package” includes inspirational stories, resources in a variety of languages, tools for adjusting and managing mental health, and platform to share your story/connect with others
- [Asian American Health Initiative](#): part of the Montgomery County Dept of Health & Human Services, but they have a lot of general Asian American resources
 - [Online Photo Novels](#)
- [National Asian American Pacific Islander Mental Health Association](#)
 - [Directory of Mental Health Service Providers for Asian Americans, Native Hawaiians, and Pacific Islanders \(by state\)](#)
 - [COVID-19 Resources](#)
 - [Combating Racism Resources](#)
- [southasiantherapists.org](#): directory of South Asian therapists, including therapists of Indian, Pakistani, Bangladeshi, Sri Lankan, Afghanistani and Nepali heritage.
- [Asian Mental Health Collective](#): raises awareness about the importance of mental health care, promotes emotional well-being, and challenges the stigma concerning

mental illness amongst
Asian communities globally.

- [Asians for Mental Health Directory](#)
- [Asian Americans with Disabilities Resource Guide](#)

Partnerships and Resources

[Mental Health Screening Resources](#)

[Asian Women for Health](#)

[National Asian American Pacific Islander Mental Health Association](#)

Topic/Source: Mental Health First Aid - National Council for Mental Wellbeing

Information: [Mental Health First Aid \(MHFA\)](#) is an evidence-based training program administered by the National Council for Mental Wellbeing that teaches you how to identify, understand and respond to signs of mental health and substance use challenges.

The training gives you the skills to reach out and provide initial help and support to someone who may be developing a mental health or substance use challenge or experiencing a crisis. More than 2.6 million people across the United States have been trained in MHFA by a dedicated base of more than 15,000 Instructors.

MentalHealthFirstAid.org

Learn more about Mental Health First Aid and find a course near you.

[about MHFA](#) [Learn More](#)

Programs

- Adult
- Youth
- Teen
- At Work
- Public Safety
- Fire/EMS
- Veterans
- Older Adults
- Rural
- Higher Education

What It Covers

- Common signs and symptoms of mental health challenges.
- Common signs and symptoms of substance use challenges.
- How to interact with a person in crisis.
- How to connect a person with help.
- Expanded content on trauma, substance use and self-care.

Three Ways to Learn

- In-person – Learners will receive their training via an Instructor-led, in-person course.
- Blended – Learners complete a self-paced online course and participate in an Instructor-led training. This Instructor-led Training can be:
 - A video conference.
 - An in-person class.

Topic/Source : Mental Health First Aid

Information: Identify. Understand. Respond. Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues. Courses Let's make Mental Health First Aid as common as CPR. Get Trained Instructors Instructors are the backbone of Mental Health First Aid.

Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues.

Topic/Source: NAMI Homefront

Information: **Introducing NAMI Homefront Mental Health Resources for Military Service Members, Veterans and Their Families!**

We understand attending an in-person class can be difficult for busy individuals and families. NAMI is excited to announce the launch of our free online suite of resources for caregivers, family members, and military service members and veterans designed to increase understanding, communication, wellness and advocacy skills.

Accessible through computers or mobile devices, **NAMI Homefront Mental Health Resources** is available 24/7 and includes information about:

- Mental health conditions
- Treatment options
- Approaches to increase overall wellness
- Tips for self-care and managing stress
- Communication strategies
- Transitioning from military to civilian life
- Links to helpful organizations and crisis services

About NAMI Homefront

NAMI Homefront is a free, 6-session educational program for families, caregivers and friends of military service members and veterans with mental health conditions.

Based on the nationally recognized [NAMI Family-to-Family](#) program, NAMI Homefront is designed to address the unique needs of family, caregivers and friends of those who have served or are currently serving our country. The program is taught by trained family members of service members/veterans with mental health conditions.

What You'll Gain

Recovery is a journey and there is hope for all people affected by mental health conditions. This in-person experience provides the opportunity for mutual support and shared positive impact. You will experience compassion and reinforcement from people who relate to your experiences. Through your participation, you have the opportunity to help others grow.

NAMI Homefront teaches you how to:

- Learn to care for yourself, including managing your stress
- Support your family member with compassion

- Identify and access federal, state and local services
- Stay informed on the latest research and information on mental health, including posttraumatic stress disorder, traumatic brain injury, anxiety, depression and substance use
- Understand current treatments and evidence-based therapies
- Navigate the challenges and impact of mental health conditions on the entire family
- Manage a crisis, solve problems and communicate effectively

What People are Saying

"This training has been really helpful for me to process much of my own emotions. I am at a point now that being able to stop and look back at exactly how far we've come and being reminded of the painful past but positive changes was very empowering. Sometimes when we get stuck in the routine of moving on we lose sight of how far we've come."

"I realized I saw signs and symptoms of PTSD but did not know how to handle my loved one — I know better how to handle situations."

"You realize that he will never be the same having been through war. I learned how to treat him more as an adult than as a hurt child." — Mother of a Veteran after graduating from a NAMI Family-to-Family class held at a VA clinic

"We are still friends with everyone that was in the class. There's always an open ear and an open heart and a shoulder to cry on if you need it." — Father of a Veteran after graduating from a NAMI Family-to-Family class held at a VA hospital

Sign Up for a Class

[Find the NAMI Homefront nearest to you.](#) If a class isn't available, [contact your local NAMI Affiliate](#) about starting one.

Thanks to [our partners](#) for making this program possible.

Source/Topic: **National Asian American Pacific Islander Mental Health Association (NAAPIMHA) - Website**

Information: NAAPIMHA strives to raise awareness of the role of mental health in an individual's health and well-being, especially in Asian American, Native Hawaiian, and Pacific Islander communities throughout the country.

The mission of the National Asian American Pacific Islander Mental Health Association (NAAPIMHA) is to promote the mental health and well being of the Asian American, Native Hawaiian, and Pacific Islander communities. NAAPIMHA strives to raise awareness of the role of mental health in an individual's health and well-being, especially in Asian American, Native Hawaiian, and Pacific Islander communities throughout the country

Trainings

[LEARN MORE](#)

[LEARN MORE](#)

Learn how you can get involved in supporting mental health for AANHPI communities in your state and across the nation.

[LEARN MORE](#)

Watch webinars that NAAPIMHA has participated in or organized

[LEARN MORE](#)

Learn about NAAPIMHA's most recent project Asians*inFocus

[LEARN MORE](#)

Learn more about the National Asian American Pacific Islander Empowerment
Network

[LEARN MORE](#)

Source/Topic: **National Institute of Mental Health - Ask Suicide-Screening
Questions (ASQ) Toolkit**

Information: The Ask Suicide-Screening Questions (ASQ) tool is a brief validated tool for use among both youth and adults. The Joint Commission approves the use of the ASQ for all ages. The ASQ toolkit consists of youth and adult versions as some of the materials take into account developmental considerations.

[Suicide Risk Screening Training: How to Manage Patients at Risk for Suicide](#) 

This video is provided for general informational purposes only and does not constitute an endorsement by NIMH.

[Webinar for Nurses - How to Use the ASQ to Detect Patients at Risk for Suicide](#) 

This video is provided for general informational purposes only and does not constitute an endorsement by NIMH.

[Universal Screening in the Emergency Department](#)

This video is provided for general informational purposes only and does not constitute an endorsement by NIMH.

[Suicide Risk Screening Training for Nurses: How to Use the ASQ to Detect Patients at Risk for Suicide](#)

This video is provided for general informational purposes only and does not constitute an endorsement by NIMH.

The Ask Suicide-Screening Questions (ASQ) tool is a brief validated tool for use among both youth and adults. The Joint Commission approves the use of the ASQ for all ages. Additional materials to help with suicide risk screening implementation are available in The Ask Suicide-Screening Questions (ASQ) Toolkit, a free resource for use in medical settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care) [that can help providers successfully identify individuals at risk for suicide](#). The ASQ toolkit consists of youth and adult versions as some of the materials take into account developmental considerations.

The ASQ is a set of four screening questions that takes 20 seconds to administer. In [an NIMH study](#), a “yes” response to one or more of the four questions identified 97% of youth (aged 10 to 21 years) at risk for suicide. Led by the NIMH, a multisite research study has now demonstrated that the ASQ is also a valid screening tool for adult medical patients. By enabling early identification and assessment of medical patients at high risk for suicide, the ASQ toolkit can play a key role in suicide prevention.

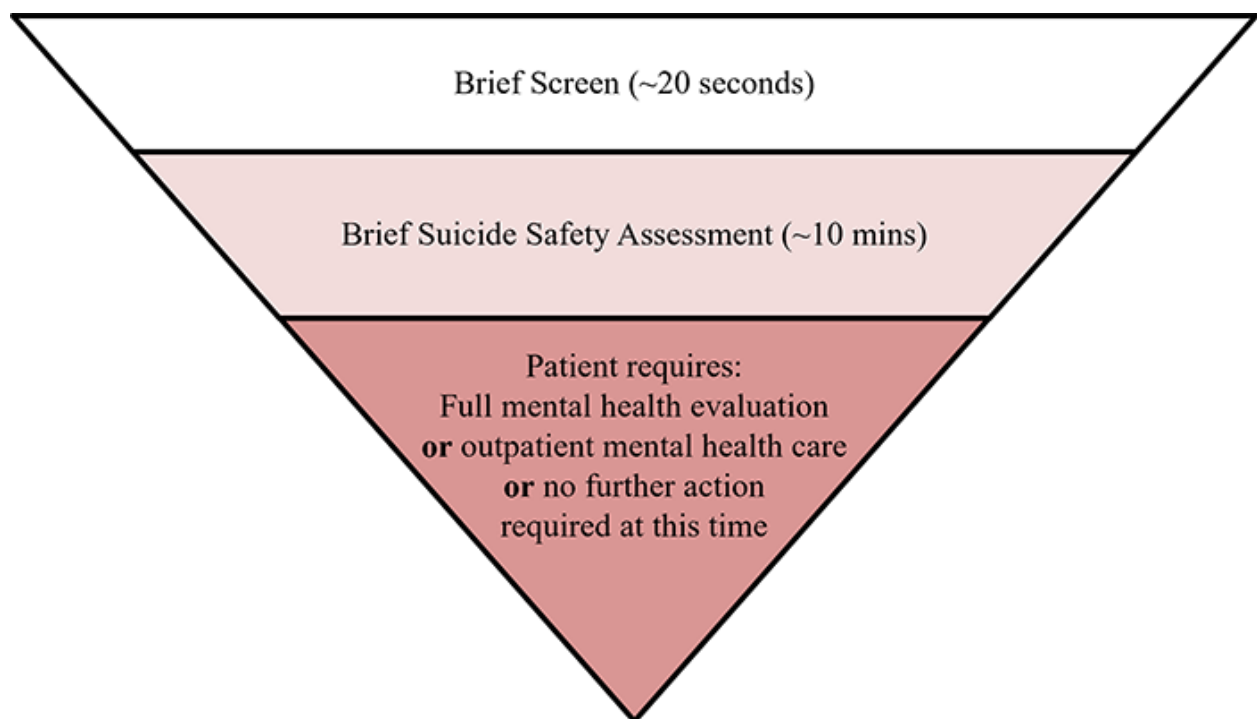
Background

[Suicide](#) is a global public health problem and a leading cause of death across age groups worldwide. Suicide is also a major public health concern in the United States, with suicide ranking as the second leading cause of death among young people ages 10-24. According to the Centers for Disease Control and Prevention (CDC), [more than 47,000 individuals killed themselves in 2019](#). Even more common than death by suicide are suicide attempts and suicidal thoughts.

Screening for Suicide Risk

Early detection is a critical prevention strategy. The majority of people who die by suicide visit a healthcare provider within months before their death. This represents a tremendous opportunity to identify those at risk and connect them with mental health resources. Yet, most healthcare settings do not screen for suicide risk. In February 2016, the Joint Commission, the accrediting organization for health care programs in hospitals throughout the United States, issued a Sentinel Event Alert recommending that all medical patients in all medical settings (inpatient hospital units, outpatient practices, emergency departments) be screened for suicide risk. Using valid suicide risk screening tools that have been tested in the medical setting and with youth, will help clinicians accurately detect who is at risk and who needs further intervention.

Using an evidence-based clinical pathway can guide the process of identifying patients at risk and managing those who screen positive. Having a pathway to follow will save time and resources when responding to a positive screen. The ASQ Toolkit has several suicide risk clinical pathways that are built on the following foundation:



About the Tool

Beginning in 2008, NIMH led a multisite study to develop and validate a suicide risk screening tool for youth in the medical setting called the Ask Suicide-Screening Questions (ASQ). In 2014 another multisite research study was launched to validate the ASQ among adults. The ASQ consists of four yes/no questions and takes only 20 seconds to administer. Screening identifies individuals that require further mental health/suicide safety assessment.

For medical settings, one of the biggest barriers to screening is how to effectively and efficiently manage the patients that screen positive. Prior to screening for suicide risk, each setting will

need to have a plan in place to manage patients that screen positive. The ASQ Toolkit was developed to assist with this management plan and to aid implementation of suicide risk screening and provide tools for the management of patients who are found to be at risk.

Using the Toolkit

The Ask Suicide-Screening Questions (ASQ) toolkit is designed to screen medical patients ages 8 years and above for risk of suicide. As there are no tools validated for use in kids under the age of 8 years, if suicide risk is suspected in younger children a full mental health evaluation is recommended instead of screening. The ASQ is free of charge and available in multiple languages.

For screening youth, it is recommended that screening be conducted without the parent/guardian present. Refer to the nursing script for guidance on requesting that the parent/guardian leave the room during screening. If the parent/guardian refuses to leave or the child insists that they stay, conduct the screening with the parent/guardian present. For all patients, any other visitors in the room should be asked to leave the room during screening.

What happens if patients screen positive?

Patients who screen positive for suicide risk on the ASQ should receive a **brief** suicide safety assessment (BSSA) conducted by a trained clinician (e.g., social worker, nurse practitioner, physician assistant, physician, or other mental health clinicians) to determine if a more comprehensive mental health evaluation is needed. The BSSA should be brief and guides what happens next in each setting. Any patient that screens positive, regardless of disposition, should be given the [Patient Resource List](#).

The ASQ toolkit is organized by the medical setting in which it will be used: emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics. For questions regarding toolkit materials or implementing suicide risk screening, please contact: Lisa Horowitz, PhD, MPH at horowitzl@mail.nih.gov or Debbie Snyder, MSW at DeborahSnyder@mail.nih.gov.

Youth

[Emergency Department \(ED/ER\)](#)

[Inpatient Medical/Surgical Unit](#)

[Outpatient Primary Care/Specialty Clinics](#)

Adults

[Emergency Department \(ED/ER\)](#)

[Inpatient Medical/Surgical Unit](#)

[Outpatient Primary Care/Specialty Clinics](#)

***Note: The following materials remain the same across all medical settings. These materials can be used in other settings with youth (e.g. school nursing office, juvenile detention centers).**

- ASQ Information Sheet ([PDF](#) | [HTML](#))
 - ASQ Tool ([PDF](#) | [HTML](#))
 - ASQ in other languages
 - Patient Resource List ([PDF](#) | [HTML](#))
 - Educational Videos ([PDF](#) | [HTML](#))
 - PHQ-A+ASQ ([PDF](#) | [HTML](#))
 - PHQ-9+ASQ ([PDF](#) | [HTML](#))
-
- Arabic ([PDF](#))
 - Catalan ([PDF](#))
 - Chinese ([PDF](#))
 - Dutch ([PDF](#))
 - Filipino ([PDF](#))
 - French ([PDF](#))
 - Hebrew ([PDF](#))
 - Italian ([PDF](#))
 - Japanese ([PDF](#))
 - Korean ([PDF](#))
 - Portuguese ([PDF](#))
 - European Portuguese ([PDF](#))
 - Russian ([PDF](#))
 - Somali ([PDF](#))
 - Spanish ([PDF](#))
 - Vietnamese ([PDF](#))

Suicide Prevention Resources

[National Suicide Prevention Lifeline](#)

1-800-273-TALK (8255)

Spanish/español: 1-888-628-9454

[Crisis Text Line](#)

Text HOME to 741-741

[Suicide Prevention Resource Center](#)

[National Institute of Mental Health](#)

[Substance Abuse and Mental Health Services Administration](#)

Topic/Source: NIMH

Information: The National Institute of Mental Health (NIMH) is the lead federal agency for research on mental disorders. Transforming the understanding and treatment of mental illnesses.

Health Topics

- [Anxiety Disorders](#)
- [Attention-Deficit/Hyperactivity Disorder](#)
- [Autism Spectrum Disorder](#)
- [Bipolar Disorder](#)
- [Borderline Personality Disorder](#)
- [Depression](#)
- [Eating Disorders](#)
- [Obsessive-Compulsive Disorder](#)
- [Post-Traumatic Stress Disorder](#)
- [Schizophrenia](#)
- [Suicide Prevention](#)
- [More Topics](#)

Topic/Source: NQAPIA

Information:

WHO WE ARE

Founded in 2005, the National Queer Asian Pacific Islander Alliance empowers LGBTQ+ Asians and Pacific Islanders through community capacity building, policy advocacy, and resource development.

[LEARN MORE](#)

WHAT WE DO

We build the capacity of local, grassroots, and affinity-based LGBTQ+API groups; advance an intersectional justice and equity agenda; and ensure LGBTQ+API representation everywhere

The National Queer Asian Pacific Islander Alliance empowers LGBTQ+ Asians and Pacific Islanders through community capacity building, policy advocacy, and resource development.

Topic/Source: Project Lotus

We are Project Lotus

We're Asian-Americans.

We're tired of discrimination and prejudice.

We're tired of mental health stigma.

We're tired of the model minority myth.

[Learn more about why we fight.](#)

3x

**LESS LIKELY TO SEEK HELP COMPARED TO OTHER
AMERICANS**

19%

**OF ASIAN-AMERICAN STUDENTS CONTEMPLATE
SUICIDE**

25%

OF ALL ASIAN-AMERICANS FACE MENTAL *DISTRESS*

Through educating and empowering today's Asian-American communities, Project Lotus advances the movement of Asian-Americans blossoming and addressing mental health stigma, shame, and overall perception and care of mental health.

FROM THE BLOSSOMS

Stories and Voices

The smallest voice can have an impact. Read our community's mental health stories, articles, and voices. Together, we can empower Asian-Americans to share, discuss, and highlight the real perspectives of mental health that are taboo and never acknowledged.

Topic/Source: South Asian Therapists - The first global directory of South Asian Therapists

Information:

We are the largest South Asian mental health community in the world. Our directory has hundreds of South Asian therapists, including therapists of Indian, Pakistani, Bangladeshi, Sri Lankan, Afghani and Nepali heritage. Here you can find culturally competent South Asian mental health professionals to help you get the support you're looking for.

Find a South Asian

Therapist Near You

[Search the directory](#)

Topic/Source: subtle asian mental health | Facebook

Information: <https://www.facebook.com/groups/subtleasianmentalhealth/?link=group>

Strives to reach as many Asians struggling with mental health, cultural issues, intergenerational trauma, and associated problems as possible.

Thank you for becoming a member of our community! We hope that you find this to be an open, safe, inclusive, and non-judgmental space to share your thoughts and feelings about anything, especially... Facebook

Topic/Source: **Asian Pacific Institute on Gender-Based Violence - Domestic Violence, Sexual Violence, and Human Trafficking in Native Hawaiian Communities - Report**

Information:

Fact Sheet: Domestic Violence, Sexual Violence, and Human

Trafficking in Native Hawaiian Communities February 2020

1. Domestic Violence

The Behavioral Risk Factor Surveillance System (BRFSS) is a random telephone health and health risks

survey of adult men and women across all 50 states. A synthesis of 2018 BRFSS data for the state of

Hawai'i suggested that more Native Hawaiian women experience intimate partner violence (IPV) than

non-Hawaiian women, beginning early in their lives:

20.6% of Native Hawaiian women between 18 to 29 years old report experiencing IPV, compared

to 13.3% of non-Hawaiian women of the same age range.

19.6% of Native Hawaiian women between 30 to 44 years old report experiencing IPV, compared

to 13.3% of non-Hawaiian women of the same age range

21.0% of Native Hawaiian women between 45 and 59 years old report experiencing IPV, compared

to 12.60% of non-Hawaiian women Haumea: Transforming the Health of Native Hawaiian Women and Empowering Wahine Well-Being. Honolulu, HI: Office of Hawaiian Affairs; 2018. The Pregnancy Risk Assessment Monitoring System (PRAMS) annually assesses roughly 1200-1500 women in Hawai'i who had recently given birth on a range of health indicators, including experience with abuse. For the years 2012-2015, PRAMS data found: 5.3% of Native Hawaiian recent mothers reported experiencing physical intimate partner violence twelve months before or during the current pregnancy, compared to 3.6% of Filipino mothers, 2.5% of Japanese mothers, 2.5% of Other Pacific Islander mothers, and 5.8% of mothers of other races. Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS): State of Hawaii PRAMS Report 2009-2015. Honolulu, HI: Hawaii State Department of Health, Family Health Services Division; 2019. Based on interviews and a focus group involving ten Native Hawaiian women residing in a predominantly Native Hawaiian community: Intimate partner violence is seen as a "family matter" kept within the immediate family. Most women found it difficult to disclose violence to a health provider unless there was a trusting relationship with the provider. The perception that both abuse and strategies to address it "start at home" was prevalent, and family can serve as both a source of risk and of protection.

Fact Sheet: Abuse in Native Hawaiian Communities | 2

Participants expressed that formal systems of Western care providers such as shelters and support

groups alone are not enough to address the historical trauma of colonization.

Oheha MF, Magnussen L, & Shoultz J. The Voices of Native Hawaiian Women: Perceptions, Responses and Needs

Regarding Intimate Partner Violence. California Journal of Health Promotion. 2010; 8(1): 72-81.

2. Dating and Sexual Violence Among Native Hawaiian Youth

The Youth Risk Behavior Survey (YRBS) monitors health risk behaviors in surveys of public high school

and middle school students in Hawai'i. In 2015 and 2017, the YRBS found:

17.5% of Native Hawaiian middle schoolers reported they had been physically abused by someone they were dating or going out with in the past 12 months, compared to 21.6% of Japanese, 20.1% of other Pacific Islander, 17.5% of Caucasian, and 15.4% of Filipino respondents. 3.8% of Native Hawaiian middle schoolers reported that they had ever been physically forced to have sexual intercourse when they didn't want to, compared to 5.1% of Black, 5.0% of other Pacific Islander, 3.0% of Filipino, 1.9% of Japanese, 1.8% of Caucasian, and 1.7% of other Asian middle schoolers.

9.8% of Native Hawaiian high schoolers reported that they had been physically abused by someone they were dating or going out with in the past 12 months, compared to 10.5% of Filipino, 9.5% of Caucasian, 8.0% of other Pacific Islander, 7.9% of other Asian, and 5.4% of Japanese high schoolers.

13.9% of Native Hawaiian high schoolers reported that they had been forced to do sexual things by someone they were dating or going out with in the past 12 months, compared to 15.3% of Filipino, 10.3% of other Pacific Islander, 7.7% of Japanese, and 6.8% of Caucasian high schoolers.

9.7% of Native Hawaiian high schoolers reported that they had ever been physically forced to have sexual intercourse when they did not want to, compared to 11.1% of Black, 8.9% of other Pacific Islander, 8.0% of Filipino, 7.6% of other Asian, 7.5% of Caucasian, and 5.9% of Japanese high schoolers.

Youth Risk Behavior Survey data for the years 2015 and 2017. Data retrieved January 2020 from the Build Your Own Report tool available at http://ibis.hhdw.org/ibisph-view/query/selection/yrbs/_YRBSSelection.html A 2017 online climate survey across all 10 University of Hawai'i (UH) statewide campuses and UH community colleges collected responses from 1,507 Native Hawaiian or Part Native Hawaiian students:

8.1% of Native Hawaiian students reported experiencing sexual harassment since being enrolled at

UH, compared to 12.8% of Caucasian, 9.2% of Japanese, and 6.1% of Filipino students.

9.5% of Native Hawaiian students reported experiencing stalking since being enrolled at UH,

compared to 11.0% of Japanese, 9.3% of Caucasian, and 8.0% of Filipino students.

20.4% of Native Hawaiian students reported experiencing dating and domestic violence since

being enrolled at UH, compared to 18.4% of Caucasian, 18.1% of Japanese, and 16.8% of Filipino

students.

Fact Sheet: Abuse in Native Hawaiian Communities | 3

5.3% of Native Hawaiian students reported experiencing nonconsensual sexual contact since being

enrolled at UH, compared to 8.5% of Caucasian, 5.2% of Japanese, and 3.3% of Filipino students. Loui PM, Fisher BS, Martin SL, Feng T. Report on University of Hawai'i

Student Campus Climate Survey on Sexual

Harassment and Gender-Based Violence. Honolulu, HI: OmniTrak Group, Inc.; 2017. In an online survey of 181,752 undergraduate, graduate, and professional students across 33 American

universities on campus sexual assault and misconduct:

Among native Hawaiians or Other Pacific Islanders (NHOPI), 9.8% of women reported

experiencing penetration or sexual touching without voluntary agreement (rates of victimization

for NHOPI men and TGQN* students not reported). * Report authors use "TGQN" to refer to students who listed their gender identity as: transgender woman, transgender

man, nonbinary/genderqueer, gender questioning, or gender not listed Cantor D, Fisher B, Chibnall S, Harps S, & Townsend R. Report on the AAU Campus Climate Survey on Sexual Assault and Misconduct. Rockville, MA: Prepared by Westat for The Association of American Universities; 2019.

3. Human Trafficking

In interviews with 22 individuals in Hawai'i, of which 15 were female survivors of sex trafficking and 7

were parents, close family members, or guardians of a child who was a victim of sex trafficking:

77.3% of sex trafficking victims were Native Hawaiian.

72.2% of victims of all races/ethnicities were first trafficked by a family member and 16.6% by a drug dealer. Roe-Sepowitz D & Jabola-Carolus K. Sex Trafficking in Hawai'i: The Stories of Survivors. Arizona State University, Office of Sex Trafficking Intervention Research and the Hawai'i State Commission on the Status of Women; 2019. In a study of individuals (12+ years old) from five Hawaiian islands receiving services from a social services agency, 100 victims of sex trafficking were identified: 64% of victims identified as being all or some Native Hawaiian (11.3% were Native Hawaiian and 52.6% part Native Hawaiian).*

25.8% of victims of all races/ethnicities were trafficked by a family member, 24.7% were trafficked by a friend, and 22.7% were trafficked by a boyfriend.

Of the 23 victims who had been under 18 when they were sex trafficked, 13% were Hawaiian and 47.8% were part Native Hawaiian. * Given that full or part Native Hawaiians made up 46% of all 363 participants surveyed in the study, they are disproportionately overrepresented among sex trafficking victims Roe-Sepowitz D & Jabola-Carolus K. Research Report: Sex Trafficking in Hawai'i: Part III. Sex Trafficking Experiences Across Hawai'i. Arizona State University, Office of Sex Trafficking Intervention Research; 2020.

Fact Sheet: Abuse in Native Hawaiian Communities | 4

4. Dynamics in Lesbian Relationships

In interviews with 24 Asian, Pacific Islander, and Native Hawaiian (APINH) lesbians who had experience with sexual or domestic violence in a woman-to-woman relationship, selected from Seattle, Chicago, New York City, and Hilo through targeted recruitment and snowball sampling: Respondents expressed that their small, tightknit communities can be sources of strength, as well as limit survivor's ability to leave abusive relationships (eg. when the abuser is more well liked).

Participants expressed that the intimacy and fulfillment found in relationships where both partners were women and APINH (after previous relationships with only men or non-APINH women) could cause them to rationalize or tolerate higher levels of abuse. Kanuha VK. "Relationships So Loving and So Hurtful": The Constructed Duality of Sexual and Racial/Ethnic Intimacy in the

Context of Violence in Asian and Pacific Islander Lesbian and Queer Women's Relationships. Violence Against Women. 2013; 19(9): 1175-1196.

Resource from the Asian Pacific Institute on Gender-Based Violence: Battered Mothers Involved with Child Protective Services: Learning from Immigrant, Refugee and Indigenous Women's Experiences (2010): This report shares the voices of immigrant, refugee and indigenous women who are survivors of intimate partner abuse and who have been involved with child protective services, in order to inform and facilitate the development of policies, practices and interventions that will more effectively address the physical, emotional and spiritual health of individuals, families and communities. For questions, information, publications, training requests and technical assistance: www.api-gbv.org | 415-568-3315 | info@api-gbv.org This publication was funded by Grant #90EV0430 from the Administration on Children, Youth and Families, Family and Youth Services Bureau, U.S. Department of Health and Human Services. Its contents are solely the responsibility of the author(s) and do not represent the official views of the U.S. Department of Health and Human Services.

Topic/Source: Asian Women's Shelter

Information:

Resource for domestic violence support for residents in the California San Francisco Bay Area

DIRECT SERVICES

Our direct services include our nationally recognized shelter program, language advocacy program, crisis line, case management, and programs in support of underserved communities such as queer Asian survivors and trafficked survivors.

- Shelter Program
- Language Access
- DV and Trafficking Crisis Line & FGM/C Support Line
- Case Management
- Queer Asian Women + Transgender Support
- Anti-Trafficking Program

- Ngoc Thi Pham Fund

To eliminate domestic violence by promoting the social, economic, and political self-determination of women and all survivors of violence and oppression.

Call us.

we listen.

24-Hour Crisis Line:

1-877-751-0880

Health and safety for all.

Asian Women's Shelter is working hard throughout these ever-changing times, and supporting our communities through the ups and downs of COVID, the community ruptures and heartbreak caused by gun violence, and the devastation of anti-Asian hate violence . We are here for you and your loved ones and community members. We're here to support allied as well as culturally specific efforts to increase health, safety, and life for Black and African American survivors and communities too. Read about AWS's commitment [here](#).

Inside the shelter, we are working hard to keep our emergency refuge a place that is safe from intimate partner violence, COVID-19, and state sanctioned violence—for everyone who lives and works there. At any time, you can support survivors at AWS by making a donation. [Cash donations](#) will directly support our mission and clients. You can also click [here](#) to make an in-kind donation. From all of us at AWS, thank you!

Topic/Source: **Asian/Pacific Islander Domestic Violence Resource Project (DVRP) - Website**

Information: Train A/PI community leaders to recognize signs of domestic violence and provide appropriate tools to respond effectively to the needs of survivors in their community

- Provide cultural humility trainings to domestic violence program staff to build skills in cultural humility
- Offer technical assistance and consultation on working with immigrant survivors or A/PI survivors
- Provide confidential assistance and referral services to survivors

Topic/Source: **Domestic Violence Action Center - Resource in Hawaii**

Information: **Ho‘oikaika ‘Ohana (HO‘O)** serves Native Hawaiian families who have suffered the harm of domestic violence. Over a 9-month period, survivors, their *keiki* (children) and *‘ohana* attend weekly group sessions. Together, they mend relationships through *mo‘olelo* (talkstory) and cultural practices, such as *lei*-making, planting and pounding *kalo* (taro), chanting and dancing hula

Ho‘oikaika ‘Ohana (HO‘O) serves Native Hawaiian families who have suffered the harm of domestic violence. Over a 9-month period, survivors, their *keiki* (children) and *‘ohana* attend weekly group sessions. Together, they mend relationships through *mo‘olelo* (talkstory) and cultural practices, such as *lei*-making, planting and pounding *kalo* (taro), chanting and dancing hula.

HO‘O was developed in response to the unfortunate reality that Native Hawaiians are the highest ethnic group receiving DVAC legal and advocacy services. The program honors the need for programs and services that are built on Native Hawaiian values and practices, to better support survivors and their families towards healing and rebuilding. The program cultivates a survivor-defined environment in which, aided by staff, they can share, encourage, and heal with one another towards peace.

Our program's goal is captured in our name:

Ho‘oikaika ‘Ohana.

Ho‘o means to strive toward...

Ikaika means strong...

‘Ohana means family...

We are striving to help strengthen families toward peace.

PARTICIPATING IN HO‘O

Native Hawaiian survivors who participate in the HO‘O program have generally moved beyond their crisis. They are ready to focus on healing and promoting their long-term health, stability, personal growth, cultural connections, and family harmony.

Groups are held across Oahu, in safe and peaceful locations.

If you or someone you know could benefit from the HO'O program, please contact us.

ABOUT THE HO'O CURRICULUM

The HO'O Curriculum was developed by a *Hui* (group) of community leaders, content experts, cultural navigators, and survivors, to be in aligned with community and family safety. The program combines the Complex Trauma Model of Dr. Carole Warshaw with traditional Hawaiian values that reflect harmony, balance, healing and positive parenting.



THE THREE PHASES OF HO'O

The program divided into 3 phases, each named after the colors of the *lehua* (blossoms) of the Native *ohi'a* tree. As the *ohi'a* tree is the first to emerge after a lava flow, it represents resilience and the strong cultural connection Native Hawaiians have to their *'aina* (land).

Phase 1, *Lehua 'apane* (Red *Lehua* blossom): Using tools such as the *Lōkahi* Wheel and a Moon Phase Journal, survivors build relationships and explore shared goals such as personal strength, understanding, and equality.

Phase 2, *Lehua mamo* (Yellow *Lehua* blossom): Survivors participate in weekly meetings with members of their extended *'ohana* to deepen understanding and healing. Survivors and their *'ohana* have the opportunity to heal in the presence of one another, and gain skills for the way forward when new challenges arise. The survivors and their *'ohana* also engage in activities consistent with the cultural identity of the family.

Phase 3, *Lehua mamo 'o 'a 'alani* (Orange-red *Lehua* blossom): Survivors and their *keiki* work together to heal and re-establish strong communication, in addition to continuing with group and *'ohana* meetings. In this phase, survivors and their children come together to make *na mea Hawai'i* (Hawaiian things) like *lauhala* (pandanus leaf) bracelets, Hawaiian quilts, *lei hulu* (feather leis), and *haku lei* (braided, woven leis). By engaging in creative activities together, survivors and their *keiki* have safe opportunities to make decisions that have positive results and outcomes.

Once survivors have completed the HO'O program, they participate in a *ho'ike* (celebration) in honor of their strength, dedication and perseverance. Survivors' *keiki* and *'ohana*, Hui members, HO'O staff and DVAC management attend the celebration. During this powerful gathering, survivors share personal statements of achievement and celebrate with food, flowers, traditional dress, music and dance.

Ho'oikaika 'Ohana is supported by from the U.S. Department of Health and Human Services, Family and Youth Services Bureau, Family Violence Prevention and Services and the Atherton Family Foundation.

Topic/Source: **Ho'ōla Nā Pua (New Life for Our Children) - addresses the dark criminal enterprise of child sex trafficking, placing the health and healing of Hawaii's youth at the center of their mission - Hawaii Resource**

Information: We serve an Islands-wide and national need through Health, Education, Advocacy, and Reintegration. Our staff, board of directors, and volunteers work tirelessly, networking and collaborating with political figures, the justice system, law enforcement, social services, faith-based communities, state licensing institutions, foundations, health care professionals, and other community members in Hawaii who share our mission to create bright futures for youth and their families.

Contact

P.O. Box 22551
Honolulu, HI 96823
info@hoolanapua.org
Office: 1(808)445-3131
Direct Services: 808.222.1872

Ho'ōla Nā Pua (New Life for Our Children) was founded to shine light on the dark criminal enterprise of sex trafficking, placing the health of Hawaii's youth at the center of our mission and vision for our community. We are committed to the prevention of sex trafficking and providing care for children who have been exploited. Ho'ōla Nā Pua (HNP) is dedicated to creating a community where children are safe and have the ability to embrace their bright futures. Today, not only does HNP offer integrated programming that reaches over thousands of youth and community members and stakeholders across the state of Hawaii annually, but is considered a national partner and a rising standard in the global effort to stop sex trafficking, permanently

Topic/Source: Pouhana O Na Wahine **National Indigenous Women's Resource Center**

Information: Pouhana O Na Wahine is a grassroots organization advocating for Native Hawaiian families who face challenges related to domestic violence and sexual assault, by exercising our inherent sovereign rights as indigenous people of Hawaii. The Board and its members come from the different islands in the Hawaiian chain.

Pouhana O Na Wahine is a grassroots organization advocating for Native Hawaiian families who face challenges related to domestic violence and sexual assault, by exercising our inherent sovereign rights as indigenous people of Hawaii. The Board and its members come from the different islands in the Hawaiian chain.

Pouhana O Na Wahine's Board and members met on the island of Oahu at the Life Source Center in the ahupua'a (land division) of Manoa, on Saturday, February 23, 2019, to continue organizing efforts for the safety of Native Hawaiian's experiencing domestic violence and sexual assault.

NIWRC has a meeting scheduled with the Pouhana's Board on August 31 – September 1, 2019 on Oahu, including discussions on national strategies for increasing the safety of Native women, priority areas addressing domestic and gender- based violence against Native Hawaiian women, and exchange opportunities with Indian tribes, tribal coalitions and domestic violence and sexual assault organizations.

515 Lame Deer Ave.

Lame Deer, MT 59043

Phone: 406.477.3896

Toll-Free: 855.649.7299

Topic/Source: Sakhi for South Asian Women

Information: **Represents the South Asian diaspora in a survivor-centered movement for gender justice**

“Sakhi for South Asian Women exists to represent the South Asian diaspora in a survivor-led movement for gender-justice and to honor the collective and inherent power of all survivors of violence. Sakhi is committed to serving survivors through a combination of efforts including—but not limited to—direct services, advocacy and organizing, technical assistance, and community outreach.”

Our Mission

Sakhi for South Asian Women exists to represent the South Asian diaspora in a survivor-centered movement for gender justice. We honor the collective and inherent power of all survivors of violence.

[Learn More](#)

Get Help

At Sakhi, we offer a safe and nonjudgmental space for you to connect with our trained advocates in eight South Asian languages. We work with people of all gender and sexual identities, ethnic, caste, class, and racial backgrounds and firmly believe that anyone can be a survivor of gender-based violence.

[Reach Out to Us](#)

Sakhi's Impact in 2022

700,000dollars in housing assistance distributed to survivors and their families

600 survivors will have worked with Sakhi

15,000+survivors supported since 1989

Topic/Source: A Native Hawaiian Call for Change | NIWRC

Information: **A Native Hawaiian Call for Change**

By Kelsey Turner, NIWRC Restoration Fellow, and Edited by Paula Julian, NIWRC Senior Policy Specialist

Using Native Hawaiian Culture to Address Violence Against Women

Every morning when Rosemond “Loke” Pettigrew pulls out of her driveway, she calls out to her ancestors and to her land. “Malama pono, aloha aina!” Loke says in Native Hawaiian. She is acknowledging her ancestors and telling them to “take care” at home while she is gone.

Loke lives on the ocean side of a small valley in Molokai, Hawaii. This valley is her “kupuna aina”—the land where her kupuna (ancestors) have resided since ancient times, where they worked the aina (the land), and where they lived. “When the land tenure system changed and it went from common to private, my kupuna claimed that ‘ahu puna’, that land division,” Loke explained. “So it’s kupuna because it’s the land of my kupuna, the aina kupuna.”

Loke’s sister is her only neighbor in the valley. The two sisters live with their kupuna, who are buried there, and who are still there with them. “That’s very important, always acknowledging your kupuna and those who have gone before us, because they are the ones where we come from,” Loke said. “The aina is a part of us. Without the aina, then who are we?”

Welcoming the Pouhana ‘O Na Wahine to the National Movement

The Pouhana ‘O Na Wahine (Pillars of Women) is a grassroots collective of Native Hawaiian women advocating against domestic and sexual violence. Loke, as Board President of the organization, along with her fellow Pouhana ‘O Na Wahine sisters Dayna Schultz (Vice President), NaniFay Paglinawan, and Dolly Tatofi, use strategies based in Native culture, language, and worldview to increase the safety of Native Hawaiian women and children.

Central to Native Hawaiian culture is the relationship of everyone with one another through the land. “We’re connected through the aina because Hawaii is our home,” Loke said. But ever since the overthrow of the Hawaiian Kingdom in 1893 and annexation of the Hawaiian Islands by the United

States in 1898, the connection of Native Hawaiian people to their land has not been respected. Colonization led to the displacement of thousands of Hawaiians, resulting in increased vulnerability to trauma and oppression. Sacred land has been stolen and violated by colonizers who do not understand the importance of the kupuna aina to Native Hawaiian peoples.

Native Hawaiian women, like their land, have been subjected to alarmingly high rates of violence, trauma, and assault since colonization and into the present day. According to a 2018 report by the Office of Hawaiian Affairs, 20.6% of Native Hawaiian women between the ages of 18 to 29 years have experienced IPV, compared with 13.3% of non-Hawaiian women, and 21% of Native Hawaiian women ages 45-59 years have experienced IPV—this rate is nearly twice as high as non-Hawaiian women (12.6%).¹

The Kahea: A Call for Unity and Change

Currently, federal programming for domestic violence, such as the Violence Against Women Act and the Family Violence Prevention and Services Act, takes place in a Western context that is applied generically to all victims of gender-based violence. But the Pouhana sisters understand that “relying on these non-Indigenous responses to domestic and sexual violence are short-term, temporary solutions which do not address the needs of Native Hawaiians.”²

To raise their voices in awareness of domestic violence against Indigenous women, Loke believes Native Hawaiian women can join together using an ancient Hawaiian tradition: the kahea.

“Kahea means to call. There are several meanings. But basically for hula, when you’re ready to start dancing, you’re going to let your teacher, or your kumu, know you’re ready, so you’re going to start with a call. In addition to being used for the start of a hula dance, kaheas are also used when you arrive at someone else’s home. You’re asking for permission to be accepted. So there’s also a return call by the other. It’s calling even your ancestors to come and join you or to guide you.”

Topic/Source: Women of Color Network, Inc. - We empower women of color activists & advocates to fight violence against ALL women

Information: in collaboration with our partners, WOCN, Inc. has been able to reach out and support the inclusion of diverse constituencies in the anti-violence against women movement. Through our partnerships, WOCN, Inc. has provided training for multifarious audiences, facilitated national dialogues, and built alliances across social justice movements.

Topic/Source: Addiction & Mental Health Resources for AAPI Communities

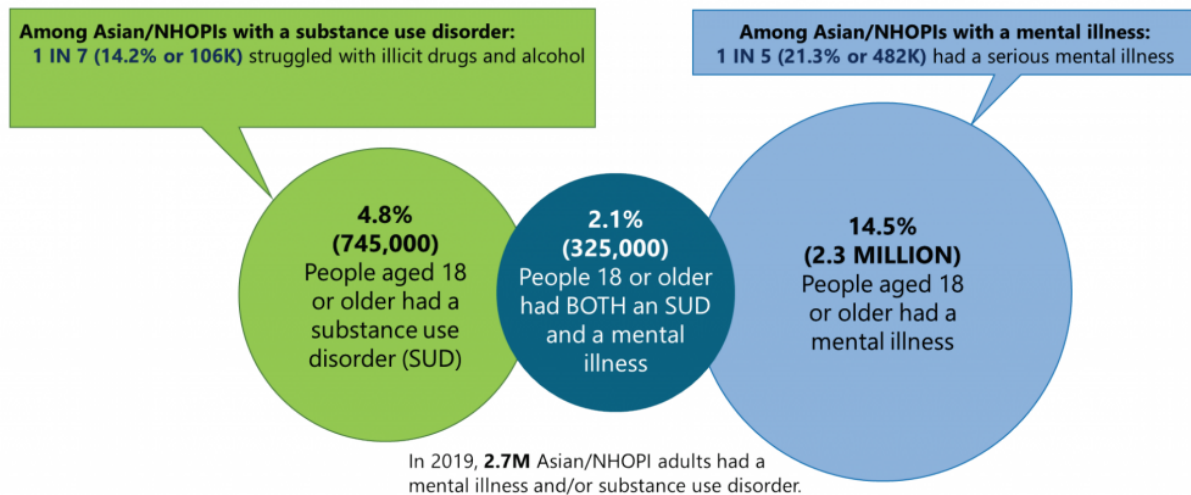
Information: In our commitment to ensure that members of the Asian American and Pacific Islander (AAPI) communities have access to recovery, prevention, and mental health resources, we have curated a list of recovery and mental health resources specifically for the Asian American and Pacific Islander communities.



Resources on Addiction & Substance Use Disorder:

- [2019 National Survey on Drug Use and Health: Asians/Native Hawaiians and Other Pacific Islanders](#): Provides a window into the state of substance use and mental health issues with the AAPI community.
- [Asian-Americans, Addictions, and Barriers to Treatment](#)
- [Substance Abuse & Asian American Pacific Islanders](#)

PAST YEAR, 2019 NSDUH, Asian/NHOPI 18+



Mental Illness and Substance Use Disorders in America among Asian/NHOPI Adults, SAMHSA



Resources for Mental Health:

- [Asian American Mental Health Advocates Changing the Narrative on Mental Illness](#)
- [Take the #NoShame pledge](#): Join SAFE Project's national movement to combat stigma, because there's #NoShame in getting help for mental health and addiction.
- [Your Journey: Asian American and Pacific Islander](#) (via [NAMI](#))
- [South Asian Therapists](#)

Organizations Focused on Addiction & Mental Health in the AAPI Community:

- [National Queer Asian Pacific Islander Alliance](#)
- [The National Asian American Pacific Islander Mental Health Association](#)
- [National Asian Pacific American Families Against Substance Abuse](#) (NAPAFASA) is a private, non-profit, 501(c)(3) membership organization dedicated to mental health advocacy through research, efforts at public health and policy reform, and community empowerment.



- **Project Lotus**
[Project Lotus](#): Project Lotus advances the movement of Asian-Americans blossoming and addressing mental health stigma, shame, and overall perception and care of mental health.
- [Subtle Asian Mental Health](#): This private Facebook group is intended to be a safe, nonjudgmental space for Asians and those of Asian descent to share thoughts and feelings about anything, especially mental health.

- [Mental Health and Substance Abuse Resource Guide](#) via Association of Asian Pacific Community Health Organizations ([AAPCHO](#))



Statistics and Educational Resources:

- [Asian American/Pacific Islander Communities And Mental Health](#) (via Mental Health America)
- [Barriers to Substance Use Disorder Treatment for Asian Americans & Pacific Islanders](#)
- [Factors Contributing to Substance Misuse Treatment Completion among Native Hawaiians, Other Pacific Islanders, and Asian Americans](#)
- [Fighting the Stigma: Mental health among Asian American and Pacific Islanders](#)

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- [Fighting the Stigma: Mental health among Asian American and Pacific Islanders](#)

Topic/Source: **Mental Health and Substance Use Resource Guide**

Information:

We are pleased to introduce the “Mental Health & Substance Use Resource Guide for Asian American and Pacific Islander (AAPI) Communities.” We hope this web-based resource, which was developed in collaboration with national AAPI organizations and community health centers, will provide you with easy access to existing resources on AAPI mental health and substance Use.

Background

Over the past several years, AAPCHO has through its [Promoting Access To Healthcare \(PATH\)](#)

[program](#), focused not only on raising awareness about mental health issues affecting AAPI communities, but on solutions that address these issues. Since 1999, AAPCHO has convened meetings/conferences that allow participants to discuss mental health issues and share resources, and developed resources for individuals/organizations that serve the mental health needs of AAPIs. This Resource Guide is another way in which AAPCHO is ensuring that organizations serving AAPIs are not only aware of the mental health resources that are available, but that they have easy access to these materials.

Acknowledgements

This resource guide was made possible with funding from the Office of Minority Health and support from SAMHSA Center for Mental Health Services. We acknowledge the following individuals and organizations for their support and guidance on this project:

- DJ Ida, National Asian American and Pacific Islander Mental Health Association (NAPIMHA)
- Ford Kuramoto, National Asian Pacific American Families Against Substance Abuse (NAPAFASA)
- Ho Tran, Asian Pacific Islander American Health Forum (APIAHF)
- Doua Thor, Southeast Asian Resource Action Center (SEARAC)
- Huy Bui, National Association of Vietnamese American Service Agencies (NAVASA)
- Cha Lee, Hmong National Development Inc. (HND)
- Juliet Choi, Asian American Justice Center
- Larke Huang, American Institute of Research
- Emily Ihara, the Office of Congressman Mike Honda
- Teddy Chen, Charles B. Wang Community Health Center in New York
- Albert Yeung, South Cove Community Health Center in Boston
- Steve Maxwell, Community-University Health Care Center in Minneapolis.

Mental Health and Substance Use Resource Guide

1. [Documents on Culturally Competent Care](#)
2. [Best Practice and Service Models](#)
3. [Fact Sheets and Health Education Materials](#)
4. [Articles, Bibliographies & Literature Databases](#)
5. [Policy & Advocacy Organizations](#)
6. [AAPI National Organizations](#)

Documents on Culturally Competent Care

This section includes useful mental health/substance use-related documents issued by the federal government, as well as AAPI-specific resources that promote culturally competent mental health care and services.

Federal Documents and Resources

- President's New Freedom Commission on Mental Health Report. [Achieving the Promise: Transforming Mental Health Care in America](#). 2003 — *In February 2001, President George W. Bush launched the New Freedom Initiative and created the New Freedom Commission on Mental Health to evaluate the mental health service delivery system. By Executive Order 13263, the Commission was tasked with identifying the problems and gaps in the current system, and recommending improvements.*
- U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. [Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General](#). 2001 — *This supplement, is an outgrowth of the Surgeon General's first report on mental health and mental illness in 1999. This document was created to provide more in-depth information on the mental health disparities affecting racial and ethnic minorities, and to document promising strategies that eliminate these disparities.*
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health. [Mental Health: A Report of the Surgeon General](#). 1999 — *This 1999 document is the Surgeon General's first-ever report on mental health and mental illness. The Surgeon General's Report on Mental Health advances the important fact that mental health is fundamental to an individual's overall health.*
- U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. [Report of a Surgeon General's Working Meeting on the Integration of Mental Health Services and Primary Health Care: Held on November 30 – December 1, 2000 at the Carter Center in Atlanta, Georgia](#). 2001 — *This report contains the proceedings of the Surgeon General's 2000 meeting to advance the integration of mental health services and primary health care. This report covers then Surgeon General David Satcher's remarks, meeting highlights, and the core principles and strategies for national action.*
- U.S. Department of Health and Human Services. [Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda](#). 2000 — *This report introduces a blueprint to address children's mental health needs. The report provides details of the meeting's national action agenda to ensure that every child has an optimal chance for a healthy start in life.*
- Substance Abuse and Mental Health Services Administration Center for Mental Health Services, U.S. Department of Health and Human Services. [Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups](#) — *This document provides standards to help guide the provision of culturally competent mental health services within the managed care environment for African Americans, Hispanics, Native Americans/Alaska Natives, and Asian/Pacific Islander Americans.*
- [Title VI of the Civil Rights Act of 1964](#) — *Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. Information on Improving Access to Services for Persons with Limited English Proficiency (Executive Order 13166) click [here](#).*
- U.S. Department of Health and Human Services, OPHS, Office of Minority Health. [National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary](#). 2001 — *In December 2000, the Office of Minority Health published the National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS*

Standards). These 14 standards provide a framework for building the cultural and linguistic competence necessary for home health care agencies.

- [The Americans with Disabilities Act](#) — The Americans with Disabilities Act (ADA) prohibits discrimination on the basis of disability in employment, public accommodations, commercial facilities, transportation, and telecommunications. This website provides information on federal civil rights laws, and links to agencies responsible for implementing the act.
- Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. [National Mental Health Information Center](#) — The National Mental Health Information Center was developed for users of mental health services and their families, and the general public. The site also includes information on federal, state, and local organizations dedicated to treating and preventing mental illness, material on federal grants, conferences, and other events.

Other Documents & Resources

- Institute of Medicine. [Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care](#). 2003 — This document examines how racial and ethnic disparities in treatment may arise in health care systems, and analyzes patients and provider attitudes, expectations and behaviors that may contribute to such disparities. It also offers recommendations for eradicating disparities including language access, community-based care and cross-cultural education within the health professionals.
- Larke Nahme Huang, Center for Child Health and Mental Health Policy, Georgetown University & D.J. Ida, National Asian American Pacific Islander Mental Health Association. [Promoting Positive Development and Preventing Youth Violence and High-Risk Behaviors in Asian American/Pacific Islander Communities: A Social Ecology Perspective](#). 2004 — This document attempts to provide a greater understanding of AAPI youth and families, the developmental and social challenges they face, the inherent strengths within their culture and communities, and strategies to prevent violence and other high risk behavior among this population.
- Larke Nahme Huang, Yuki Lee & Girlyn Arganza, Georgetown University Center for Child and Human Development. [Promising Approaches in Youth Development and Risk Prevention for Asian American/Pacific Islander Youth: Voices from the Field](#). 2004 — This document highlights the developmental and social challenges facing AAPI youth, and effective community programs that meet the needs of these youth and their families.
- [Task Panel Reports Submitted to the President's Commission on Mental Health: "Report of the Special Populations on Mental Health of Asian/Pacific Americans."](#) February 1978 — This report, issued by the Special Populations Sub-panel: Mental Health of Asian/Pacific Americans, includes a discussion on the condition of AAPIs with respect to mental health, recommendations, and a statement regarding priorities for the AAPI population.
- [Commission on Asian and Pacific Islander Affairs—"Rising to the Task: Facing New Challenges in California's APIA Communities." Annual Report](#). 2005 — This report of the Commission on Asian and Pacific Islander American Affairs (CAPIAA) provides an overview of the problem of gambling among AAPIs, commission-supported legislation related to this issue and activities for 2005.
- [Addictive Behaviors](#) — This document addresses the prevalence of addictive disorders such as gambling and alcohol and drug use among Asian Americans.

- [Cultural Competence of Social Workers: A Guide for Alcohol and Other Drug Abuse Prevention Professionals Working with Ethnic/Racial Communities](#) — This document provides a review of available literature on alcohol and other drug use within specific AAPI subpopulations.

[Culturally Based Intervention for Substance Use and Child Abuse Among Native Hawaiians](#) — This article presents an overview of child use among culturally diverse populations in Hawaii, substance use among culturally diverse students in Hawaii, and culturally-based strategies for preventing child use and substance use in Native Hawaiian families

Topic/Source: Barriers to Substance Use Disorder Treatment for Asian Americans & Pacific Islanders - IRETA

Information: *Editor's note: Special thanks to Samarth Mathapathi, who gathered this research in June 2015. Samarth is a medical student at the Rosalind Franklin University School of Medicine & Science who participated in our [Scaife Advanced Medical Student Fellowship](#).*

Treating substance use disorders requires a significant degree of cultural competency.

Recognizing a possible substance use disorder and providing a referral to treatment (perhaps using the [SBIRT model](#)) also requires cultural competency. In both cases, **you can screw up the good work you're trying to do by not understanding a person's background or context.**

Asian-Americans and Pacific Islanders (AAPIs) have long been lauded as the “model minority,” a term that manages to deny the diversity within this massive category and insult other minority populations in one fell swoop. The model minority notion has also contributed to a dearth of information about treatment-seeking and culturally-appropriate treatment modalities for AAPIs.

In fact, with the exception of tobacco, it appears that AAPIs *do* have lower rates of substance use than the average American. But even given that lesser rate of use, **AAPIs seek addiction treatment less often than we would expect**, compared to the national average. What's that about? And where are opportunities to change it?

Quick Stats

- In recent years, AAPIs have edged out Hispanics as America's [fastest-growing](#) minority.
- [In 2010](#), there were 17.3 million AAPIs in America, which represents 5.6% of the total population.
- [According to Pew](#), most AAPIs don't identify as “Asian-American;” rather, they identify with their country of origin. The six most common countries of origin for AAPIs in the U.S. are China (23.2%), The Philippines (19.7%), India (18.4%), Vietnam (10%), Korea (9.9%), and Japan (7.5%).
- Overall, AAPIs are more likely to live on the West Coast, but **different regions in America have different types of AAPIs**. For example, more than 70% AAPIs of Japanese descent live on the west coast. People of Indian descent are the dominant AAPI subgroup in many

Northeast states (including Pennsylvania). To explore these regional differences (for hours, if you want to) check out [this cool map](#) by Pew Research Center.

- [According to SAMHSA](#), **AAPIs are less likely to meet the criteria for a substance use disorder than the American average** (4.9 versus 9.5%).
- **However, among those whose substance use suggests a need for treatment, a larger proportion of AAPIs feel they do not need treatment** (97.9 versus 94.7%). This number begs questions about how AAPIs regard addiction, addiction treatment, and the quality of treatment they receive.

Cultural Factors

Collectivism: AAPIs and other collective cultures tend to treat the family unit as particularly important. That is to say, an AAPI considering treatment might not only be concerned about how the prejudice will affect herself, but also its impact on her family. [In interviews](#), AAPIs in addiction treatment have described mixed influences from family members: some were pushed into treatment by their families, whereas others said they were pressured to handle the problem within the family. One respondent said:

Although [my father] hated me using...it's harder for him to know that I'm coming here and getting treatment than using. He's so uncomfortable with the fact that I'm going somewhere, ...[and] that I couldn't solve the problem myself...that we couldn't solve it in our own family...[Another issue is] how it makes the family look... how shameful, how embarrassing, and [so], what do I talk about here? What are people going to think?

High-context environments: Associated with collective cultures, [a high-context environment](#) is one where individuals more often have an implicit understanding of culturally accepted norms. In these environments, trust and non-verbal cues are more important than what is directly communicated. In the words of a business manager from Japan: "We are a homogeneous people and don't have to speak as much as you do here. When we say one word, we understand ten, but here you have to say ten to understand one."

Immigration: In 2012, [fully 74% of AAPI adults in America](#) were foreign-born. More so than any other minority population, AAPIs are likely to be dealing directly with issues related to immigration: language barriers, generational divides, cultural misunderstandings, and the health effects of acculturation.

Adaptations in Treatment and Treatment-Seeking

Results of [a relatively small study](#) suggest that AAPIs are less likely to use mental health services, talk to a physician, and use Alcoholics/Narcotics Anonymous, Alanon/Alateen or other associated 12-step programs, and are more likely to prefer seeking treatment or counseling from a minister, priest, or other religious leaders. These findings suggest that it is important to integrate substance use services into multiple systems, including religious settings.

[There is also research](#) showing that AAPIs tend to enter treatment with less severe addiction, but they exhibit significantly more negative attitudes towards treatment compared with non-AAPIs. A

shortage of culturally-tailored, empirically-supported treatment options may contribute to this dissatisfaction.

The late David Powell, an addiction counselor and marriage and family therapist whose extensive work in Asian countries spanned 30 years, suggests a number of approaches to AAPIs in therapeutic settings. For example:

- Keep in mind that for your client, the first treatment session is a crisis: discussing personal issues with a stranger is particularly unusual in Asian cultures.
- Emphasize your credentials and experience to build a sense of credibility and trust.
- Be aware of “face” issues. Declining gifts (even if accepting them is against your organization’s policy) can cause an AAPI client to lose face. Regularly consider face issues and be prepared to talk about them with your client. “Although I have been visiting Asia for nearly 30 years, I am still making cultural mistakes,” said Powell.
- Consider the possibility that your AAPI client has an entirely different concept of mental health issues than your Western one. Many Asian cultures have a traditionally more holistic concept of physical and behavioral health.
- When providing treatment for AAPIs in the United States, be aware of generational issues related to immigration. Families are likely to be experiencing “values clashes” related to the process of assimilation.

Do these suggestions resonate with you and your experiences working with AAPIs? [Read the rest of Powell’s essay](#) for more.

Resources

[Need for and Receipt of Substance Use Treatment among Asian Americans and Pacific Islanders](#), SAMHSA (2013)

[Possible Barriers to Enrollment in Substance Abuse Treatment Among a Diverse Sample of Asian Americans and Pacific Islanders: Opinions of Treatment Clients](#), *Journal of Substance Abuse Treatment* (2013)

[Comparison of Substance Abuse Treatment Utilization and Preferences Among Native Hawaiians, Asian Americans, and Euro Americans](#), *Journal of Substance Use* (2011)

[Asian-Americans, Addictions, and Barriers to Treatment](#), *Psychiatry* (2007)

Topic/Source: Conceptualizing a New System of Care in Hawai’i for Native Hawaiians and Substance Use

Information: **Abstract**

Native Hawaiians of all age groups tend to show a higher prevalence of substance use than other ethnic groups in the state. Research shows that this inequitable health status results from several complex and interconnected social determinants of health, including historical trauma, discrimination, and lifestyle changes.

Before European contact, Native Hawaiians understood that balanced nutrition, physical activity, social relationships, and spirituality were fundamental to maintaining optimal health. Western influences triggered an imbalance in Native Hawaiian society, shifting the paradigm of Native Hawaiian family systems.

Historical and cultural trauma affect multiple generations and are linked to Native Hawaiian health disparities. Cultural trauma is defined as “the loss of identity and meaning that negatively affects group consciousness. It marks and changes them in fundamental and irreversible ways, often resulting in the loss of language, lifestyles, and values.” The remedy for cultural trauma is cultural reclamation. Historical trauma is defined as psychosocial trauma experienced by Indigenous groups as a result of colonization, war, genocide, or cultural, social, and political subjugation. These historical and cultural aspects have impacted and reached across generations of Native Hawaiians. The outcomes of these traumas are reflected in higher rates of health disparities, including mental health and addiction, which have affected the social determinants of health.

Current access to treatment and recovery is limited for Native Hawaiian residents with substance use problems. This article will look at a system of care that would reduce silos and incorporate cultural aspects to improve outcomes for Native Hawaiians receiving services. This article will also introduce an *‘āina*- (land-) based model for creating healthy, thriving Native Hawaiian individuals, *‘ohana* (family), communities, and care systems.

Keywords: Native Hawaiian, treatment modalities, cultural support

[Go to:](#)

Background and Introduction

Native Hawaiians historically sought healing within their *‘ohana* (family) systems. Prior to European contact, Native Hawaiians understood that *lōkahi* (harmony), which included balanced nutrition, physical activity, social relationships, and spirituality were fundamental to maintaining optimal health.¹⁻³ Native Hawaiian health has been illustrated in a *lōkahi* Triangle¹⁻³ as an equilateral triangle, with the apex labeled as *Nā Akua* (Gods/Goddesses/spirituality), and the base on one end labeled as *kānaka* (person) and the other as *‘āina* (land).

Historical trauma is defined as psychosocial trauma experienced by Indigenous groups as a result of colonization, war, genocide, or cultural, social, and political subjugation.⁴ From the first European arrival in 1778, colonization, systematic oppression, and Western imperialism have led to a loss of traditional healing practices, and our [This article includes the first person voice from the lens of the Native Hawaiian authors and to acknowledge Indigenous ways of knowledge.] Native peoples were forced into Western treatment frameworks for matters that were historically addressed within the *‘ohana*. Today, Native Hawaiians suffer from health disparities in chronic diseases⁵ and overrepresentation across all social services, including addiction services,⁶ incarceration for drug offenses, and offenses due to addiction diseases.⁷ Intergenerational substance use and incarceration impact individual, *‘ohana*, *keiki* (children), and community health.

Disproportionate numbers of our Native population have been consistently overrepresented among those who are seeking or thrust into Western treatment for substance use disorders.⁶ Existing systems of care continue to assign treatment within the same Western frameworks leading to this consistent overrepresentation. In the present paper, we highlight key points from a chapter of the Hawai'i Department of Health Alcohol and Drug Abuse Division (ADAD) State Plan which examines the roots of disparities in the intersections of Native Hawaiians and substance use and reimagines a system of care that would reduce silos and incorporate cultural aspects to improve outcomes for Native Hawaiians receiving services. For more background and context around the overall State Plan project, readers are referred to the introductory article of this special supplement.

[Go to:](#)

Observations and Rationale

Cultural trauma is defined as “the loss of identity and meaning that negatively affects group consciousness. It marks and changes them in fundamental and irreversible ways, often resulting in the loss of language, lifestyles, and values.”⁸ Our Native *‘ohana* have become disconnected from their cultural heritage throughout generations. Many of these *‘ohana* carry intergenerational trauma created by oppression and criminalization of the Native identity at the hands of those who colonized our island home. Further layers of complexity are added through the loss of land and abrupt lifestyle changes from subsistence living into a capitalistic environment, the ramifications of which created stark socioeconomic differences between Native Hawaiians and their Western counterparts. These differences have led to generations of poverty, houselessness, and mental health issues for Native Hawaiians that continue today.

The Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) recognizes the unique nature and importance of cultural concepts of distress.⁹ However, a Native Hawaiian worldview has not yet been included in those listed. The Cultural Formulation Interview and supplemental modules in the DSM-5 provide a framework for assessment and a first step in approaching these areas through a broader lens. However, when in distress, seeking medical, behavioral/mental health, or substance use services, our Native people are treated by clinicians trained in predominantly Western ways. Therefore, clinicians working with Native individuals and families must be educated on our history, historical injustices, traumas, the impacts of colonization, traditional beliefs and practices, and understanding of the Hawaiian worldview.¹⁰

Paglinawan and colleagues maintain that the remedy for cultural trauma is cultural reclamation.¹¹ To develop effective, culturally focused approaches for working with Native Hawaiians, we must look *i ka wā kahiko* (to ancient times), to our *kūpuna* (elders), and to respected healers within our community to understand how *ma‘i* (sickness) was approached during ancestral times. Hawaiian *ma‘i*, Hawaiian illnesses, or *ma‘i kama‘āina*, call for Hawaiian assessment, diagnosis, and treatment which is an ancient concept with deep roots in Hawaiian healing. *Ma‘i malihini* or illnesses that stem from Western influence, such as infectious or chronic disease, could be treated through Western medicinal pathways. However, they are still best coupled with traditional *kānaka* health and well-being approaches to heal the spirit. For substance use, the root of this kind of *ma‘i* is much deeper, and it could be understood almost as an amalgamation of *ma‘i kama‘āina* and *ma‘i malihini*. Understanding these concepts requires deep reflection and study (with practitioners of Hawaiian

healing) of *ma'i* that contributes to an unhealthy *kānaka* environment, such as historical/intergenerational trauma and the loss of connection. Also, by understanding the root causes of *ma'i kama'āina*, as well as the manifestation of addiction as a symptom of this deeper trauma¹² practitioners can be better prepared to provide culturally focused interventions.

Loea Ho'oponopono Auntie Lynette Paglinawan, a revered *haku ho'oponopono* (cultural practitioner in the Native Hawaiian practice of healing families through forgiveness) and social worker who studied under Auntie Mary Puku'i (a revered cultural practitioner), offers us some of the most valuable insight into assessing Native Hawaiian individuals and 'ohana.

Assessment and intake from a Western approach can be off-putting and invasive for some Native Hawaiians. Culturally, we must take a more Indigenous approach by “talking story” with the 'ohana or individuals. Caseworkers must voice intentions, explaining “why questions may be asked and how they will be applied to the problem at hand.”¹³ During the intake or assessment process, it is also important to determine the best approach for our Native people to determine whether a culturally grounded healing would be most beneficial.

Similarly, there exists a gap in the development of culturally-focused interventions. Okamoto provides an assessment of the strengths and limitations of developing culturally focused interventions ([Table 1](#)).¹⁴ In summary, culturally grounded interventions provide a “ground-up” approach from a foundation of culture. Non-adaptation, surface-structure cultural adaptation interventions provide a “top-down” approach, altering the original model to add cultural components. Finally, deep-structure cultural adaptations use a “sprinkling in” approach of integrating culture into the intervention, providing “changes to images or phrases throughout its content or lessons, to align the program with familiar concepts or references of a specific cultural group.” Providers who utilize culturally-based treatment focusing on Native Hawaiians provide interventions in alignment with Okamoto's categories. However, most providers lack the capacity to develop an evidence base that meets Western requirements, as illustrated in the limitations set by Okamoto et al.¹⁴

Table 1.

Strengths and Limitations of Approaches in Developing Culturally Focused Interventions^a

Culturally grounded prevention intervention		Deep-structure cultural adaptation intervention		Non-adaptation/surface intervention	
Strengths	Limitations	Strengths	Limitations	Strengths	Limitations

Community is engaged and invested in the development of the program	Time Consuming	Based on empirically supported intervention principles	Assumes the core components of an evidence-based program are applicable across cultural groups	Tests the applicability of generic/universal prevention principles to unique groups	Often unacceptable to or disconnected from the community
Directly addresses core cultural constructs	Expensive	Balances length of time and costs to develop curriculum with the ability to bring the program to scale	Need to specify and retain the core prevention components for fidelities	Faster to develop, implement, and bring to scale	Can potentially avoid core cultural components
Core prevention components are derived organically (from the “ground up”) and can therefore be intertwined with core cultural components	Difficult to evaluate and replicate in similar settings	Engages the community, but within the parameters of a specific evidence-based program	May inadvertently alter core components and decrease their effectiveness	Based on empirically supported interventions, but with questionable “fit.”	

[Open in a separate window](#)

^aUsed with permission from Okamoto et al.¹⁴

Indigenous ways of knowing provide evidence that predates any semblance of Western evidence, yet the Western way is somehow dominant today. An Indigenous evidence base has been established orally by passing down the knowledge of our people through traditional practices, storytelling, song, and much more. The Indigenous-based evidence, coupled with evidence from community-based participatory action research approaches, should be used to develop and measure the efficacy of culturally resonant/attuned interventions.

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Current System of Care in Hawai'i

According to ADAD, Native Hawaiians were admitted to treatment 1358 times in 2017, which is 42.3% of the state total and the most of any ethnic group.¹⁵ This overrepresentation has been reflected throughout the past decade.⁶ In that same year, over 30% of Native Hawaiian admissions to ADAD treatment were referred via the criminal justice system, increasing to over 40% in 2020.¹⁶ Of those Native Hawaiians accessing services, over 40% indicated methamphetamine addiction as their primary substance of issue.¹⁶ This consistent overrepresentation further illustrates the ineffective nature of the Western treatment of Native peoples.

ADAD collects, uses, and develops fund allocations based on ethnicity data. Due to those efforts, ADAD can identify the disproportionate representation of Native Hawaiians receiving services for substance use in the state. Current policies allow for flexibility for treatment providers in set activities tailored to Native Hawaiians, thus allowing for the offering and inclusion of alternative treatment methods. However, the current gap exists in providers, cultural practitioners, and ADAD discussing and agreeing upon culturally resonant documentation and reporting of cultural services in clinical notes on how their treatment improves protective factors or reduces risk factors. This gap can be addressed by developing a culturally responsive system of care that uplifts and values Indigenous knowledge and cultural healing pathways.

The current system of care in Hawai'i does include some providers who use varying degrees of culturally based or culturally adapted treatment and prevention programs. Treatment providers who contract with the ADAD adhere to the 5 Levels Of Care model established by the American Society of Addiction Medicine,¹⁷ which includes early intervention, outpatient, intensive outpatient, residential, and medically managed services.¹⁸ Most providers utilize Western interventions such as cognitive-behavioral therapy, dialectical behavior therapy, or 12-step programs (a model used for Alcoholics Anonymous/Narcotics Anonymous).

Treatment providers who employ utilization of culturally based treatment with a specific focus on Native Hawaiian values continue to find difficulty in billing for cultural services to ADAD, as well as including cultural services in treatment plans to accurately capture the successive impact that cultural reclamation can have on the individual, the *'ohana*, and the community. For *Kānaka Maoli* (Native Hawaiians), cultural reclamation can be defined as a spiritual/cultural healing process of a reawakening within the *na'au* (visceral mind) to deeper learning and understanding of the underlying reasons for their cultural beliefs, cultural practices, and their true identity as *Kānaka Maoli*.¹⁹ Learning about one's history and cultural heritage, genealogy, and cultural morals and values, making ancestral connections, engaging in cultural practices (eg, working in the *lo'i* (taro field), dancing the hula) and learning to speak one's language facilitates healing and cultivates cultural pride, which nurtures the development of a positive cultural identity and overall self-image.¹⁹ Most providers are dependent on outside funding to cover the costs of cultural practitioners to provide culturally-based healing, which only further silos culturally-based approaches from Western treatment constructs and places a burden on the provider to maintain 2 separate pathways of healing.

The State also supports school and community-based youth prevention programs.¹⁸ Given the reliance on nationally endorsed evidence-based practices, the majority of youth substance use

programs implemented in Hawai'i have not been designed to support Native Hawaiian youth and communities specifically.²⁰ Two exceptions are the school-based Ho'ouana Pono middle school drug prevention curriculum²¹ and the Hawaiian Homestead-based Puni Ke Ola adolescent substance use program.²² The National Institute on Drug Abuse funded Ho.ouana Pono Program which has been evaluated in a set of studies²³ and is currently working with their state partners to develop a sustainability strategy.²⁴ The Puni Ke Ola program has been supported through a variety of local and national sources in the intervention development²⁵ and feasibility phases,²⁶ aligns with a Culture-as-Health Framework,²⁷ and currently is funded by ADAD and Papa Ola *lōkahi* in preparation for multi-community implementation.

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Interventions (Re-imagined)

Re-envisioning a culturally responsive system of care first requires us to identify parallel strengths and potentially detrimental differences that form the existing colonized/Western system's foundation through the examination of 3 key areas: (1) Cultural perceptions of self; (2) Shifting to a cyclical continuum, and (3) the *ahupua'a* model. Recent research indicates that re-envisioning treatment for the Native population, utilizing cultural reconnection, and methodologies that speak to Native perspectives, are more influential in creating positive health outcomes for Native peoples.⁵

Native Hawaiians need a sense of place to anchor values and balance life. Beyond Western practices, Native Hawaiians need to care for the *'āina*, which they understand to deeply care for them. Native Hawaiians need the resiliency and protection that culture provides through language, traditions, and ceremonies, allowing ways to reconnect to ancestral knowledge and spirituality. Native Hawaiians need not become Western to heal.⁵

According to Papa Ola lōkahi and a Native Hawaiian Partnership, 'Imi Ke Ola Mau (a community collaboration Co-Occurring State Incentive Grant [COSIG]), for Native Hawaiians to heal, "[They] need a sense of self, retrieved from our past through ancestors, present through purpose, and future through descendants. [They] need our language, traditions, and ceremonies, which provide ways to reconnect to our spirituality and the concept of our source. [They] need the resiliency and protection our culture provides, in order to prevent relapse and redefine ourselves away from pathological diagnoses."²⁸

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Cultural Perceptions of Self

Current care systems addressing substance use are rooted in historically colonized systems, centered on Western approaches to individualistic care.²⁹ This individualistic and egocentric concept of the person can be contrasted with more sociocentric, ecocentric, or cosmocentric views, which understand the person in relation to the social world, the environment, and the cosmos.²⁹ The collective vs individual mindset within the Hawaiian worldview is dramatically different from Western approaches that are highly individualistic, and often do not account for historical and cultural trauma.

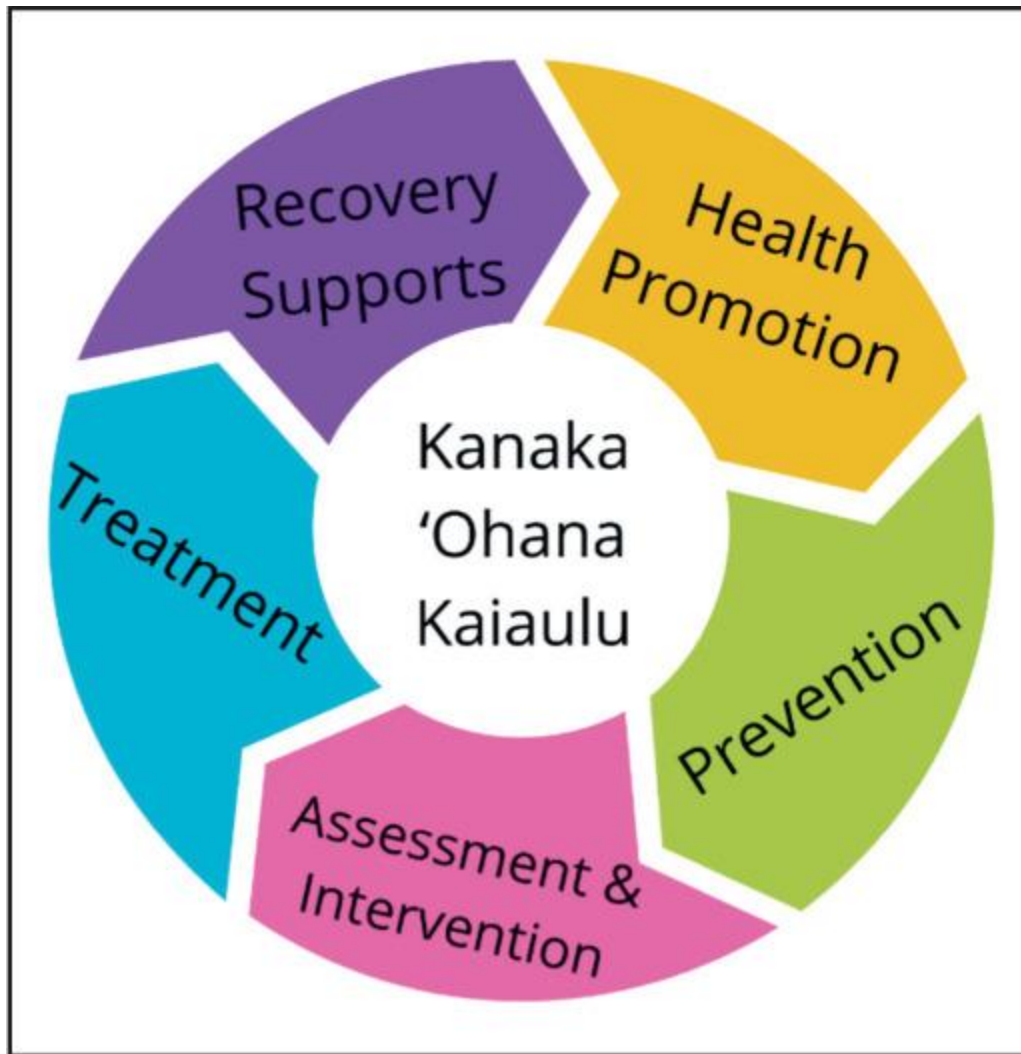
However, personal boundaries and understanding of self are not identical in every culture. The same methods used to treat and heal cultures rooted in individualism can be harmful to those rooted in various other cultural configurations of the self, such as Indigenous cultures. Ignoring the self's internalized concept can leave the client with no way to reconcile their internal self-healing within the larger society's connective tissue, those social interactions that sustain the self within the community, and their collective healing.²⁸ Each categorical perception of self varies in the ways the self is defined; the values underpin and characterize a healthy perception of the ideal self, the understanding of one's role in specific actions or events, and associated healing systems.²⁹

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Shifting to a Cyclical Continuum

On a traditional continuum of care, recovery is viewed as the phase after treatment. These individual areas can frequently become siloed, only concentrating on their specific prevention, treatment, or recovery areas. The depth of the recovery field often overlaps within the treatment area, as there are many pathways toward healing and recovery, and not all individuals in recovery have followed a path that involves clinical treatment. Recovery and healing are lifelong processes. Therefore, we must begin to re-envision the existing continuum of care, embrace culturally grounded approaches, and begin to see the entire continuum as cyclical rather than linear, with each area of focus informing the next.

The linkages between recovery and prevention lie in using one to inform the other through the feedback of successful outcomes, promoting *mauli ola* (well-being), and educating clients about making healthy, informed choices.²⁸ We can approach this shift toward a cyclical continuum through systems thinking as a way to see the phases along the continuum as interrelationships rather than as siloed components. This shift allows us to look for patterns of change rather than accepting static snapshots or defaulting to how it has always been.³⁰ From a culturally informed or holistic perspective, systems thinking can help us understand whether the purpose of the existing system is being accomplished and look for ways to create more equitable and resonating systems of care, thereby achieving better results with fewer resources in lasting ways.³⁰ Keeping this cyclical nature in mind, we can move toward a resiliency- and recovery-oriented care system where each phase informs one another, as seen in [Figure 1](#) which spans the entire continuum of care.



[Figure 1.](#)

Kanaka (person) 'Ohana (family) Kaiaulu (community)^a

^a Original unpublished figure created by the authors/Lilinoe Kauahikaua of Papa Ola Lokahi, and duplicated with permission 2021

At the center of [Figure 1](#), the *piko*, we can see the depiction of self, *'ohana*, and community: 3 interrelated, interconnected healing targets. You cannot heal just one; all must be healthy for each to flourish. The Substance Abuse and Mental Health Services Administration explains that the resiliency- and recovery-oriented care system “is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve improved health and wellness outcomes for those at risk or experiencing issues with substance misuse.”³¹

The Recovery Ready Ecosystems Model (RREM) provides a model to increase recovery prevalence and focus on supporting and building recovery-informed infrastructure within communities.³²

Collective healing of our communities is needed to combat intergenerational traumas that lead to stigma and NIMBYism (“not in my backyard”), which inhibit the healing of our Native people and their communities. The recovery-informed infrastructure allows for a backward mapping approach to building a culturally resonant system, beginning with what is working. Recovery through an RREM lens encompasses the many pathways to healing, including harm reduction, behavioral/mental health, reentry, peer recovery services, diversion courts, and many more. RREM provides an avenue of alignment with Indigenous, collective healing approaches.

Another way to acknowledge, value, and uplift the Indigenous experience is through culturally grounded peer support. Peer support can only be provided by someone with lived experience and provides a layer of support, empathy, and understanding unparalleled by other clinical support. Peer recovery specialists can be invaluable for our Native people, who often struggle with Western recovery spaces and language. Culturally grounded peer support services help address that dichotomy of individualism on the Western spectrum, with a more collectivist or holistic approach toward healing, *ola*, and the well-being of the whole environment. Recovery for many may even take the place of clinical treatment. We must support these services with the same vigor and intent as the areas of promotion, prevention, and treatment. A newly conceptualized healing journey for Native Hawaiians should utilize and uplift stories of resilience to resonate with, inform, educate, and empower those impacted, those who help navigate these systems, and those who choose to walk alongside the healing journey.

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ahupua‘a Model

Our Native people thrived in Hawai‘i for centuries before Western contact. Native Hawaiians developed a complex resource management system through the *ahupua‘a* system, a land division of interconnected systems stretching from the mountain to the sea. The *ahupua‘a* model provides a framework to implement cultural interventions at various places within the *ahupua‘a* to effectively provide healing that impacts not only the individual but their *‘ohana* and community as well. Interventions within the metaphorical framework would aim to effectively decrease the intergenerational transmission of risk factors (intergenerational/historical/cultural trauma, colonization, poverty, oppression, loss of traditional healing practices, criminalization of Native identity, loss of land, and family/community history of use/incarceration) and increase the intergenerational transmission of protective/resiliency factors (*‘ohana* relationships, cultural wisdom, traditional healing, community connection, *mo‘okūauhau* [genealogy], *‘āina*, respect for *kupuna*, and culture). The model draws from Dr. Keawe Kaholokula’s model of the social and cultural determinants of health and their relation to *Mauli Ola* (health).³³ Our *ahupua‘a* stretched *ma uka a i kai* (mountain to sea), connected through *wai* (water), which flowed through each system section to bring life. *Wai* ran through our *lo‘i* (*kalo* patch), and *loko i‘a* (fishponds), and down into the ocean, where it evaporates and becomes *ua* (rain) to once again fall from the *lani* (sky), run through our *nāhele* (forests), and down throughout the rest of the *ahupua‘a*. No one system functioned independently. *Kānaka*, our people, tended these systems knowing that resources were finite and the land must flourish for us to survive. *He ali‘i ka ‘āina, he kawa ke kānaka*,³⁴ the land is chief, and us its servant.

Looking at the *lo'i* system, within our *ahupua'a* system, *I ka wa kahiko* (ancient times), if these systems were not functioning correctly, or not healthy, and if those who *mālama* (to take care of) these spaces were not *ma'a* (accustomed, used to, familiar) to this understanding, no one would be fed. *Lo'i* is the Native Hawaiian's agricultural system using terraces along the hillsides. They developed complex systems, similar to water paddies, to grow their staple food of *kalo* (taro) along the valleys. We should understand the external impact on this substantive system. We can understand *kalo* as a reflection of ourselves, of *hāloa*, our ancestor, our root, both metaphorically and physically. We conceptualize this new system of care, one where Native people can thrive and pursue healing pathways that embrace, empower, and value an Indigenous worldview. We achieve this by recognizing interconnections within systems and understanding how feedback from each area along the continuum of care impacts and informs other system areas as a whole, much like the *ahupua'a*.

As we visualize the system through this culturally informed and holistic lens, we must also acknowledge that current data often aggregates ethnicities, is disparity-focused, and has a history of portraying Native/Indigenous populations by showing what is wrong. Therefore, the *ahupua'a* model ([Figure 2](#)) provides a metaphorical model to understand collective healing through a Native lens and embraces a recovery perspective that recognizes substance use as a symptom of a larger trauma. The *ahupua'a* is a living, breathing example of a thriving, healthy Native system. Through this model, practitioners can identify the root causes of trauma, and develop effective culturally informed interventions to engage in collective healing from trauma and celebrate resiliency outcomes.

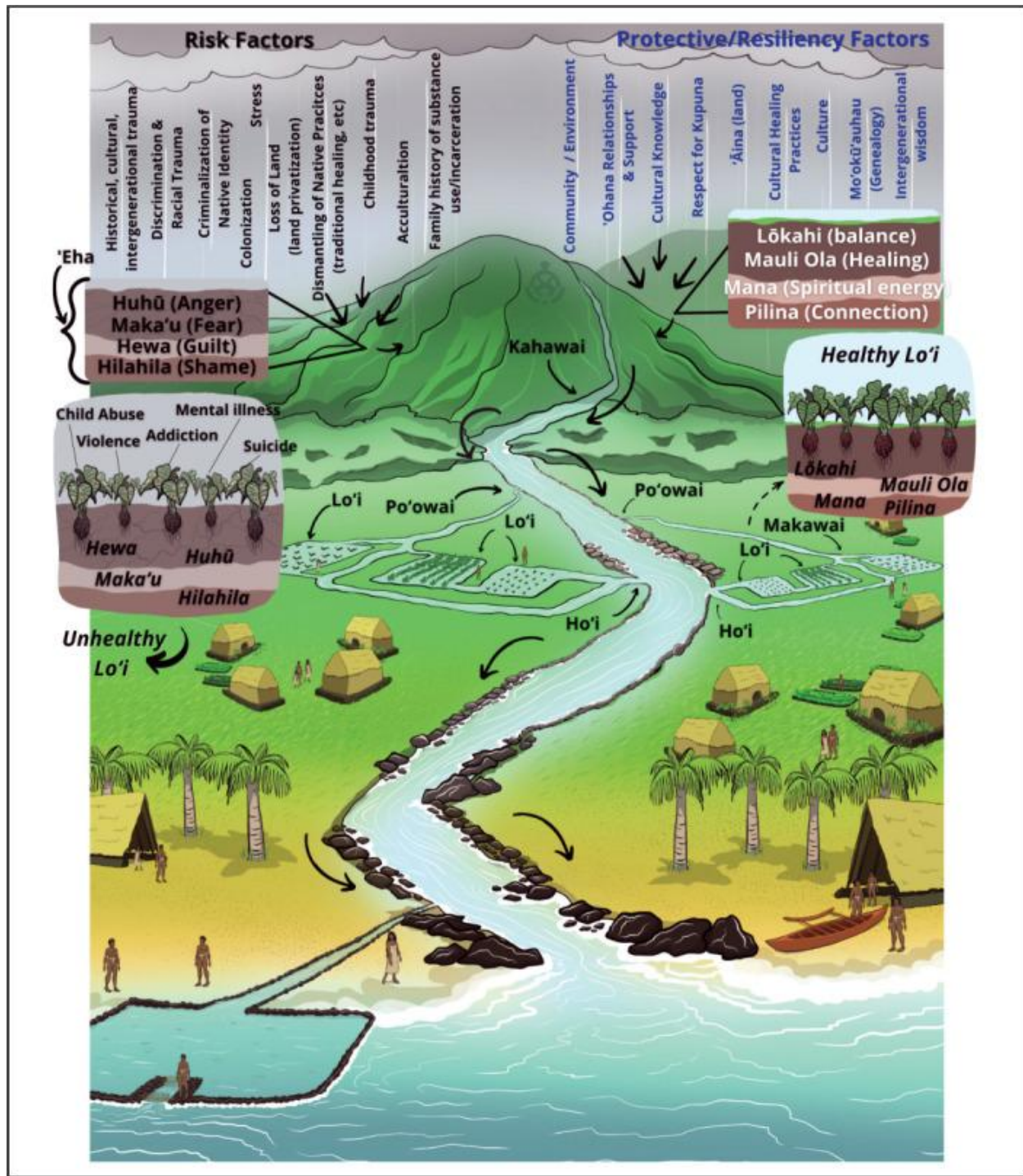


Figure 2.

The Impacts of Colonization on Ahupua'a. Conceptualization by Lilinoe Kauahikaua and Papa Ola Lōkahi V3.0^a

^a Original Copyrighted Unpublished figure created by Kimo Apaka and edited by the authors and duplicated with permission 2022.

With the help of our Indigenous cousins, we continue to explore the manifestations of deeper trauma within ourselves, 'ohana, and communities through the model of a Healing *ahupua'a*, inspired by the Healing Forest model created by White Bison.^{35,36}

Pre-contact, our *ahupua'a* were healthy and existed in a harmonious relationship, tended by *kānaka* (Native people) who understood that each interconnected system within the *ahupua'a* must be healthy for all to thrive. However, [Figure 2](#) outlines the impacts of colonization, racial/cultural traumas, negative socio-economic impact, the criminalization, and subsequent loss of the Native identity has had on Native Hawaiian individuals, 'ohana, and communities. These impacts are carried through the *ahupua'a* system as risk factors impacting generations.

We visualize these risk factors entering our *ahupua'a* through the *ua* or rain. This 'ēha, or pain/trauma, is passed down from generation to generation and compounded by unresolved grief. All of this 'ēha creates layers of *huhū* (anger), *hewa* (guilt), *hilahila* (shame), and *maka'u* (fear), which enter into our *ahupua'a* just as the metaphorical rain feeds into the soil. We look at the systems and visualize the 'ēha (pain/trauma) impacting the soil to understand the pollution and other toxins that have found their way into our environment and continue to impact our systems through the environmental water cycle cyclically. The potentially unhealthy/impacted soil would then run off into the *kahawai* (river) and be carried downstream, impacting the rest of our interconnected systems. But, just as trauma is passed down generationally, our ancestors pass down the strengths and resilience (as seen in the *ua*).

We can understand the interconnected *ahupua'a* systems as our care systems, our 'ohana, and our communities. In understanding care systems and approaches to healing within the larger continuum, we focus on the *lo'i* as 'āina-based model to visualize the internal and external impacts of trauma and the manifesting symptom of substance use on our *lāhui* ecosystem. As the unhealthy soil enters into our *lo'i*, it becomes that which feeds the next generation of *kalo* or *hāloa* that emerges from it.

Today, we may have generations of people born with internal 'ēha buried deep within them. If the 'ēha begins to bubble up to the surface, it can manifest in many different ways in our *kalo*; anger, violence, substance use, etc, giving way to an unhealthy *ahupua'a*. However, we can remember that our strengths and cultural resilience are also contained in the *ua* and soil. In that case, we see a path forward in cleaning our water of the risk factors to improve and increase our protective/resilience factors for generations to come.

We can imagine that, while working in the *lo'i* one day, we find a *kalo* that is sick (manifesting trauma as addiction). First, we must look around to the other *kalo* to find the source of the sickness. Are the other *kalo* sick? Is the whole *lo'i* sick? How could this sickness be getting in? We must look up the interconnected 'auwai (canal) and the *kahawai* for the source of this sickness, this pollution, this 'ēha. If we cannot find the source of this *ma'i*, this sickness, and we instead decide we will just take that one *kalo* out, heal it, and then put it back into that potentially unhealthy environment, it will only get sick again.

This metaphor illustrates we will face the same result we began with if we decide to solve the problem on the surface that we see. We need to put in the work to address the root of the problem, look far enough up the system, and dig deep enough to find the source that creates the unhealthy environment.

Recognizing how Native Hawaiians experience the self through ecocentric, cosmocentric, and sociocentric definitions provides a lens for understanding and developing more impactful and effective interactions for Native people are implemented through the *ahupua'a* framework. Thereby cleaning our *wai* as it traverses throughout our interconnected systems and is reborn through the water cycle to fall as *ua* once again, reducing risk factors and increasing protective factors. This increase in protective factors will contribute to the healthy *lo'i* and *ahupua'a* through the soil *waiwai* (rich) with *lōkahi* (balance), *mauli ola* (health), *mana* (spiritual energy), and *pilina* (connection/bonds), foundational values for a thriving *lāhui kānaka* (Native Hawaiian people), as seen on the right side of the image ([Figure 2](#)). The *ahupua'a* conceptual framework is intended to develop and grow as the framework is embraced and actualized across systems and care spaces.

Embracing a more culturally grounded approach would effectively provide a paradigm shift in how society and individuals see themselves. Imagine the empowerment of nurturing and uplifting these unique gifts contained within Native Hawaiian protective/resiliency factors and the impact or effect they would have on someone's life, how they grew up, and how they perceive themselves. By understanding the multiple threads impacting their lives, a more robust, comprehensive (holistic) approach that incorporates (blends) the interventions used will have more value for this Native person.

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Recommendations

Table 2 displays proposed recommendations to guide the initial steps toward implementing of a newly conceptualized system. These recommendations were based on the synthesis of the existing literature and available data, but also Indigenous knowledge and feedback from our stakeholder groups.

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Conclusion

Current culturally grounded interventions have struggled for some time to meet the requirements for evidence-based interventions and assessments required by Requests for Proposals (RFP's) and Grant applications. These methods often do not align with culturally grounded intervention programs which tend to be more fluid in approach as each intervention is tailored to the individual and family. It is also impractical to assess the successive impact of cultural interventions through standard Western assessment.

The current Western definition of evidence-based interventions are practices or programs with peer-reviewed, documented empirical evidence of effectiveness. But what does this mean for culturally grounded interventions? The current Western dominant paradigm of evidence base prioritizes research, peer review, and randomized controlled trials. However, we cannot continue to adhere to this Western dominant paradigm, which heavily bases itself on the assumption that research in the social sciences is essentially the same as natural sciences.³⁷

Western research looks for themes formulated together to produce “laws” or one size fits all, blanket approaches to social issues.³⁸ “This way of understanding people and their struggles has become dominant in a very particular economic and cultural milieu, one that, despite the forces of globalization, is alien to many communities around the world. Its materialist and individualist focus means that it is often a specifically inappropriate vehicle to use with Indigenous communities.”³⁹

A newly conceptualized journey of healing for Native Hawaiians should utilize and uplift stories of resilience to resonate with, inform, educate, and empower those impacted, those who help navigate these systems, and those who choose to walk alongside the healing journey.

Therefore, our recommended approach is centered around healing the *ahupua’a* system through culturally grounded programs that allow for tailored interventions that meet the specific needs of individuals and families living within the healthy, thriving *ahupua’a* system.

Topic/Source: Implications for a System of Care in Hawai’i: Primary Care Integration of Substance Use Disorder Treatment

Information: **Abstract**

Primary care physicians (PCPs) in Hawai’i face many challenges in treating patients with substance use disorders (SUD) who tend to have higher medical complexity and thus require more resources. PCPs play a vital role in identifying early misuse, integrating and coordinating care for patients with SUD including office-based interventions like medication-assisted treatment, and connecting patients to community treatment programs. In addition to enormous burdens to care for and increasingly complex patient panels, the challenges include lack of education on addiction medicine, insufficient resources and SUD treatment programs in the office and community, low reimbursement for the complexity of care provided, and an overall physician shortage which drives higher patient volume and less time for any given physician. This article suggests responses to address these challenges such as providing more training and continuing education in SUD for PCPs and trainees, enhancing team-based care to better support PCPs, and funding more SUD treatment programs. More funding should widen accessibility to treatment and reduce the overall burden on the health care system by preventing or treating the disease early, which is a core principle of primary care. Additionally, incentives to practice in Hawai’i in primary care, and especially to treat patients with SUD, need to be improved. Such steps must be taken to address the overall physician shortage that limits patients’ access to SUD treatment. A collaborative care model between PCPs, care managers, and addiction specialists is an example of an integrated care system that may address many of these challenges in the short term. To truly improve care for all in Hawai’i, however, system wide interventions are essential to increase the incentive for PCPs to remain and practice in Hawai’i to take care of its unique population, including those dealing with SUD.

Keywords: primary care, primary care physicians, substance use disorder, medication assisted treatment, Hawai'i

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Background & Introduction

Substance use is a pervasive public health issue in the United States and in Hawai'i, where substance use disorders (SUD), especially for methamphetamine, have been prevalent for decades.¹ According to the National Survey on Drug Use and Health 2018-2019, 68.2% of individuals ages 12 and older in Hawai'i used illicit drugs, tobacco products, or alcohol in the past year, with 5.2% (estimated 60 000 people) having alcohol abuse/dependence, and 2.4% (estimated 28 000 people) having an illicit drug abuse/dependence, in the past year.² Due in part to its geographic isolation, Hawai'i faces many challenges including shortages in primary care physicians (PCPs) and addiction treatment resources which make it difficult to provide adequate care for patients with SUD. Since substance use is common and can lead to a multitude of health issues, PCPs, as the first entry point to health care for most people, play a vital role to assist patients with SUD. By identifying and managing problematic substance use early, PCPs can make a significant impact on health care outcomes. As part of the larger Hawai'i Department of Health Alcohol and Drug Abuse Division (ADAD) State Plan Systems of Care Implications project, this article will focus on the challenges PCPs face and recommendations to alleviate the situation. For more background and context around the overall State Plan project, readers are referred to the introductory article. Although challenges discussed in this manuscript are primarily physician focused, many of these also apply to other health care providers who practice in the primary care setting, such as advanced practice providers. Primary care-based interventions such as early screening and medication assisted treatment (MAT) will be emphasized since these are available tools for PCPs. A collaborative care model between PCPs, care managers and addiction specialists, is also described as an example of an integrated care system that would address many of the current system's challenges.

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Challenges in the Current System of Care in Hawai'i

In order to better understand the current system of care (SoC) and needs related to substance use, a literature review was conducted, and input and feedback was obtained from stakeholder groups which included community PCPs, representatives from the administrative aspects of the system (ie, pharmacy, billing and coding), behavioral health providers, resident training programs, and ADAD. These sources were incorporated into determining the scope of the issues and describing the needs in the SoC.

Overall Primary Care Physician Shortages

According to the 2020 Hawai'i Physician Workforce Report, more than 400 additional PCPs are needed across Hawai'i to meet the demand,³ resulting in enormous burdens on existing PCPs to

care for large and increasingly complex patient panels. The ideal PCP panel size is difficult to estimate, but according to Altschuler et al, in a non-delegated model (eg, physician completes majority of tasks instead of delegating work to non-physician staff) a manageable volume is 983.^{4,5} HMSA (Hawai'i Medical Service Association), the largest medical insurance company with more than half of Hawai'i population as members,⁶ currently sets an ideal number of patients for each PCP as 1500. In addition to current shortages, Hawai'i's pool of physicians is aging with 46% being 55 years or older, and many are expected to retire in the next 10-15 years. Hawai'i has its own medical school and several primary care residency programs and, on average 35% of Hawai'i residency/fellowship graduates practice as PCPs in Hawai'i. However, from 2010-2020 the retention rate has varied greatly from 11.8% to 64.8%, depending on the program and specialty.⁷ While physician shortages persist, PCPs are increasingly tasked to identify early substance misuse, to treat patients with substance use disorders (SUDs), and to integrate and coordinate care for complex patients with SUD.

Challenges in Use of SBIRT in Primary Care

The United States Preventive Services Task Force recommends universal screening for substance use for anyone age 18 and over and the American Academy of Pediatrics recommends a universal screening for adolescents.^{8,9} Primary care offices are the ideal setting to provide this screening service for early detection and intervention. Screening alone, however, is insufficient.¹⁰ Several different models exist for acting on positive screening results. Screening, brief intervention, and referral to treatment (SBIRT) has been extensively studied, proven to improve patient outcomes, and has the flexibility and feasibility for implementation in the primary care setting.¹¹⁻¹⁴ Motivational interviewing (MI) is another evidence-based tool that can help to elicit change in a patient's risky behavior and lead to healthier lifestyles. Practicing SBIRT and MI enables PCPs to detect and intervene with patients with mild to moderate SUD symptoms, preventing conditions from developing or worsening.^{15,17}

There are many reasons cited why SBIRT or other interventions are not routinely conducted in the primary care setting, including workload, lack of training and low reimbursement for the time spent.^{18,19} According to a survey of PCPs in New Mexico, only 25% of primary care offices from a predominantly minority serving southwest regional practice-based research network conducted universal screening for alcohol and illicit drug use.¹⁶ Yoast et al²⁰ report that "reimbursement has been a commonly identified barrier to physicians' ability to address SUD concerns with their patients."

The Hawai'i SBIRT Project progress report identified several common challenges among PCPs in Hawai'i related to lack of infrastructure and support. One challenge included difficulty securing buy-in from small private offices to train staff to provide SBIRT, with time needed for training and capacity to have in-house behavioral services cited as primary barriers. For neighbor island PCPs, the fewer number of outpatient and inpatient treatment services to refer to was a significant limitation. Another systems level challenge was the lack of standardization among electronic health record programs, since modifying electronic health records to enable implementation of SBIRT requires significant financial and IT resources.¹⁵

To unify care for its more than 720 000 members state wide,⁶ HMSA, launched its "Māhie 2020"⁶ initiative in 2015 and, as part of this initiative, launched "Payment Transformation" which pays a fixed

amount upfront on a per-member per-month (PMPM) basis. Hawai'i providers participating in HMSA's Payment Transformation receive average \$24 PMPM (range \$8-\$70 PMPM)⁶ with higher rates for patients who have complex medical conditions, or who are at higher risk based on disease burden and certain social determinants of health. However, documenting the codes for medical complexity correctly is a highly onerous task for physicians, and the exact increase in PMPM based on the codes is often not transparent.²¹ These direct payments are insufficient to keep smaller, independent, and younger providers' practices open. This high administrative burden combined with taking on more patients to meet growing overhead costs with insufficient compensation has contributed to high rates of burnout among PCPs and is associated with an overall decrease in quality of care.⁶ More than 80% of Hawai'i providers surveyed felt that Payment Transformation has worsened the PCP shortage in Hawai'i and said they would not recommend that someone entering the field of medicine come to Hawai'i to practice medicine as a PCP.⁶ Incorporating screening and treatment of SUD in addition to routine preventive care and other health needs into a 15-minute office visit is a constant struggle for PCPs.

Continuing Care for SUD

Among those who had illicit drug/alcohol dependence or abuse in the past year in Hawai'i, 30.1% had Medicaid/QUEST plans.² Follow-up rates for these patients are lower for a variety of reasons, including factors related to social determinants of health such as transportation barriers and decreased access from clinicians who accept Medicaid. Patients with SUD need frequent follow-ups, especially those who are on MAT, with studies showing increased primary care visits coupled with decreased overall health care costs due to less acute care utilization.²² An external quality review of QUEST Integration Health Plans showed that follow up care after emergency department (ED) visits for alcohol or drug abuse/dependency within 7 days for their patients was poor, with scores between 2-3 stars (highest, 5 stars) compared to national standards.²³ Per the National Committee for Quality Assurance, the majority of QUEST Integration Health Plans in Hawai'i are rated 1-2 stars by their members under items "Getting Needed Care" and "Getting Care Quickly".²⁴

Gaps in Physician Education and Support to Manage Patients with SUD

Training for physicians to motivate behavioral change and address addictions is historically lacking. Medical schools often do not provide adequate education in SBIRT, MI, and substance use education. According to a report from the Surgeon General, only 8% of medical schools had a separate required course on addiction medicine and 36% had an elective course.²⁵ More recently, medical schools have started to implement curricula for appropriate opioid management and treatment for opioid use disorder, but lack of faculty expertise continues to be a major obstacle. The average required hours for postgraduate substance use training during a 3-year residency for family medicine, internal medicine, and pediatrics was only 12 hours, 5 hours, and 4 hours respectively.²⁶ This limitation in training is reflected locally in the number of clinicians licensed to prescribe buprenorphine: there are currently 167 health care providers (primarily physicians, but also nurse, and physician associate practitioners who consented to release their practice information) listed on the Substance Abuse and Mental Health Services Administration Buprenorphine Practitioner Locator for the State of Hawai'i, compared to 3290 physicians actively practicing in the state.^{3,26,27}

Additionally, stigma and discrimination by health care professionals toward patients with SUD is well described in the literature and can result in suboptimal health care. For example, there is an ongoing negative attitude toward evidence-based treatments such as prescribing MAT for SUD among PCPs,²⁸ especially among those who lack confidence to provide treatment.²⁹ Moreover, there are no Food and Drug Administration approved MAT options for methamphetamines (one of the most commonly abused substances in Hawai'i) and successful treatment requires a significant investment of time and behavioral resources not readily available for most PCPs.³⁰

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Interventions

Strengthening SBIRT Implementation

Screening for SUD is the vital first step to initiating treatment. Locally, ADAD has conducted training for SBIRT implementation among primary care offices throughout the state with promising results. A progress report on the Hawai'i SBIRT Project showed that providers trained in SBIRT gained skills and increased their capacity for SBIRT use in the community. This report also found that having organizational champions to support leadership, promote use of SBIRT, and obtain resources were key factors in enhancing sustainability of SBIRT.¹⁵

Education alone however may not be sufficient to implement SBIRT and other screening tools in the PCP office. Palmer et al,³¹ discussed various barriers for PCPs such as time constraints to perform SBIRT. Referral to treatment programs was frequently perceived as a challenge by PCPs, in part due to a local shortage of such programs especially outside of O'ahu.³² To alleviate time constraints, an increased reimbursement rate may improve screening rates by increasing the incentive to screen. Adequate financial support for physicians to have dedicated staff and time would support workflow enhancements to implement SBIRT and improve the consistency of its procedures.³¹

Use of Telehealth to Reduce Stigma

Telehealth or telephone visits are useful methods to decrease stigma and increase access to care for all patients, especially those in rural/underserved areas.³³ Patients with SUD often report feeling discrimination in PCP offices,³⁴ which can discourage them from seeking medical help; telemedicine can help to reduce potentially stigmatizing interactions that would occur in a physical waiting room.³⁵ Studies show that telemedicine is an effective method to manage SUD patients by improving follow-up rates and treatment completion leading to overall improved outcomes.³⁶⁻³⁸ Since the COVID-19 pandemic, reimbursement for telemedicine has improved. The authors strongly advocate this should continue indefinitely.³⁹ PCPs can implement brief interventions and refer patients to behavioral health specialists for ongoing therapy.⁴⁰

MAT

As stated above, SUD treatment program shortage is a serious problem in Hawai'i.³² To increase accessibility for proven SUD treatment such as MAT, the Drug Enforcement Agency (DEA) recently

waived the requirement of a separate registration for mobile components of registrants approved to dispense narcotic drugs in schedules II-V (includes methadone) at remote location(s) for the purpose of maintenance or detoxification treatment. These revisions to the regulations are intended to make MAT treatments more widely available,⁴¹ thereby providing additional referral sites for PCPs. MAT is shown to decrease substance use, overdose death, criminal activity, and infectious disease transmission.⁴² Although, receiving MAT treatment in PCP office may be most ideal, mobile MAT providers can provide additional referral sites for PCPs who may feel uncomfortable dealing with MAT or too busy to provide MAT themselves.

Collaborative Care Model

A collaborative care model integrating PCPs, recovery coaches and addiction specialists can help address the issues of education/training, physician shortages and limited MAT/SUD treatment program availability.⁴³ A 2019 study by Wakeman et al⁴³ showed that an intervention linking PCPs and patients with recovery coaches and addiction specialists led to significantly more primary care visits during the 9 month follow up period, along with fewer ED visits and fewer total inpatient bed days.⁴³ For the intervention group in the study, interdisciplinary teams were organized into groups including PCPs, nurses, administrative staff and recovery coaches. This team met twice a month to discuss care plans of complex SUD patients where an addiction specialist provided input about the patients as well as support and education for the team. Recovery coaches played a major role in supporting patients and facilitating referrals to treatment. The control group did not have recovery coaches or integrated addiction treatment within the practice. The study suggested that the collaborative care for 1000 SUD patients would result in 98 fewer hospital days, 90 fewer ED visits, and an additional 627 primary care visits in a year. The study also showed an increase in MAT when an addiction specialist provided education and support.⁴³

The Substance Use Motivation and Medication Integrated Treatment study, a randomized trial conducted by Watkins et al,⁴⁴ clearly showed that collaborative care (CC) for opioid and alcohol use disorder increased treatment use and self-reported abstinence compared to traditional primary care. In the CC group, all treatment progress was tracked and reviewed during the team meetings. The patients in CC groups received a prompt by coordinators reaching out to them when appointments were missed. Participants in traditional care were only given a phone number for making appointments and a list of community/clinic treatment referrals. CC integrated into primary care for substance use treatment resulted in improved patient outcomes.⁴⁴

Hawai'i has already implemented similar integration systems between PCPs and mental health providers. Queen's Clinically Integrated Physician Network (QCIPN) Collaborative Care Model (CoCM) is one such system. Being part of QCIPN allows PCPs to participate in team-based mental health care. The team has 3 full time care managers (CMs) and 2 social work assistants. When PCPs refer patients for psychiatric consultation, a CM initially interviews the patient, typically via Webex or phone. The CM then presents the case to the psychiatrist at the weekly meeting. Based on the CM report, the psychiatrist gives their diagnostic impression and treatment recommendations. Phone calls are made directly to the PCP as needed. The CM regularly follows up with the patient by phone, which includes providing counseling to keep the patient engaged in treatment and tracking progress using anxiety and depression scales as applicable.

The team-based approach supports PCPs to work more efficiently while also focusing on higher complexity patients, enables CMs to address the social determinants of health that are crucial to recovery, and empowers all team members to work at the highest level of their licensure. Extending this care model to patients with SUD through the involvement of addiction specialists would address many of the challenges listed previously.

A panel for 1 full time CM is estimated to be up to 50 SUD patients at any given time. Estimating that these patients require an average of 6 months follow up, 1 full time CM is capable of serving 100 patients per year.⁴⁵ Preliminary data by QCIPN shows encouraging results including a decrease in ED visits, hospital admissions and readmissions among those who are under the care of CoCM, resulting in significant cost savings for the entire health care system.⁴⁶

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Recommendations

The following recommendations are proposed as part of a larger group working on SoC Integration for Substance Use in Hawai'i. These recommendations were based on the synthesis of the existing literature, interventions, feedback from members of the Hawai'i Academy of Family Physicians and from the Hawai'i Addictions Conference. In particular, discussions with the QCIPN (behavioral health provider network) were important in arriving at recommendations involving the collaborative care model. These recommendations were also reviewed and vetted by key stakeholder groups which provided information around the existing challenges.

Improve Clinician Education to Optimally Manage Patients with SUD

Education is essential to treat patients with SUD because it leads to less stigma and more confidence in substance abuse treatments.^{47,48} PCPs are more likely to offer addiction treatment after receiving education and support from initiatives that promote increasing access to SUD treatment.⁴⁹ Education and additional resources for PCPs to take care of patients with SUD may include: establishing a website where busy PCPs can obtain information to prescribe MAT at the point of care; and offering short webinars with useful tools to treat SUD. Offering continuing medical education credits may further incentivize providers to utilize these educational resources. Collaborating with the current free weekly Hawai'i State Rural Health Care Association project ECHO (Extension for Community Healthcare Outcomes) may be ideal. Training sessions can also be offered as live in-person workshops at the annual Hawai'i Addictions Conference. Hawai'i primary care residency programs should incorporate mandatory trainings on substance use, MAT, and DEA X-waiver training for buprenorphine, so that all new physicians are optimally prepared to manage SUD at the start of their careers. Medical schools should incorporate more substance use education and training into the standard curriculum for students to get earlier exposure. Further methods to support PCPs could include a non-emergent email/phone line to access advice from an addiction team such as the Hawai'i Society of Addiction Medicine. One of the major obstacles to provide this education/support however is financial; keeping the course modules up to date, providing a help desk function, organizing courses, and contacting speakers puts a high burden on all involved.⁵⁰

Expand MAT

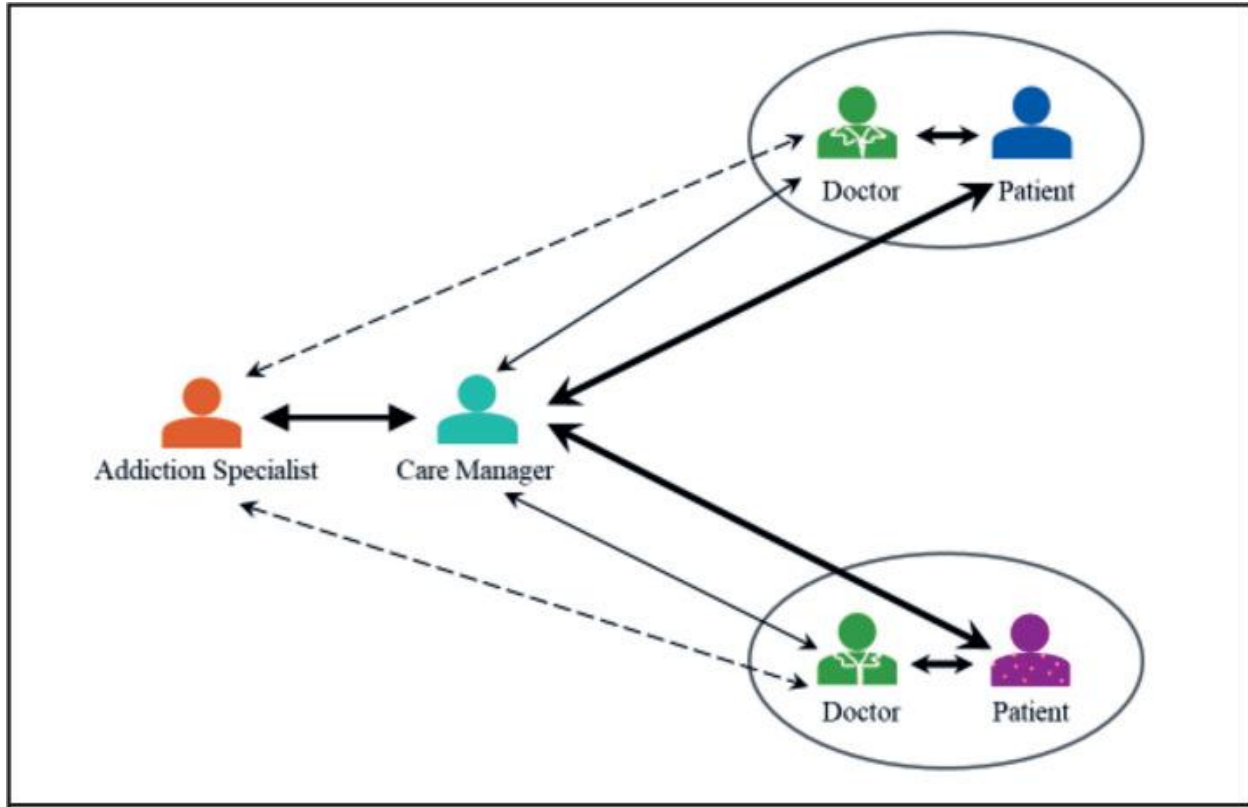
To expand the availability of treatment programs, funding mobile clinics is proposed so that MAT, especially methadone will be available for all islands. Unlike other forms of MAT, patients must go to the clinic daily to obtain methadone (federal law),⁵¹ therefore having clinics at a reasonable distance is essential. As of writing this article, there is no clinic that can dispense methadone for opioid use disorder on Kaua'i, Moloka'i or Lana'i.⁵² Moreover, clinics are only available in limited locations on the other islands (in Honolulu, Hilo, and Wailuku). Methadone is a full opioid agonist and studies have shown better retention rate as compared to buprenorphine, a partial opioid agonist which can be filled as a regular prescription.⁵³ Increasing accessibility of MAT will provide additional sites and support PCPs can refer their patients to for treatment.

Incentivize Care for Patients with SUD

The authors recommend a more comprehensive SoC, including better reimbursement rates and more resources for wraparound care provided by CMs or patient navigators to screen and provide brief intervention to patients with SUD or at risk for SUD. As suggested by the current literature, increasing reimbursement would allow PCPs to have additional support staff for administrative tasks and to address social determinants of health. This would free up more PCP time for counseling and treating higher complexity SUD patients. As for HMSA HMO patients, an increase in base PMPM as well as transparency in payment increases may improve motivation for PCPs to spend more time and schedule frequent follow up visits with their more vulnerable patients. The authors also propose higher PMPM for all complex patients, including those who on MAT since they typically require more office visits, counseling, and coordination of care. Payers should provide additional incentives and reward physicians who care for medically and socially complex patients, such as those with SUD, as high-quality primary care for these individuals leads to decreased costs for the system as a whole.⁵⁴

Collaborative Care between Primary Care and Addiction Specialists

Adapting the existing QCIPN CoCM model by substituting psychiatrists for addiction specialists could increase access to addiction care ([Figure 1](#)). It is uncertain at this time how many full-time primary care practices can be covered by 1 full time CM. Due to lack of education and training to take care of SUD patients among PCPs, the numbers of referrals may be higher initially. Such collaboration would expand the use of MAT for opioid use and alcohol use disorders among PCPs and improve access for patients.



[Figure 1.](#)

Diagram of Proposed Integrated Addiction Specialist and PCP Clinic: Collaborative care. (Line thickness corresponds to frequency and depth of the encounter.) Original diagram illustration by Micaiah Cape. Used with permission.

This model can be implemented first on O.ahu within the major health systems and their affiliated PCPs who use the same electronic medical record system. Addiction specialists eventually can also serve the other islands via virtual meeting platforms

Another recommendation is an integration of PCPs and addiction specialists at methadone clinics that serve opioid use disorder patients. In a recent study, methadone patients who had a designated PCP were associated with a roughly 50% reduced risk of having 2 or more ED visits in a year.⁵⁵ Having a co-located PCP within methadone clinics would also likely lead to more consolidated and coordinated care for patients' SUD and primary care needs.

Increase Interest, Incentives, and Funding to Build Primary Care Workforce

A full discussion on increasing physician retention and compensation, especially for PCPs, is outside the scope of this article. However, it is impossible to discuss improving primary care integration for substance use treatment without fully understanding the current state of primary care and the health care environment in Hawai'i. Nationally, medical students are less interested in going into primary care for a variety of reasons including low income compared to specialist peers and high administrative burden.⁵⁶ Hawai'i has one of the highest costs of living nationally, yet simultaneously

is one of the worst states for physicians in terms of pay, ranking 5th worst in the nation for lowest average annual wage for physicians in 2021.^{57,58} New physicians with accumulated debt from medical school and residency training are more likely to move to more affordable, higher paying states to enable faster payment of debt. Increasing incentives, such as loan repayment programs may play a role in physicians' choice of practice location.⁵⁹ Rourke⁶⁰ suggests some factors for increasing the number of physicians includes increasing numbers of medical students from the area, stable practices with appropriate facilities and health care teams, functional referral networks, and improved financial incentives for practicing in the area. Increasing incentives for PCPs to work in Hawai'i by expanding loan repayment, scholarships, or other incentive programs, and higher reimbursements, would lead more students to pursue primary care fields and more residents to stay local after completing training.^{61,62}

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Conclusion

PCPs in Hawai'i face many challenges in managing patients with SUD to prevent adverse health and social outcomes. Issues outlined include: a need for better training in SUD, inadequate resources to support physicians (such as SUD treatment program shortages),³² disincentives to manage patients with SUD, and a significant physician shortage that is worse among PCPs.³ These combined challenges place heavy burdens on currently practicing physicians as well as advanced practice providers. Hawai'i's access to follow up especially for those with SUD is subpar, and funding SUD programs and telemedicine will provide wider access to SUD treatment. PCPs also need a supportive environment and adequate professional education to take care of patients with SUD early before problems multiply. Collaboration between PCPs and addiction specialists is a model that could address many of local challenges in Hawai'i including increased access to care for patients and more support for PCPs. To truly improve care for all in Hawai'i, however, systemic interventions such as adequate reimbursement, loan re-payment programs, and rewards to manage complex patients including those with SUD, are essential to increase incentives for PCPs to remain and practice in Hawai'i.

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Abbreviations and Acronyms

CC	Collaborative Care
CoCM	Collaborative Care Model
CM	Care Manager
DEA	Drug Enforcement Agency
ED	emergency department
HMO	health maintenance organization
HMSA	Hawai'i Medical Service Association
MAT	medication assisted treatment
MI	motivational interviewing
PCP	primary care physician
PMPM	per member per month
QCIPN	Queen's Clinically Integrated Physician Network
SBIRT	screening, brief intervention, and referral to treatment
SoC	system of care
SUD	substance use disorder

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Conflict of Interest

None of the authors identify a conflict of interest.

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Notice of Duplicate Publication

This article is based on the draft version of a chapter from the Hawai'i State Department of Health Alcohol and Drug Abuse Division (ADAD) State Plan, and all or a majority of the contents within will be subsequently also reproduced in the corresponding chapter of the final version of the ADAD State Plan (<https://health.hawaii.gov/substance-abuse/state-plan/>). While the ADAD State Plan may later be modified as a living document following its release, the material and content found in this article

represents a snapshot of the highlights of the ADAD State Plan at the time of the article's publication.

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Topic/Source: **National Asian Pacific American Families Against Substance Abuse (NAPAFASA) - Website**

Information: Since 1988, the National Asian Pacific American Families Against Substance Abuse (NAPAFASA) has served and worked with Asian American, Native Hawaiian, and Pacific Islander communities on initiatives and projects addressing behavioral health in our communities.

We aim to involve

This means direct participation by everyday people, sharing their views and experiences.

We aim to connect

It means bringing people together to share knowledge, tools, personal stories, and encouragement with each other.

We aim to represent

While we are rooted in serving Asian American, Native Hawaiian, and Pacific Islander communities, we know that the well-being of one community is bound up with the well-being across diverse communities, so we work with people from all backgrounds.

Topic/Source: Opioid Response Network

Information: For individuals seeking information about treatment, please visit SAMHSA or call SAMHSA's National Helpline. 1-800-662-HELP (4357) 1-800-487-4889 (TTY) Free and confidential information in English and Spanish for individuals and family members facing substance use and mental health issues is available 24 hours a day, 7 days a week.

Opioid Response Network

The Substance Abuse and Mental Health Services Administration (SAMHSA) funded the State Opioid Response – Technical Assistance grant to the American Academy of Addiction Psychiatry in collaboration with the Addiction Technology Transfer Center (ATTC), Columbia University Division on Substance Use Disorders and a large national coalition. In response, this coalition, representing over

2 million stakeholders, created the *Opioid Response Network (ORN)* to provide training and address the opioid crisis.

The *Opioid Response Network* has local consultants in all 50 states and nine territories to respond to local needs by providing free educational resources and training to states, communities and individuals in the prevention, treatment and recovery of opioid use disorders and stimulant use.

Every organization, individual, community, state and region has unique strengths and challenges, which is why it is imperative for the *Opioid Response Network* to have local consultants and technology transfer specialists to work with you to meet your needs at the local level. We are here to help.

What Can We Do For You?

The *Opioid Response Network's* local consultants and partner organizations are providing:

- Community trainings on the prevention, treatment and recovery of opioid use disorder.
- Education and training in evidence-based clinical practices for all health professionals in how to create treatment models that work for your specific healthcare system and patients.
- Training for justice/corrections/law enforcement on evidence-based practices for the prevention, treatment and recovery of substance use disorders with a focus on opioid use disorder and stimulant use.
- Resources communities and organizations can use, such as promising care models, trainings, educational materials.
- Educational materials to help your community address the stigma surrounding this disease.
- Training on primary components needed in creating local coalitions to address opioid use disorders and stimulant use in your community.
- Guidance on implementation of treatment modalities.



How Does It Work?

Individuals make a request by [completing a TA request form](#). Within 24 business hours, the designated technology transfer specialist for your state will respond to obtain more information from you about your request. Note: *The more specific your request is, the easier it will be to assist you.*

Keep in mind that the *Opioid Response Network* cannot provide assistance in obtaining grants, nor can it allocate funds to support your event, but we can provide someone to train/educate or provide feedback on your work. Simply put, the network provides education and training at the local level to make sure your needs are addressed in the form of education, training and educational resources.

Topic/Source: Recovery Dharma Online

Information: Recovery Dharma Online (RDO) is a thriving and robust community of [Recovery Dharma](#) members from around the world. We meet up at Online/Phone meetings and stay in contact between events. The fruit of this effort is a growing community of meetings driven by Spiritual Friends. We support each other on our paths of recovery.

Our Meetings

RDO members facilitate many different meetings each week using variations of the Recovery Dharma meeting format. Many combine meditation with readings from the book to inspire discussion, others focus on meditation and sharing alone, while others have special formats like speaker meetings or self-inquiry practice. From the meeting list you can click through to read the full details of the format and structure of each meeting.

For some, the video+phone meetings serve as our home-base for community. For others, these meetings serve to augment attendance at local in-person meetings. We encourage everyone to attend whatever meetings fit in their schedule!

[View the full meeting list on the homepage »](#)

Governance and Intersangha Meetings

RDO, like Recovery Dharma Global, is a peer-led project. Leadership is shared among the various meeting facilitators, volunteers who've made a commitment to care for a meeting and ensure a reliable schedule for attendees.

Long-term decision making and shared projects are discussed at our [quarterly Intersangha meetings](#), which take place on the third Saturday of the month every three months, in January, April, July, and October.

“Sangha” means community, and we call these meetings “Intersangha” because they are a coming together of the various smaller communities that attend each meeting.

Agendas for upcoming meetings, as well as detailed notes from all past ones can be found on the RDO Intersangha Meeting Rolling Agenda (<http://bit.ly/rdo-agenda>)

All facilitators and any interested participants are encouraged to attend Intersangha meetings to get involved! Here are some of the items likely to be discussed:

- Reports from facilitators about how meetings are going and any support they need from the wider community.
- Financial updates about fundraising and expenses.
- Infrastructure discussions about the meeting platforms and website.
- Discussions on meeting formats and issues/solutions for meeting facilitators.
- Planning of future special workshops and events.
- Other issues brought up by community members and facilitators.

For more info see [Intersangha Meetings »](#)

Suggested Meeting Script

While each RDO meeting is independent, and free to determine its own format and meeting script, the RDO Intersangha maintains a version of the script that sets a recommended baseline for all meetings. You can find the Google Doc here: [RDO Suggested Meeting Script](#).

This script contains improvements and tweaks for running online meetings that are safe and effective. Changes to this script, which are always ongoing and agreed to during our quarterly Intersangha calls, can be suggested and commented on in this “discussion” Google Doc: [RDO Suggested Meeting Script: DISCUSSION VERSION](#)

Please read the introductory text in the DISCUSSION VERSION for more details on how you can participate!

Gratitude and Generosity

RDO is organized by and for peers who are traveling and working on the RD Path. All events and resources are offered freely on a volunteer basis.

We collect donations to cover the technical expenses involved in hosting this website and the Zoom videoconference platform.

Topic/Source: Napafasa

Information: NAPAFASA is a private, non-profit, 501(c)(3) organization dedicated to mental health advocacy through research, efforts at public health and policy reform, and community empowerment.

We are committed to social justice and health equity through working to reduce substance use disorder, promoting harm reduction, and partnering with our communities to achieve mental wellness.

In order to get there, we know it takes putting community voices at the heart of our work.

Since 1988, the National Asian Pacific American Families Against Substance Abuse (NAPAFASA) has served and worked with Asian American, Native Hawaiian, and Pacific Islander communities on initiatives and projects addressing behavioral health in our communities.

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Topic/Source: U.S. Code § 11701 - Findings on Native Hawaiian Health Bill - Historical

Information: The Congress finds that:

(1)

[Native Hawaiians](#) comprise a distinct and unique indigenous people with a historical continuity to the original inhabitants of the Hawaiian archipelago whose society was organized as a Nation prior to the arrival of the first nonindigenous people in 1778.

(2)

The [Native Hawaiian](#) people are determined to preserve, develop and transmit to future generations their ancestral territory, and their cultural identity in accordance with their own spiritual and traditional beliefs, customs, practices, language, and social institutions.

(3) The constitution and statutes of the State of Hawaii:

(A)

acknowledge the distinct land rights of [Native Hawaiian](#) people as beneficiaries of the public lands trust; and

(B)

reaffirm and protect the unique right of the [Native Hawaiian](#) people to practice and perpetuate their cultural and religious customs, beliefs, practices, and language.

(4)

At the time of the arrival of the first nonindigenous people in Hawaii in 1778, the [Native Hawaiian](#) people lived in a highly organized, self-sufficient, subsistence social system based on communal land tenure with a sophisticated language, culture, and religion.

(5)

A unified monarchical government of the Hawaiian Islands was established in 1810 under Kamehameha I, the first King of Hawaii.

(6)

Throughout the 19th century and until 1893, the United States: (A) recognized the independence of the Hawaiian Nation; (B) extended full and complete diplomatic recognition to the Hawaiian Government; and (C) entered into treaties and conventions with the Hawaiian monarchs to govern commerce and navigation in 1826, 1842, 1849, 1875 and 1887.

(7)

In the year 1893, the United States Minister assigned to the sovereign and independent Kingdom of Hawaii, John L. Stevens, conspired with a small group of non-Hawaiian residents of the Kingdom, including citizens of the United States, to overthrow the indigenous and lawful Government of Hawaii.

(8)

In pursuance of that conspiracy, the United States Minister and the naval representative of the United States caused armed naval forces of the United States to invade the sovereign Hawaiian Nation in support of the overthrow of the indigenous and lawful Government of Hawaii and the United States Minister thereupon extended diplomatic recognition of a provisional government formed by the conspirators without the consent of the native people of Hawaii or the lawful Government of Hawaii in violation of treaties between the two nations and of international law.

(9)

In a message to Congress on December 18, 1893, then President Grover Cleveland reported fully and accurately on these illegal actions, and acknowledged that by these acts, described by the President as acts of war, the government of a peaceful and friendly people was overthrown, and the President concluded that a "substantial wrong has thus been done which a due regard for our national character as well as the rights of the injured people required that we should endeavor to repair".

(10)

Queen Lili'uokalani, the lawful monarch of Hawaii, and the Hawaiian Patriotic League, representing the aboriginal citizens of Hawaii, promptly petitioned the United States for redress of these wrongs and for restoration of the indigenous government of the Hawaiian nation, but this petition was not acted upon.

(11)

In 1898, the United States annexed Hawaii through the Newlands Resolution without the consent of or compensation to the indigenous people of Hawaii or their sovereign government who were thereby denied the mechanism for expression of their inherent sovereignty through self-government and self-determination, their lands and ocean resources.

(12)

Through the Newlands Resolution and the 1900 Organic Act, the United States Congress received 1.75 million acres of lands formerly owned by the Crown and Government of the Hawaiian Kingdom and exempted the lands from then existing public land laws of the United States by mandating that the revenue and proceeds from these lands be “used solely for the benefit of the inhabitants of the Hawaiian Islands for education and other public purposes”, thereby establishing a special trust relationship between the United States and the inhabitants of Hawaii.

(13)

In 1921, Congress enacted the [Hawaiian Homes Commission Act, 1920](#) which designated 200,000 acres of the ceded public lands for exclusive homesteading by [Native Hawaiians](#), thereby affirming the trust relationship between the United States and the [Native Hawaiians](#), as expressed by then [Secretary](#) of the Interior Franklin K. Lane who was cited in the Committee Report of the United States House of Representatives Committee on Territories as stating, “One thing that impressed me . . . was the fact that the natives of the islands who are our wards, I should say, and for whom in a sense we are trustees, are falling off rapidly in numbers and many of them are in poverty.”.

(14)

In 1938, the United States Congress again acknowledged the unique status of the Hawaiian people by including in the Act of June 20, 1938 ([52 Stat. 781](#) et seq.), a provision to lease lands within the extension to [Native Hawaiians](#) and to permit fishing in the area “only by [native Hawaiian](#) residents of said area or of adjacent villages and by visitors under their guidance”.

(15)

Under the Act entitled “An Act to provide for the admission of the State of Hawaii into the Union”, approved March 18, 1959 ([73 Stat. 4](#)), the United States transferred responsibility for the administration of the Hawaiian Home Lands to the State of Hawaii but reaffirmed the trust relationship which existed between the United States and the Hawaiian people by retaining the exclusive power to enforce the trust, including the power to approve land exchanges, and legislative amendments affecting the rights of beneficiaries under such Act.

(16)

Under the Act entitled “An Act to provide for the admission of the State of Hawaii into the Union”, approved March 18, 1959 ([73 Stat. 4](#)), the United States transferred responsibility for administration over portions of the ceded public lands trust not retained by the United States to the State of Hawaii but reaffirmed the trust relationship which existed between the United States and the Hawaiian

people by retaining the legal responsibility of the State for the betterment of the conditions of [Native Hawaiians](#) under section 5(f) of the Act entitled “An Act to provide for the admission of the State of Hawaii into the Union”, approved March 18, 1959 ([73 Stat. 4](#), 6).

(17)

The authority of the Congress under the United States Constitution to legislate in matters affecting the aboriginal or indigenous peoples of the United States includes the authority to legislate in matters affecting the native peoples of Alaska and Hawaii.

(18)

In furtherance of the trust responsibility for the betterment of the conditions of [Native Hawaiians](#), the United States has established a program for the provision of comprehensive [health promotion](#) and [disease prevention](#) services to maintain and improve the health status of the Hawaiian people.

(19)

This historical and unique legal relationship has been consistently recognized and affirmed by the Congress through the enactment of Federal laws which extend to the Hawaiian people the same rights and privileges accorded to American Indian, Alaska Native, Eskimo, and Aleut communities, including the [Native American Programs Act of 1974](#) [[42 U.S.C. 2991](#) et seq.]; the [American Indian Religious Freedom Act](#) [[42 U.S.C. 1996](#), 1996a]; the [National Museum of the American Indian Act](#) [[20 U.S.C. 80g](#) et seq.]; and the [Native American Graves Protection and Repatriation Act](#) [[25 U.S.C. 3001](#) et seq.].

(20)

The United States has also recognized and reaffirmed the trust relationship to the Hawaiian people through legislation which authorizes the provision of services to [Native Hawaiians](#), specifically, the [Older Americans Act of 1965](#) [[42 U.S.C. 3001](#) et seq.], the [Developmental Disabilities Assistance and Bill of Rights Act](#) Amendments of 1987, the Veterans' Benefits and Services Act of 1988, the [Rehabilitation Act of 1973](#) [[29 U.S.C. 701](#) et seq.], the [Native Hawaiian Health Care Act of 1988](#), the [Health Professions Reauthorization Act of 1988](#), the [Nursing Shortage Reduction and Education Extension Act of 1988](#), the [Handicapped Programs Technical Amendments Act of 1988](#), the [Indian Health Care Amendments of 1988](#), and the [Disadvantaged Minority Health Improvement Act of 1990](#).

(21)

The United States has also affirmed the historical and unique legal relationship to the Hawaiian people by authorizing the provision of services to [Native Hawaiians](#) to address problems of alcohol and drug abuse under the [Anti-Drug Abuse Act of 1986](#).

(22)

Despite such services, the unmet health needs of the [Native Hawaiian](#) people are severe and the health status of [Native Hawaiians](#) continues to be far below that of the general population of the United States.

([Pub. L. 100–579, § 2](#), Oct. 31, 1988, [102 Stat. 2916](#); [Pub. L. 100–690, title II, § 2302](#), Nov. 18, 1988, [102 Stat. 4223](#); [Pub. L. 102–396, title IX, § 9168](#), Oct. 6, 1992, [106 Stat. 1948](#).)

Topic/Source: **Code Chapter 122 - NATIVE HAWAIIAN HEALTH CARE - Native Hawaiian comprehensive health care - Educational Resource**

Information: Papa Ola Lokahi shall serve as a clearinghouse for:

- (1) the collection and maintenance of data associated with the health status of [Native Hawaiians](#);
- (2) the identification and research into diseases affecting [Native Hawaiians](#);
- (3) the availability of [Native Hawaiian](#) project funds, research projects and publications;
- (4) the collaboration of research in the area of [Native Hawaiian](#) health; and
- (5) the timely dissemination of information pertinent to the [Native Hawaiian health care systems](#).

Topic/Source: **Hā Kūpuna, the National Resource Center for Native Hawaiian Elders - Website**

Information: Hā Kūpuna, the National Resource Center for Native Hawaiian Elders, is one of three National Resource Centers for Native Elders funded by the U.S. Administration on Aging (AoA), Department of Health and Human Services. Funded since 2006, Hā Kūpuna seeks to improve health and increase life expectancy of our treasured *kūpuna* (Native Hawaiian elders). On this website you can find:

- [Our mission and goals](#)
 - [Advisory Council](#)
 - [Training and Technical Assistance](#)
 - [Research](#)
 - [Publications and Presentations](#)
 - [Resources for Nā Kūpuna and their families](#)
 - [Resources for Professionals and Academics](#)

Topic/Source: **Conceptualizing a New System of Care in Hawai'i for Native Hawaiians and Substance Use**

Information: Abstract

Native Hawaiians of all age groups tend to show a higher prevalence of substance use than other ethnic groups in the state. Research shows that this inequitable health status results from several

complex and interconnected social determinants of health, including historical trauma, discrimination, and lifestyle changes. Before European contact, Native Hawaiians understood that balanced nutrition, physical activity, social relationships, and spirituality were fundamental to

maintaining optimal health. Western influences triggered an imbalance in Native

Hawaiian society, shifting the paradigm of Native Hawaiian family systems.

Historical and cultural trauma affect multiple generations and are linked to

Native Hawaiian health disparities. Cultural trauma is defined as “the loss of

identity and meaning that negatively affects group consciousness. It marks and changes them in fundamental and irreversible ways, often resulting in the loss of language, lifestyles, and values.”

The remedy for cultural trauma

is cultural reclamation. Historical trauma is defined as psychosocial trauma

experienced by Indigenous groups as a result of colonization, war, genocide, or cultural, social, and political subjugation. These historical and cultural aspects have impacted and reached across generations of Native Hawai-

ians. The outcomes of these traumas are reflected in higher rates of health

disparities, including mental health and addiction, which have affected the social determinants of health. Current access to treatment and recovery is limited for Native Hawaiian residents with substance use problems. This article will look at a system of care that would reduce silos and incorporate cultural aspects to improve outcomes for Native Hawaiians receiving services. This article will also introduce an ‘āina- (land-) based model for creating healthy, thriving Native Hawaiian individuals, ‘ohana (family), communities, and care systems.

Keywords

Native Hawaiian, treatment modalities, cultural support

Abbreviations and Acronyms

ADAD = Hawai'i State Department of Health Alcohol and Drug Abuse Division
DSM-5 = Diagnostic and Statistical Manual of Mental Disorders 5th Edition
RREM = Recovery Ready Ecosystems Model

Background and Introduction

Native Hawaiians historically sought healing within their ‘ohana

(family) systems. Prior to European contact, Native Hawaiians understood that *lōkahi* (harmony), which included balanced nutrition, physical activity, social relationships, and spiritual-

ity were fundamental to maintaining optimal health.¹⁻³ Native Hawaiian health has been illustrated in a Lōkahi Triangle¹⁻³ as

an equilateral triangle, with the apex labeled as Nā Akua (Gods/Goddesses/spirituality), and the base on one end labeled as

kānaka (person) and the other as ‘āina (land). Historical trauma is defined as psychosocial trauma experienced by Indigenous groups as a result of colonization, war, genocide, or cultural, social, and political subjugation.⁴ From the first European arrival in 1778, colonization, systematic oppres-

sion, and Western imperialism have led to a loss of traditional healing practices, and our [This article includes the first person voice from the lens of the Native Hawaiian authors and to acknowledge Indigenous ways of knowledge.] Native peoples were forced into Western treatment frameworks for matters that were historically addressed within the ‘ohana. Today, Native Hawaiians suffer from health disparities in chronic diseases⁵

and overrepresentation across all social services, including ad-

diction services,⁶ incarceration for drug offenses, and offenses due to addiction diseases.⁷ Intergenerational substance use and incarceration impact individual, ‘ohana, keiki (children), and community health. Disproportionate numbers of our Native population have been consistently overrepresented among those who are seeking or thrust into Western treatment for substance use disorders.⁶

Existing systems of care continue to assign treatment within the same Western frameworks leading to this consistent over-

representation. In the present paper, we highlight key points from a chapter of the Hawai‘i Department of Health Alcohol and Drug Abuse Division (ADAD) State Plan which examines the roots of disparities in the intersections of Native Hawaiians and substance use and reimagines a system of care that would reduce silos and incorporate cultural aspects to improve outcomes for Native Hawaiians receiving services. For more background and context around the overall State Plan project, readers are referred to the introductory article of this special supplement.

Observations and Rationale

Cultural trauma is defined as “the loss of identity and meaning that negatively affects group consciousness. It marks and changes them in fundamental and irreversible ways, often resulting in the loss of language, lifestyles, and values.”⁸ Our Native ‘ohana

have become disconnected from their cultural heritage through-

out generations. Many of these ‘ohana carry intergenerational trauma created by oppression and criminalization of the Native

identity at the hands of those who colonized our island home. Further layers of complexity are added through the loss of land and abrupt lifestyle changes from subsistence living into a capitalistic environment, the ramifications of which created stark socioeconomic differences between Native Hawaiians and their Western counterparts. These differences have led to generations of poverty, houselessness, and mental health issues for Native Hawaiians that continue today. The Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) recognizes the unique nature and importance of cultural concepts of distress.⁹ However, a Native Hawaiian worldview has not yet been included in those listed. The Cul-

tural Formulation Interview and supplemental modules in the DSM-5 provide a framework for assessment and a first step in approaching these areas through a broader lens. However, when in distress, seeking medical, behavioral/mental health, or substance use services, our Native people are treated by clinicians trained in predominantly Western ways. Therefore, clinicians working with Native individuals and families must be educated on our history, historical injustices, traumas, the impacts of colonization, traditional beliefs and practices, and understanding of the Hawaiian worldview.¹⁰ Paglinawan and colleagues maintain that the remedy for cultural trauma is cultural reclamation.¹¹ To develop effective, culturally

focused approaches for working with Native Hawaiians, we must look i ka wā kahiko (to ancient times), to our kūpuna (elders),

and to respected healers within our community to understand how ma‘i (sickness) was approached during ancestral times. Hawaiian ma‘i, Hawaiian illnesses, or ma‘i kama‘aina, call for Hawaiian assessment, diagnosis, and treatment which is an an-

cient concept with deep roots in Hawaiian healing. Ma‘i malihini

or illnesses that stem from Western influence, such as infectious or chronic disease, could be treated through Western medicinal pathways. However, they are still best coupled with traditional

kānaka health and well-being approaches to heal the spirit. For substance use, the root of this kind of ma‘i is much deeper, and it could be understood almost as an amalgamation of ma‘i

i kama‘aina and ma‘i malihini. Understanding these concepts requires deep reflection and study (with practitioners of Hawai-

ian healing) of ma‘i that contributes to an unhealthy kānaka

environment, such as historical/intergenerational trauma and the loss of connection. Also, by understanding the root causes of ma‘i kama‘aina, as well as the manifestation of addiction as a

symptom of this deeper trauma¹² practitioners can be better prepared to provide culturally focused interventions. Loea Ho`oponopono Auntie Lynette Paglinawan, a revered haku

ho`oponopono (cultural practitioner in the Native Hawaiian practice of healing families through forgiveness) and social worker who studied under Auntie Mary Puku`i (a revered cultural practitioner), offers us some of the most valuable insight into assessing Native Hawaiian individuals and `ohana.

Assessment and intake from a Western approach can be off-putting and invasive for some Native Hawaiians. Culturally, we must take a more Indigenous approach by “talking story” with the `ohana or individuals. Caseworkers must voice inten-

tions, explaining “why questions may be asked and how they will be applied to the problem at hand.”¹³ During the intake or assessment process, it is also important to determine the best approach for our Native people to determine whether a cultur-

ally grounded healing would be most beneficial. Similarly, there exists a gap in the development of culturally-focused interventions. Okamoto provides an assessment of the strengths and limitations of developing culturally focused interventions (Table 1).¹⁴ In summary, culturally grounded in-

terventions provide a “ground-up” approach from a foundation of culture. Non-adaptation, surface-structure cultural adapta-

tion interventions provide a “top-down” approach, altering

the original model to add cultural components. Finally, deep-structure cultural adaptations use a “sprinkling in” approach of integrating culture into the intervention, providing “changes to images or phrases throughout its content or lessons, to align the program with familiar concepts or references of a specific cultural group.” Providers who utilize culturally-based treat-

ment focusing on Native Hawaiians provide interventions in alignment with Okamoto’s categories. However, most provid-

ers lack the capacity to develop an evidence base that meets Western requirements, as illustrated in the limitations set by Okamoto et al.¹⁴

Indigenous ways of knowing provide evidence that predates any semblance of Western evidence, yet the Western way is somehow dominant today. An Indigenous evidence base has been established orally by passing down the knowledge of our people through traditional practices, storytelling, song, and much more. The Indigenous-based evidence, coupled with evidence from community-based participatory action research approaches, should be used to develop and measure the efficacy of culturally resonant/attuned interventions.

Current System of Care in Hawai‘i

According to ADAD, Native Hawaiians were admitted to treat-

ment 1358 times in 2017, which is 42.3% of the state total and the most of any ethnic group.¹⁵ This overrepresentation has been

reflected throughout the past decade.⁶ In that same year, over 30% of Native Hawaiian admissions to ADAD treatment were referred via the criminal justice system, increasing to over 40% in 2020.¹⁶ Of those Native Hawaiians accessing services, over 40% indicated methamphetamine addiction as their primary substance of issue.¹⁶ This consistent overrepresentation further illustrates the ineffective nature of the Western treatment of Native peoples. ADAD collects, uses, and develops fund allocations based on ethnicity data. Due to those efforts, ADAD can identify the

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Table 1. Strengths and Limitations of Approaches in Developing Culturally Focused Interventions^a

Culturally grounded prevention intervention	Deep-structure cultural adaptation intervention	Non-adaptation/surface intervention
Strengths	Limitations	Strengths
Limitations	Strengths	Limitations
Community is engaged and invested in the development of the program	Time Consuming	Based on empirically supported intervention principles
Assumes the core components of an evidence-based program are applicable across cultural groups	Tests the applicability of generic/ universal prevention principles to unique groups	Often unacceptable to or disconnected from the community
Directly addresses core cultural constructs	Expensive	Balances length of time and costs to develop curriculum with the ability to bring the program to scale
Need to specify and retain the core prevention components for fidelities	Faster to develop, implement, and bring to scale	Can potentially avoid core cultural components
Core prevention components are derived organically (from the “ground up”) and can therefore be intertwined with core cultural components	Difficult to evaluate and replicate in similar settings	Engages the community, but within the parameters of a specific evidence-based program
May inadvertently alter core components and decrease their effectiveness	Based on empirically supported interventions, but with questionable “fit.”	

^a Used with permission from Okamoto et al.¹⁴

disproportionate representation of Native Hawaiians receiving services for substance use in the state. Current policies allow for flexibility for treatment providers in set activities tailored to Native Hawaiians, thus allowing for the offering and inclusion of alternative treatment methods. However, the current gap exists in providers, cultural practitioners, and ADAD discussing and agreeing upon culturally resonant documentation and report-

ing of cultural services in clinical notes on how their treatment improves protective factors or reduces risk factors. This gap can be addressed by developing a culturally responsive system of care that uplifts and values Indigenous knowledge and cultural healing pathways. The current system of care in Hawai‘i does include some providers who use varying degrees of culturally based or cul-

turally adapted treatment and prevention programs. Treatment providers who contract with the ADAD adhere to the 5 Levels Of Care model established by the American Society of Addic-

tion Medicine,¹⁷ which includes early intervention, outpatient, intensive outpatient, residential, and medically managed ser-

vices.¹⁸ Most providers utilize Western interventions such as cognitive-behavioral therapy, dialectical behavior therapy, or 12-step programs (a model used for Alcoholics Anonymous/Narcotics Anonymous). Treatment providers who employ utilization of culturally based treatment with a specific focus on Native Hawaiian values con-

tinue to find difficulty in billing for cultural services to ADAD, as well as including cultural services in treatment plans to accurately capture the successive impact that cultural reclamation can have on the individual, the ‘ohana, and the community. For Kānaka

Maoli (Native Hawaiians), cultural reclamation can be defined as a spiritual/cultural healing process of a reawakening within the na‘au (visceral mind) to deeper learning and understand-

ing of the underlying reasons for their cultural beliefs, cultural practices, and their true identity as Kānaka Maoli.¹⁹ Learning about one’s history and cultural heritage, genealogy, and cultural morals and values, making ancestral connections, engaging in cultural practices (eg, working in the lo‘i (taro field), dancing the hula) and learning to speak one’s language facilitates healing

and cultivates cultural pride, which nurtures the development of a positive cultural identity and overall self-image.¹⁹ Most providers are dependent on outside funding to cover the costs of cultural practitioners to provide culturally-based healing, which only further silos culturally-based approaches from Western treatment constructs and places a burden on the provider to maintain 2 separate pathways of healing. The State also supports school and community-based youth prevention programs.¹⁸ Given the reliance on nationally endorsed evidence-based practices, the majority of youth substance use programs implemented in Hawai‘i have not been designed to support Native Hawaiian youth and communities specifi-

cally.²⁰ Two exceptions are the school-based Ho‘ouana Pono middle school drug prevention curriculum²¹ and the Hawaiian Homestead-based Puni Ke Ola adolescent substance use pro-

gram.²² The National Institute on Drug Abuse funded Ho‘ouana Pono Program which has been evaluated in a set of studies²³

and is currently working with their state partners to develop

a sustainability strategy.²⁴ The Puni Ke Ola program has been supported through a variety of local and national sources in the intervention development²⁵ and feasibility phases,²⁶ aligns with a Culture-as-Health Framework,²⁷ and currently is funded by ADAD and Papa Ola Lōkahi in preparation for multi-community implementation.

Interventions (Re-imagined)

Re-envisioning a culturally responsive system of care first requires us to identify parallel strengths and potentially det-

rimental differences that form the existing colonized/Western system’s foundation through the examination of 3 key areas: (1)

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Cultural perceptions of self; (2) Shifting to a cyclical continuum, and (3) the Ahupua‘a model. Recent research indicates that re-envisioning treatment for the Native population, utilizing cultural reconnection, and methodologies that speak to Native perspectives, are more influential in creating positive health outcomes for Native peoples.⁵

Native Hawaiians need a sense of place to anchor values and balance life. Beyond Western practices, Native Hawaiians need to care for the ‘āina, which they understand to deeply care for them. Native Hawaiians need the resiliency and protection that culture provides through language, traditions, and ceremonies, allowing ways to reconnect to ancestral knowledge and spiri-

tuality. Native Hawaiians need not become Western to heal.⁵ According to Papa Ola Lōkahi and a Native Hawaiian Partner-

ship, ‘Imi Ke Ola Mau (a community collaboration Co-Occurring State Incentive Grant [COSIG]), for Native Hawaiians to heal, “[They] need a sense of self, retrieved from our past through ancestors, present through purpose, and future through descen-

dants. [They] need our language, traditions, and ceremonies, which provide ways to reconnect to our spirituality and the concept of our source. [They] need the resiliency and protection our culture provides, in order to prevent relapse and redefine ourselves away from pathological diagnoses.”²⁸

Cultural Perceptions of Self

Current care systems addressing substance use are rooted in historically colonized systems, centered on Western approaches to individualistic care.²⁹ This individualistic and egocentric concept of the person can be contrasted with more sociocen-

tric, ecocentric, or cosmocentric views, which understand the person in relation to the social world, the environment, and the cosmos.²⁹ The collective vs individual mindset within the Hawaiian worldview is dramatically different from Western approaches that are highly individualistic, and often do not account for historical and cultural trauma. However, personal boundaries and understanding of self are not identical in every culture. The same methods used to treat and heal cultures rooted in individualism can be harmful to those rooted in various other cultural configurations of the self, such as Indigenous cultures. Ignoring the self's internalized concept can leave the client with no way to reconcile their internal self-healing within the larger society's connective tissue, those social interactions that sustain the self within the community, and their collective healing.²⁹ Each categorical perception of self varies in the ways the self is defined; the values underpin and characterize a healthy perception of the ideal self, the understanding of one's role in specific actions or events, and associated healing systems.²⁹

Shifting to a Cyclical Continuum

On a traditional continuum of care, recovery is viewed as the phase after treatment. These individual areas can frequently become siloed, only concentrating on their specific prevention, treatment, or recovery areas. The depth of the recovery field often overlaps within the treatment area, as there are many pathways toward healing and recovery, and not all individuals in recovery have followed a path that involves clinical treat-

ment. Recovery and healing are lifelong processes. Therefore, we must begin to re-envision the existing continuum of care, embrace culturally grounded approaches, and begin to see the entire continuum as cyclical rather than linear, with each area of focus informing the next. The linkages between recovery and prevention lie in using one to inform the other through the feedback of successful outcomes, promoting maui ola (well-being), and educating clients about making healthy, informed choices.²⁸ We can approach this shift

toward a cyclical continuum through systems thinking as a way to see the phases along the continuum as interrelationships rather than as siloed components. This shift allows us to look for patterns of change rather than accepting static snapshots or defaulting to how it has always been.³⁰ From a culturally informed or holistic perspective, systems thinking can help us understand whether the purpose of the existing system is being accomplished and look for ways to create more equitable and resonating systems of care, thereby achieving better results with fewer resources in lasting ways.³⁰ Keeping this cyclical nature in mind, we can move toward a resiliency- and recovery-oriented care system where each phase informs one another, as seen in

Figure 1 which spans the entire continuum of care. At the center of Figure 1, the piko, we can see the depiction of self, ‘ohana, and community: 3 interrelated, interconnected healing targets. You cannot heal just one; all must be healthy for each to flourish. The Substance Abuse and Mental Health Services Administration explains that the resiliency- and

recovery-oriented care system “is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve improved health and wellness outcomes for those at risk or experiencing issues with substance misuse.”³¹ The Recovery Ready Ecosystems Model (RREM) provides a model to increase recovery prevalence and focus on supporting and building recovery-informed infrastructure within com-

munities.³² Collective healing of our communities is needed to combat intergenerational traumas that lead to stigma and NIMBYism (“not in my backyard”), which inhibit the healing of our Native people and their communities. The recovery-

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Figure 1. Kanaka (person) ‘Ohana (family) Kaiaulu (community)^{aa} Original unpublished figure created by the authors/Lilinoe Kauahikaua of Papa Ola Lōkahi, and duplicated with permission 2021

informed infrastructure allows for a backward mapping approach to building a culturally resonant system, beginning with what is working. Recovery through an RREM lens encompasses the many pathways to healing, including harm reduction, behavioral/mental health, reentry, peer recovery services, diversion courts, and many more. RREM provides an avenue of alignment with Indigenous, collective healing approaches. Another way to acknowledge, value, and uplift the Indigenous experience is through culturally grounded peer support. Peer support can only be provided by someone with lived experience and provides a layer of support, empathy, and understanding unparalleled by other clinical support. Peer recovery specialists can be invaluable for our Native people, who often struggle with Western recovery spaces and language. Culturally grounded peer support services help address that dichotomy of individualism on the Western spectrum, with a more collectivist or holistic approach toward healing, ola, and the well-being of the whole environment. Recovery for many may even take the place of clinical treatment. We must support these services with the same vigor and intent as the areas of promotion, prevention, and treatment. A newly conceptualized healing journey for Na-

tive Hawaiians should utilize and uplift stories of resilience to resonate with, inform, educate, and empower those impacted, those who help navigate these systems, and those who choose to walk alongside the healing journey.

Ahupua‘a Model

Our Native people thrived in Hawai‘i for centuries before Western contact. Native Hawaiians developed a complex resource management system through the ahupua‘a system, a land division of interconnected systems stretching from the mountain to the sea. The ahupua‘a model provides a framework to implement cultural interventions at various places within the ahupua‘a to effectively provide healing that impacts not only the individual but their ‘ohana and community as well. Interventions within the metaphorical framework would aim to effectively decrease the intergenerational transmission of risk factors (intergenerational/historical/cultural trauma, colonization, poverty, oppression, loss of traditional healing practices, criminalization of Native identity, loss of land, and family/community history of use/incarceration) and increase the intergenerational transmission of protective/resiliency factors

(‘ohana relationships, cultural wisdom, traditional healing, com-

munity connection, mo‘okū‘auhau [genealogy], ‘āina, respect for kupuna, and culture). The model draws from Dr. Keawe Kaholokula’s model of the social and cultural determinants of health and their relation to Maui Ola (health).³³ Our ahupua‘a

stretched ma uka a i kai (mountain to sea), connected through

wai (water), which flowed through each system section to bring life. Wai ran through our lo‘i (kalo patch), and loko i‘a

(fishponds), and down into the ocean, where it evaporates and becomes ua (rain) to once again fall from the lani (sky), run through our nāhele (forests), and down throughout the rest of the ahupua‘a. No one system functioned independently. Kānaka, our people, tended these systems knowing that resources were finite and the land must flourish for us to survive. He ali‘i ka ‘āina, he kawa ke kānaka,³⁴ the land is chief, and us its servant. Looking at the lo‘i system, within our ahupua‘a system, I ka wa kahiko (ancient times), if these systems were not function-

ing correctly, or not healthy, and if those who mālama (to take care of) these spaces were not ma‘a (accustomed, used to, familiar) to this understanding, no one would be fed. Lo‘i

is the Native Hawaiian’s agricultural system using terraces along the hillsides. They developed complex systems, similar to water paddies, to grow their staple food of kalo (taro) along the valleys. We should understand the external impact on this substantive system. We can understand kalo as a reflection of ourselves, of hāloa, our ancestor, our root, both metaphorically and physically. We conceptualize this new system of care, one where Native people can thrive and pursue healing pathways that embrace, empower, and value an Indigenous worldview. We achieve this by recognizing interconnections within sys-

tems and understanding how feedback from each area along the continuum of care impacts and informs other system areas as a whole, much like the ahupua‘a.

As we visualize the system through this culturally informed and holistic lens, we must also acknowledge that current data often aggregates ethnicities, is disparity-focused, and has a history of portraying Native/Indigenous populations by showing what is wrong. Therefore, the ahupua‘a model (Figure 2) provides a metaphorical model to understand collective healing through a Native lens and embraces a recovery perspective that recognizes substance use as a symptom of a larger trauma. The ahupua‘a

is a living, breathing example of a thriving, healthy Native system. Through this model, practitioners can identify the root causes of trauma, and develop effective culturally informed interventions to engage in collective healing from trauma and celebrate resiliency outcomes. With the help of our Indigenous cousins, we continue to explore the manifestations of deeper trauma within ourselves, ‘ohana, and communities through the model of a Healing Ahupua‘a, inspired by the Healing Forest model created by White Bison.^{35,36} Pre-contact, our ahupua‘a were healthy and existed in a har-

monious relationship, tended by kānaka (Native people) who understood that each interconnected system within the ahupua‘a

must be healthy for all to thrive. However, Figure 2 outlines the impacts of colonization, racial/cultural traumas, negative socio-economic impact, the criminalization, and subsequent loss of the Native identity has had on Native Hawaiian individuals,

‘ohana, and communities. These impacts are carried through the ahupua‘a system as risk factors impacting generations. We visualize these risk factors entering our ahupua‘a through the ua or rain. This ‘eha, or pain/trauma, is passed down from generation to generation and compounded by unresolved grief. All of this ‘eha creates layers of huhū (anger), hewa

(guilt), hilahila (shame), and maka‘u (fear), which enter into our ahupua‘a just as the metaphorical rain feeds into the soil. We look at the systems and visualize the ‘eha (pain/trauma) impacting the soil to understand the pollution and other toxins that have found their way into our environment and continue to impact our systems through the environmental water cycle cyclically. The potentially unhealthy/impacted soil would then run off into the kahawai (river) and be carried downstream, impacting the rest of our interconnected systems. But, just as trauma is passed down generationally, our ancestors pass down the strengths and resilience (as seen in the ua). We can understand the interconnected ahupua‘a systems as our care systems, our ‘ohana, and our communities. In understand-

ing care systems and approaches to healing within the larger continuum, we focus on the lo‘i as an ‘āina-based model to visualize the internal and external impacts of trauma and the manifesting symptom of substance use on our lāhui ecosystem. As the unhealthy soil enters into our lo‘i, it becomes that which feeds the next generation of kalo or hāloa that emerges from it. Today, we may have generations of people born with internal

‘eha buried deep within them. If the ‘eha begins to bubble up to the surface, it can manifest in many different ways in our kalo; anger, violence, substance use, etc, giving way to an unhealthy

ahupua‘a. However, we can remember that our strengths and cultural resilience are also contained in the ua and soil. In that

case, we see a path forward in cleaning our water of the risk factors to improve and increase our protective/resilience factors for generations to come. We can imagine that, while working in the lo‘i one day, we find a kalo that is sick (manifesting trauma as addiction). First, we must look around to the other kalo to find the source of the sickness. Are the other kalo sick? Is the whole lo‘i sick? How could this sickness be getting in? We must look up the interconnected ‘auwai (canal) and the kahawai for the source of this sickness, this pollution, this ‘eha. If we cannot find the source of this ma‘i, this sickness, and we instead decide we will just take that one kalo out, heal it, and then put it back into that potentially unhealthy environment, it will only get sick again.

This metaphor illustrates we will face the same result we began with if we decide to solve the problem on the surface that we see. We need to put in the work to address the root of the problem, look far enough up the system, and dig deep enough to find the source that creates the unhealthy environment. Recognizing how Native Hawaiians experience the self through ecocentric, cosmocentric, and sociocentric definitions provides a lens for understanding and developing more impactful and effective interactions for Native people are implemented through the ahupua‘a framework. Thereby cleaning our wai as it traverses throughout our interconnected systems and is reborn through the water cycle to fall as ua once again, reducing risk factors and increasing protective factors. This increase in protective factors will contribute to the healthy lo‘i and ahupua‘a through the soil waiwai (rich) with lōkahi (balance), maui ola (health),

mana (spiritual energy), and pilina (connection/bonds), foun-

dational values for a thriving lāhui kānaka (Native Hawaiian people), as seen on the right side of the image (Figure 2). The

ahupua‘a conceptual framework is intended to develop and grow as the framework is embraced and actualized across systems and care spaces. Embracing a more culturally grounded approach would effec-

tively provide a paradigm shift in how society and individuals see themselves. Imagine the empowerment of nurturing and uplifting these unique gifts contained within Native Hawai-

ian protective/resiliency factors and the impact or effect they would have on someone’s life, how they grew up, and how they perceive themselves. By understanding the multiple threads impacting their lives, a more robust, comprehensive (holistic) approach that incorporates (blends) the interventions used will have more value for this Native person.

Figure 2. The Impacts of Colonization on Ahupua'a. Conceptualization by Lilinoe Kauahikaua and Papa Ola Lōkahi V3.0_{aa} Original Copyrighted Unpublished figure created by Kimo Apaka and edited by the authors and duplicated with permission 2022.

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Recommendations

Table 2 displays proposed recommendations to guide the initial steps toward implementing of a newly conceptualized system. These recommendations were based on the synthesis of the existing literature and available data, but also Indigenous knowledge and feedback from our stakeholder groups.

Conclusion

Current culturally grounded interventions have struggled for some time to meet the requirements for evidence-based inter-

ventions and assessments required by Requests for Proposals (RFP's) and Grant applications. These methods often do not align with culturally grounded intervention programs which tend to be more fluid in approach as each intervention is tailored to the individual and family. It is also impractical to assess the successive impact of cultural interventions through standard Western assessment. The current Western definition of evidence-based interven-

tions^{37,38} are practices or programs with peer-reviewed, docu-

mented empirical evidence of effectiveness. But what does this mean for culturally grounded interventions? The current Western dominant paradigm of evidence base prioritizes research, peer

Table 2. Recommendations to Guide the Initial Steps toward Implementation of a Newly Conceptualized System_a

1. Infrastructure Development Reporting Standards

- Create a network within Native Hawaiian communities across the State to increase engagement capacity (accountability and ongoing feedback loop).

Inter-agency

- With other State departments, develop a cross-discipline group to focus on creating inter-agency engagement strategies (protocols) and outcomes (procedures) (i.e., specialty cultural court).- Identify areas where language and processes can be updated to shift the narrative and create a more inclusive space for integrating Native Hawaiian values and beliefs.

Peer Support

- Value and uplift lived experience- Develop culturally grounded, resonant, inclusive, and supportive peer spaces for Indigenous people on their healing journey from substance use.- Create reimbursement pathways for care systems employing peers.

2. Data Collection & Disaggregation Data Disaggregation

- Address the need for data sovereignty that allows Native Hawaiians to develop data collected for, by, and about us.- Create mechanisms that identify culturally relevant data collection.- Develop culturally anchored evaluation tools that state-funded treatment programs

use related to the efficacy of programming specific to Native Hawaiians.

3. Funding & Monitoring/Oversight Funding

- Track federal dollars that are sought after and awarded to the State of Hawai'i

where Native Hawaiians (and or other marginalized groups indicated on request for

proposal) are targeted, and create a clear plan for accountability and meaningfulness

of programming.- Analyze spending on Native Hawaiian programs throughout the department.- Create a policy oversight position to develop criteria and monitor cultural adherence.

Advisory Council

- Establish a council of relevant partners (providers, government, stakeholders) to monitor compliance and review accountability of funds and programming related to Native Hawaiians. - Convene a group of Native Hawaiian health and well-being specialists from across the state to provide feedback and guidance on the process of funding.^a Dr. Sheri Daniels, Papa Ola Lōkahi (2021)

review, and randomized controlled trials. However, we cannot continue to adhere to this Western dominant paradigm, which heavily bases itself on the assumption that research in the social sciences is essentially the same as natural sciences.³⁷Western research looks for themes formulated together to pro-duce “laws” or one size fits all, blanket approaches to social issues.³⁸ “This way of understanding people and their struggles has become dominant in a very particular economic and cultural milieu, one that, despite the forces of globalization, is alien to many communities around the world. Its materialist and indi-

vidualist focus means that it is often a specifically inappropriate vehicle to use with Indigenous communities.”³⁹A newly conceptualized journey of healing for Native Hawaiians should utilize and uplift stories of resilience to resonate with, inform, educate, and empower those impacted, those who help navigate these systems, and those who choose to walk alongside the healing journey. Therefore, our recommended approach is centered around heal-

ing the ahupua‘a system through culturally grounded programs that allow for tailored interventions that meet the specific needs of individuals and families living within the healthy, thriving

ahupua‘a system.

Topic/Source: