

Papa Ola Lōkahi

E OLA MAU A MAU

THE NEXT GENERATION OF NATIVE HAWAIIAN HEALTH

MENTAL & BEHAVIORAL HEALTH & WELLNESS REPORT

E OLA MAU A MAU – THE NEXT GENERATION OF NATIVE HAWAIIAN HEALTH

Copyright © 2019. Papa Ola Lōkahi. All Rights Reserved.

No part of this report may be reproduced or transmitted in whole or in part in any form without the express written permission of Papa Ola Lōkahi.

Suggested Citation:
Papa Ola Lōkahi. (2019). E Ola Mau A Mau – The Next Generation of Native Hawaiian Health. Honolulu, HI: Papa Ola Lōkahi.

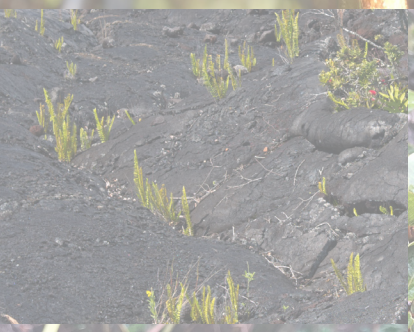
For the electronic version and additional resources on Hawaiian health and well-being please visit: www.papaolalokahi.org





















Chapter Two:
Mental and Behavioral Health and Wellness

Mental and Behavioral Health and Wellness

Naleen N. Andrade, Deborah Goebert, Earl Hishinuma
Kate Leilani Kahoano, Pohaokalani Sonoda-Burgess, Jessi Cadorna
Isabella Ahrens, Kalei Chandler-Ahsing, Melissa Hamada, Kauanoe Kamanā
Noella Kong, Sasha Madan, Nālani Minton, Deja Ostrowski, Charlie Schlather
Aukahi Austin Seabury, Jeanelle Sugimoto-Matsuda, Ian Chun, Mark Alapaki Luke
Anaeliz Colon, Ciera Pagud, Adriano (Puna) Sabagala
Kealoha Fox, Palama Lee, Jane Ka‘ala Pang, William Rezentes

Executive Summary

Increased Understanding

There has been a tremendous amount of research over the last 30 years with nearly **20,000** scholarly publications and reports related to Native Hawaiian mental or behavioral health.

- ❖ The volume of publications increased with the disaggregation of Native Hawaiians from other Pacific Islanders and Asians, expanding our understanding of the scope of the issues as well as risk and protective factors.
- ❖ With few exceptions, Native Hawaiians manifest greater mental health challenges than do non-Hawaiians.
- ❖ Native Hawaiians are dealing with multiple stressors and external factors that impact their overall health, including individual and social challenges, perceived racism, oppression and social injustice.
- ❖ Native Hawaiian cultural activities can promote healthy lifestyles and decrease stress. More than three-quarters of Native Hawaiians believe it is important to live and practice Hawaiian culture on a daily basis.
- ❖ Despite the challenges that Native Hawaiians face, there are clear protective and resiliency factors, including a strong sense of hope, and positive ‘ohana[1] and community support.

Effective and Promising Approaches

The primary value of our community is service. A community is not a community if nobody's giving of themselves. The value of family and togetherness only comes to light when people give unconditionally. The giving of oneself, which we loosely translate as Aloha, is at the heart of every thriving community.

C. Kimo Alameda, PhD
Clinical Psychologist
Hawai‘i Island

Dr. Alameda, a Native Hawaiian clinical psychologist who has played a major role in public mental health services that incorporate Native Hawaiian cultural traditions and practices, succinctly captures the thematic focus of community engagement defined within the matrix of aloha (i.e., a core Native Hawaiian value and practice of empathic caring and compassion) which runs through the promising approaches, described below, that are effectively addressing mental and behavioral health disparities.

- ❖ Commonalities among wellness, substance abuse treatment, and mental health treatment programs for Native Hawaiians that have been shown to be effective include strengths, community, indigenous, and culturally informed approaches.
- ❖ Most of these programs provide a balance between Western best practices and cultural teachings and activities. There is a need to experience a sense of belonging and sense of place. Integration of Native Hawaiian traditional approaches and practices is essential for developing paths for healing.
- ❖ Programs have increased capacity to address the growing mental and behavioral health care needs of rural Hawai‘i through training and clinical service, integrating cultural and community-based perspectives.

[1] family

❖ These programs, designed to optimize Native Hawaiian mental and behavioral health, are frequently initiated and led by Native Hawaiians as key stakeholders. While the focus of many of these programs is on Native Hawaiians, the individuals they serve are multicultural.

Gaps

Progress made within mental and behavioral health services and initiatives has helped clinicians and researchers identify important gaps. In the bulleted paragraphs below, we describe those that must be addressed to accelerate our understanding and further refine our assessments and interventions.

❖ Data on Native Hawaiian mental and behavioral health and well-being status are challenging to find and not consistently or regularly collected and reported. Indigenous data governance can assert Native Hawaiian data rights and interests; ensure that data for and about Native Hawaiians are protected; and require quality and integrity of Native Hawaiian data and their collection.

❖ Disparities are magnified by limitation in access and availability of services, particularly in rural, primarily Native Hawaiian communities.

❖ While some programs have been found to be successful at improving well-being, most culturally based and adapted mental health interventions for Native Hawaiians have not been formally evaluated.

❖ A connection between historically traumatic events (physical, emotional, social, and spiritual genocide) and contemporary stressors has been posited to impact physical and emotional well-being but has not been well-studied among Native Hawaiians.

❖ While primary care integration and co-occurring disorder treatment have made significant advances, there remains a lack of a wholistic[2] approach to well-being.

❖ Few studies focus on Native Hawaiians across the lifespan. There is limited information on keiki[3] and kūpuna.[4] Research needs to examine developmental trajectories of Native Hawaiian mental health, which would provide essential information on the mental health needs across the Hawaiian lifespan. Treatment also needs to span multiple generations.

❖ Systems of care remain in silos, resulting in fractured and inadequate coordination.

Recommendations for Impact

- ❖ **Promulgate Effective Community Engagement Programs**
  - ❖ Programs that promote community engagement improve reintegration and social networking.
  - ❖ When programs can engage families instead of individuals, programs are more effective and can improve mental health status for more than just one individual.
  - ❖ Communities want to help shape the direction and focus of efforts through collaborations.
- ❖ **Expand Effective Culturally Based and Culturally Adapted Prevention and Treatment Interventions**
  - ❖ There is a need for programs using cultural and wholistic approaches designed to foster healthy Native Hawaiian mental health and behaviors and that prevent mental health challenges before they occur.
  - ❖ Such interventions bridge the gaps that Native Hawaiians may experience between their behavior and their values.
- ❖ **Decrease Stigma and Ensure Access to Services**
  - ❖ The stigma of mental illness adversely impacts all levels of well-being, including prevention, help-seeking, access, recovery and resilience.
  - ❖ A responsive system of care will improve access to mental health treatment and will eliminate health disparities for Native Hawaiians, their families, and communities.
  - ❖ An effective behavioral health system must be capable of providing an array of prevention and treatment options in multiple settings, including services that are culturally responsive and that contribute to and support improvement of treatment outcomes.

[2] The term wholistic is used intentionally to refer to the whole person. Locally many see negative connotations with the term hole-istic, suggesting this approach is not superior.

[3] young children

[4] elders

- **Increase Workforce Development and Training for Behavioral Health Providers**
  - Shortages of mental health providers disproportionately impact residents from neighbor islands and other rural communities.
  - Treatment for Native Hawaiians can have lasting effects if the provider uses treatments or skills that are relevant to the beliefs and values of the person being treated.
  - Native Hawaiian practitioners, mental health care providers, community health workers, and educators have direct linkages to appropriate resources that make them essential wellness navigators for the Native Hawaiian community.
- **Enhance Funding and Resources for Mental Health**
  - Native Hawaiian community-engaged and culturally based programs led by well-trained providers require funding.
  - More funding and resources in health, education, justice, and other systems are needed for sustainable effects.
- **Incorporate a Systems Approach that Utilizes the Socioecological Model and Focuses on Long-Term Sustainability**
  - The socioecological model considers the complexity of well-being and mental health, including interdisciplinary factors at various levels: individual, family, social, community, and societal.
  - Effective leadership will be crucial to develop, implement, and evaluate efforts and plans that address mental and behavioral health from a system's and sustainability approach.

Introduction

E Ola Mau Revisited

The *E Ola Mau Health Needs Study* (Native Hawaiian Health Research Consortium, 1985a, 1985b) was the first study that documented the scope of mental health needs among Native Hawaiians. Based on clinical populations, the study showed that among Hawaii's major ethnic groups, Kānaka[5] had higher rates of alcohol and substance abuse, depression, suicide, physical abuse and neglect, incarceration, and disruptive disorders. Further, the *E Ola Mau* study reported that Native Hawaiians were underrepresented in mental health professions and there were no senior researchers of Native Hawaiian ancestry. Major recommendations of the report included increasing the numbers of Native Hawaiians in mental health professions, training Native Hawaiian mental health researchers, conducting research on mental disorders among Native Hawaiians, and designing prevention and intervention strategies which addressed the unique cultural needs of Native Hawaiians.

My whole focus was to do clinical work, teaching, and research for Native Hawaiian health...I was one of the researchers for the E Ola Mau *report. I started working on it when I was still a resident [physician in training] under Dr. Kekuni Blaisdell. That was considered the whole plan and path for my professional career in terms of Native Hawaiian mental health because, at the time, there was really no epidemiologic map to tell us what was going on for Hawaiians…so I initiated [that] as part of my research. It took a while because no one had been doing that kind of research [in Native Hawaiian communities]…If you look back at the recommendations, we've made some significant progress in particular areas. But there are still some major gap areas where the recommendations are either forgotten or not fully implemented. We need to go back on the second go-a-round and get those implemented. The new* E Ola Mau a Mau *report update shows where it works, and where it didn't work. I think it brought tremendous awareness. It gave Hawaiian activists, in particular, factual evidence to make an appeal, which became a demand, about the rights of our people as indigenous people…I think Queen Emma and King Kamehameha IV [founders of The Queen's Hospital] knew that, and that was their legacy–to ensure that the health of their nation would be restored. I see the necessity to keep that going and to be mindful about how we have to do it.*

Naleen N. Andrade, MD
Professor, Department of Psychiatry
Director, Native Hawaiian & Pacific Peoples
Behavioral Health Research Programs
University of Hawai`i at Manoa
John A. Burns School of Medicine

[5] Native Hawaiians

❖ ***E Ola Mau a Mau***

As of July 2015, approximately 26% of the population in Hawai‘i self-identified as at least part Native Hawaiian or other Pacific Islander, which equates to approximately 363,000 people in the state of Hawai‘i (Department of Business, Economic Development & Tourism, 2015). This group of people, indigenous to the islands of Hawai‘i as "evidenced by genealogical records, kupuna (elder) or kama‘aina (resident) verification, certified birth certificates" (42 U.S.C. 11711), and/or self-identification on census reports, makes up the largest Pacific Islander population, accounting for 35% of all Pacific Islanders (Ta & Chen, 2008). Not only do Native Hawaiians make up the largest Pacific Islander population, "they are also the fastest growing racial and ethnic group in Hawai‘i" (p. 411). A major hindrance to research on Native Hawaiians and other Pacific Islanders is their underrepresentation in studies conducted in the United States. Within the United States, Native Hawaiians and Pacific Islanders make up the smallest ethnic group listed on the census in the United States, constituting only 0.2% of the population when counted alone, or 0.4% when including those of mixed race who are at least part Native Hawaiian or other Pacific Islander (U.S. Department of Commerce, 2015). With such a small percentage, Native Hawaiians are often underrepresented in research, and if they are included, they are usually part of an aggregate with the significantly larger Asian American population, which essentially masks the subgroup differences of the Native Hawaiians, especially in terms of health disparities. This was exemplified by approximately 20% of Native Hawaiians diagnosed with a depressive disorder compared to only 3.8% of Asian Americans (Cook, Chung, Ve'e, & Sousa, 2010). However, over half of the people who identify as being Native Hawaiian also reported belonging to at least another race, with European American and Asian being the most common (Hixson, Hepler, & Ouk Kim, 2012). As the population becomes more and more diverse, it is essential to understand how the changes affect mental health behaviors. While the numbers indicate an enduring and increasing presence of the Native Hawaiian people, it is obvious through critical exploration and review of scholarly literature that the Native Hawaiian perspective and participation in research, as well as culturally relevant forms of treatment, are still vastly underrepresented and undervalued.

This chapter describes the epidemiological profile of mental and behavioral health among Native Hawaiians that by necessity remains a continual work in progress; and the need for Native Hawaiian communities to understand sociocultural determinants of mental and behavioral health to develop culturally aligned interventions. During the past 15 years, new research methodologies have directed efforts toward social-cultural determinants and the development of culturally congruent mental health programs through community-engaged research—the vast majority of which has been by and with Native Hawaiian direction. Communities and researchers have worked together to eliminate mental health disparities and improve well-being in ways that are both culturally and scientifically sound. In this chapter, gaps are identified and potential solutions are proposed. The recommendations also highlight work that needs to continue. Key informant interviews, ‘ōlelo no‘eau,[6] and mele[7] are shared to capture the essence of the topic areas and island communities. It is our hope that this review will help chart the direction for the next generation as they strive to increase understanding, eliminate disparities, and improve the well-being of Native Hawaiians.

Increased Understanding

Since the 1985 *E Ola Mau – Mental Health Task Force Report* (Native Hawaiian Health Research Consortium, 1985b), there has been a substantial increase in our understanding of Native Hawaiian mental and behavioral health, including prevalence, risk and resilience factors, promising approaches, and recommendations.

❖ **The volume of publications has increased with the disaggregation of Native Hawaiians from other Pacific Islanders and Asians, expanding our understanding of the scope of the issues as well as risk and protective factors.**

The 1985 *E Ola Mau – Mental Health Task Force Report* compiled a remarkable reference list of 133 resources that were utilized by the Task Force members in formulating conclusions and recommendations, including sources that were not readily available publicly. Since then, there has been a tremendous amount of research and literature published on Native Hawaiian mental and behavioral health. For example, searches in July 2017 of three national databases found the following: (1)

[6] ancestral sayings
[7] song lyrics, chants, and poetry

PsycINFO:[8] > 420 references; database by the American Psychological Association, focused on the social sciences; (2) PubMed:[8] > 19,000 references; database by the U.S. National Library of Medicine of the National Institutes of Health, focused on medicine and health; and (3) Google Scholar:[9] > 77,000 references; database by Google, with a broader focus including non-peer-reviewed publications.

Given the sheer volume of the literature, the present review attempted to highlight the original source of the most recent, disaggregated, larger-scale, community-based epidemiologic studies, with greater emphasis on mental health diagnoses (versus symptomatology) and objective behavioral measures (e.g., arrest & incarceration), although self-reports were included where relevant (e.g., perceived social support). In addition, the focus was on results that disaggregated Native Hawaiians from other Pacific Islanders and American Asians, which excluded many large-scale studies. However, when results could not be found specifically for Native Hawaiians, aggregated findings were reported to shed some light on possible disparities (e.g., between Native Hawaiians combined with other Pacific Islanders as compared to other major ethnic groups).

❖ **With few exceptions, Native Hawaiians manifest greater mental health challenges than do non-Native Hawaiians.**

In comparison to statewide population estimates, the 1985 *Mental Health Task Force Report* concluded that Native Hawaiians had:

1. Higher proportions of social problems with family, people, and children, including higher proportions of assaultive acts and antisocial behavior;
2. Higher proportions of alcohol and narcotics use;
3. Higher proportions of school performance impairment;
4. Higher rates of suicide among young adult and elderly males;
5. Higher rates of child abuse and neglect (second only to Samoan populations);
6. Higher rates of residence in correctional institutions;
7. Higher rates of academic failure and poor school performance; and
8. Higher levels of stress as indexed by leading stress markers including poverty, educational level, single family households, dwelling density, and so forth.

The findings of the past 30 years have generally been consistent with the mental-behavioral health disparity revealed by the 1985 *Mental Health Task Force Report*. As a broad indicator of mental health, Native Hawaiian adults in Hawai‘i self-reported a higher average number of days within the past 30 days when their mental health was not good (4.2 days compared to 2.9 days statewide) (2015 Behavioral Risk Factor Surveillance System [BRFSS]; Nguyen & Salvail, 2015).

Table 1 provides results from epidemiologic studies on overall mental-behavioral health issues (i.e., “any”) and more specific areas (i.e., anxiety, mood/depression, suicide attempts/deaths, & substance use) for Native Hawaiians compared to non-Hawaiians, European Americans, Asian Americans, or statewide. Overall, Native Hawaiians have higher rates of these measures. The exceptions are as follows:

(1) There were similar rates for overall mental health problems and anxiety for Native Hawaiian adults compared to statewide. However, only 29.0% of the Native Hawaiians received treatment compared to 64.2% of European Americans (Reyes-Salvail, Liang, & Gross, 2009). The results for substance use treatment are different. In Fiscal Year 2015-2016, the Hawai‘i State Department of Health’s Alcohol and Drug Abuse Division (ADAD) provided treatment services to 2,830 adults and 1,885 adolescents (Alcohol and Drug Abuse Division, 2016). Native Hawaiians were the largest ethnic group admitted for ADAD-funded services, composing 43.8% of adult admissions and 46.0% of adolescent admissions. The primary types of substance use involved in these admissions were methamphetamine (50.5%) and alcohol (22.2%) for adults, and marijuana (66.8%) and alcohol (21.5%) for adolescents.

(2) Suicide death rates were lower for Native Hawaiians compared to European Americans from about 45 years of age and older (Hawai‘i State Department of Health, 2012). Native Hawaiians had a

[8] Hawaiian* AND mental OR “behavioral health” OR psychiatr* OR psycho* self-concept OR self-esteem OR well-being OR wellbeing OR violen* OR suicid* OR substance OR marijuana OR cannabis OR alcohol* OR cocaine OR amphetamine OR schizo* OR mood OR depress* OR bipolar OR anxi* OR phobi* OR stress OR distress OR PTSD OR obsessi* OR somat* OR eating OR bulimi* OR anorexi* OR impulse OR attention-deficit OR hyperact* OR “conduct disorder” OR “oppositional defiant disorder” OR “adjustment disorder” OR personality OR autis* OR Asperger* OR dementia OR Alzheimer*; where * represented different variations of the root word

[9] Hawaiian AND mental OR psycholog OR psychiatr; where * represented different variations of the root word

higher rate per 100,000 (46.2) as compared to Chinese Americans (8.0), Filipino Americans (22.8), and Japanese Americans (34.9) in Hawai‘i (2007-2011; Hawai‘i State Department of Health, 2012). However, European Americans had the highest rate (57.2). In addition, the suicide death rates by ethnic group were very different dependent upon age. For example, Native Hawaiian rates per 100,000 were highest for 15-24 year olds (70) and 25-44 year olds (81) compared to 45-64 year olds (55) and 65+ year olds (46). In contrast, European Americans' highest rates were for the two older age ranges; their rates were 41, 51, 104, and 89 for the different age ranges in ascending order (Hawai‘i State Department of Health, 2012).

(3) No studies were found on overall mental health problems or anxiety for elders.

Table 1
Mental-Behavioral Health Disparities for Native Hawaiians

Behavioral Health Area	**‘Opio (Youth)**	**Mākua (Adults)**	**Kūpuna (Elders)**
Any	32.7%[a] (current)	14.1%[e] (current)	Unknown
	(1.4 times higher)	*(similar)*	
Anxiety	20.8%[a] (current)	8.3%[f] (lifetime)	Unknown
	(1.7 times higher)	*(similar)*	
Mood/Depression	10.0%[a] (current)	14.6%[g] (lifetime) 4.5%[f] (current)	5%[l] (down-hearted)
	(1.4 times higher)	*(1.3 times higher)* *(1.4 times higher)*	*(1.3 times higher)*
Suicide Attempts or Suicide Deaths	14.1%[b] (attempt) 70/100,000[c] (death)	Prevalence not reported[h] (attempt) 81/100,000[i] (death) 55/100,000[j] (death)	28/100,000[m] (death)
	(1.3 times higher) *(1.7 times higher)*	*(2.8 odds ratio)* *(1.6 times higher)* *(1.9 times lower)*	*(3.2 times lower)*
Substance Use	12.4%[a] (current) 19.2%[d] (binge)	27.1%[k] (binge)	8.9%[n] (binge)
	(1.4 times higher) *(1.4 times higher)*	*(1.4 times higher)*	*(1.3 times higher)*

Note: Below the prevalences are the respective comparisons (e.g., 1.7 times higher) to other non-Hawaiian or statewide rates.

[a]Compared to non-Hawaiians in Hawai‘i (any = 23.7%, anxiety = 12.4%, mood = 7.4%, substance abuse or dependency = 8.8%); based on 1992-1996 Diagnostic Interview Schedule for Children (Version 2.3) and Diagnostic and Statistical Manual III-R criteria (American Psychiatric Association, 1987) (Andrade et al., 2006)
[b]Compared to statewide (10.5%); based on past 12 months, 2015 Youth Risk Behavior Survey (YRBS) (Hawai‘i Health Data Warehouse, 2016)
[c]Compared to European Americans (suicide deaths per 100,000 = 41); based on 15-24 year olds (Hawai‘i State Department of Health, 2012)
[d]Compared to statewide (binge drinking of 5 or more drinks within a couple of hours = 13.4%); based on, “During the past 30 days, what is the largest number of alcoholic drinks you had in a row, that is, within a couple of hours?”, 2015 YRBS (Office of Hawaiian Affairs, 2017)
[e]Compared to statewide (13.9%); based on frequent mental distress, serious psychological distress, and/or mental health treatment; 2007 Behavioral Risk Factor Surveillance System (BRFSS) (for scoring algorithm, see Reyes-Salvail, Liang, & Gross, 2009);
[f]Compared to statewide (lifetime anxiety = 8.0%, current major depression = 3.3%); based on lifetime anxiety = “Has a doctor or other healthcare provider EVER told you that you had an anxiety disorder (including acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, posttraumatic stress disorder, or social anxiety disorder)?”, 2006 BRFSS (Salvail & Smith, 2007); current major depression = for Patient Health Questionnaire, 8 questions (PHQ-8) (for scoring algorithm, see Salvail & Smith, 2007, pp. 19-20)
[g]Compared to statewide (lifetime depression = 11.6%); based on, “Has a doctor or other healthcare provider EVER told you that you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?”, 2015 BRFSS (Nguyen & Salvail, 2015)
[h]Compared to Chinese Americans in Hawai‘i; based on past 12 months, 2006-2011 (excluding 2008) BRFSS; odds ratio comparing Chinese Americans with Japanese Americans was 0.8, and Chinese Americans with Filipino Americans was 1.1 (Baker, 2013)
[i]Compared to European Americans (suicide deaths per 100,000 = 51); based on 25-44 year olds (Hawai‘i State Department of Health, 2012)
[j]Compared to European Americans (suicide deaths per 100,000 = 104); based on 45-64 year olds (Hawai‘i State Department of Health, 2012)
[k]Compared to statewide (binge drinking = 18.9%); based on past 30 days of men having 5 or more drinks on one occasion, or women having 4 or more drinks on one occasion, 2015 BRFSS (Nguyen & Salvail, 2015)
[l]Compared to statewide (4%); based on “percent feeling down-hearted & blue all, most, or a good bit of the time,” age 60+ years, 2005 BRFSS (Braun, Mokuau, & Browne, 2010).
[m]Compared to European Americans (suicide deaths per 100,000 = 89); based on 65/+ year olds (Hawai‘i State Department of Health, 2012)
[n]Compared to statewide (7.0%); based on “percent at risk of binge drinking (4-5+ drinks at once),” age 60+ years, 2005-2007 BRFSS (Braun, Mokuau, & Browne, 2010).

- **Native Hawaiians are dealing with multiple stressors and external factors that impact their overall health, including individual and social challenges, perceived racism, oppression, and social injustice.**

The World Health Organization (2014a) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.” Unfortunately, disparities in multigenerational trauma, discrimination, and poverty, and inequities in housing, education, the environment, health care access, and social capital disproportionately predispose Native Hawaiians to mental health issues (Liu & Alameda, 2011). In a national study of adults, 5.9% of Native Hawaiians who indicated that they were of a single ethnicity, and 4.5% of Native Hawaiians who indicated that that they were of multiple ethnicities, reported that they experienced serious psychological stress during the past 30 days compared to only 3.1% of the U.S. adult population (Galinsky, Zelaya, Simile, & Barnes, 2017). In another study, 8.9% of Native Hawaiians reported being very or extremely dissatisfied with life in comparison to 6.5% of non-Hawaiians (2011 Hawaiian Community Well-Being Survey; Kamehameha Schools, 2014).

Disparities affecting the Native Hawaiian community lead to marginalization from the larger community and can exacerbate social stressors (Kaholokula, Nacapoy, & Dang, 2009). For example, a decrease in social capital was correlated with an increase in depression and a decrease in social support. Further leading to the marginalization of Native Hawaiians are persistent derogatory stereotypes, such as those portraying Native Hawaiians as lazy, uneducated, irresponsible, and violent. Internalization of these perceptions prevents individuals within the community from improving their social status and further aggravates inequities (Kaholokula, Nacapoy, & Dang, 2009). Native Hawaiian adults who had higher levels of perceived discrimination had higher depressive symptoms ($r = .32$, $p < .001$; Antonio et al., 2016). In addition, Native Hawaiian adults who had higher Hawaiian Culture Identity also reported higher levels of perceived racism (i.e., oppression, $r = .35$, p

< .001, Kaholokula, Iwane, & Nacapoy, 2010; "felt oppression," $r = .21$, $p < .05$; Kaholokula et al., 2012). When examining the associations with physiological measures, oppression was found to be positively associated with hypertension (Kaholokula, Iwane, & Nacapoy, 2010), and Kaholokula et al. concluded, "Racism appears to be a chronic stressor that can 'get under the skin' of Native Hawaiians by affecting their physical health and risk for stress-related diseases, possibly through mechanisms of cortisol dysregulation" (2012, p. 27).

Mental illness can take a significant toll on the economy and an individual's potential earnings. The World Health Organization (WHO) estimates that mental illness is the leading factor in disability-adjusted life years worldwide (Insel, 2011). Mental illness accounts for 37% of healthy life years lost from non-communicable diseases; depression accounts for one third of this figure. The global costs of mental illness are approximately $2.5 trillion, which is only two-thirds of the indirect costs (Insel, 2011). In the United States, mental illness accounts for approximately 59% of economic costs deriving from injury or illness-related loss of productivity (World Health Organization, 2003). On average, individuals with psychosis took 42 days off from work per year and persons with two or more neurotic disorders took an average of 28 days off per year compared to 8 days off for those with one neurotic disorder. Furthermore, mental illness decreases annual income by $3500 to $6000 per individual per year (World Health Organization, 2003). Mental illness poses a serious and significant burden to the individual and society. Interventions that target marginalizing disparities are vital in preventing exacerbation of initial inequities and reducing the economic and social impacts of mental illness.

For Native Hawaiians, there has been improvement over the past decade or so in some socioeconomic indicators related to education (e.g., preschool enrollment, reading and math proficiency from kindergarten through high school), poverty, child abuse and neglect, public assistance use, income, attainment of professional and managerial occupations, and homeownership, in comparison to past years and other ethnic groups (Kamehameha Schools, 2014). 43.2% of Native Hawaiian adults report that things have gotten better over the past five years, compared to 36.0% for non-Hawaiians (2011 Hawaiian Community Well-Being Survey; Kamehameha Schools, 2014).

Despite these gains, many socioeconomic areas remain concerns for Native Hawaiians, particularly special education, high school graduation, college enrollment and achievement, livable wages, employment, support for families with children, violence prevention, and stable housing (Kamehameha Schools, 2014). In the case of special education during the 1997-1998 school year, Native Hawaiian students from kindergarten through high school were found to be overrepresented in all of the major special education categories (Andrade & Hishinuma, 2000). In the case of homelessness in Hawai‘i from 2006 to 2013, there was an increase of 55.8% in homeless shelter use for Native Hawaiians, which was comparable to non-Hawaiians at 54.4% (for analysis, see Kamehameha Schools, 2014). In 2015, Native Hawaiians constituted 30.5% of clients receiving services for the homeless in Hawai‘i, which was the highest among the major ethnic groups (29.3% European American, 9.1% Micronesian, 5.9% Marshallese, 5.5% Other Pacific Islander, 5.5% Filipino, 5.5% African American, 4.5% Other Asian, 1.8% Native American, 2.5% unknown) (Yuan, Vo, Gleason, & Azuma, 2016). Services for the homeless included emergency shelter, transitional shelter, outreach, and rapid rehousing services.

Native Hawaiian youth and adults have been overrepresented in Hawai‘i's justice system. Based on Hawai‘i juvenile arrests from 2000-2010, "Native Hawaiian youth are the most overrepresented group relative to their proportion of the youth population and face disproportionately negative outcomes at the greatest number of decision points compared to other ethnic groups" (Umemoto, Spencer, Miao, & Momen, 2012, p. 7). Native Hawaiian minors (0-17 years of age) constitute approximately 31.1% of Hawai‘i's minor population (U.S. Census Bureau, 2000a, 2000b). Of the individual youth arrested, 33% were of Native Hawaiian ancestry, and of all arrests (including more than one arrest of the same adolescent), 42% were of youth with Native Hawaiian ancestry. "As the cases progress deeper into the system, the proportion of Native Hawaiian involvement incrementally increases to 46% of the cases referred to Family Court, 49% of the cases petitioned to appear in court and subsequently adjudicated, then 50% of the cases sentenced to probation placement without incarceration and 54% of the cases sentenced to incarceration" (p. 29), replicating previous studies (e.g., Kassebaum et al., 1995a, 1995b; MacDonald, 2003). While the overall census at the Hawai‘i Youth Correctional Facility has decreased substantially, 69% of the adolescents there were of Native Hawaiian ancestry in 2015 (Office of Youth Services; cited in Office of Hawaiian Affairs, 2017).

For Native Hawaiian adults, who represent approximately 24% of Hawai‘i's population, decreases in arrest rates have been found from 2003 to 2009 (Kamehameha Schools, 2014). However, as with Native Hawaiian youth, there is increasing overrepresentation of Native Hawaiian adults as the

cases progress deeper into the justice system: 25% arrest, 33% pretrial detention, 29% admissions to probation, 36% admissions to incarceration, 39% incarcerated, 39% release on parole, and 41% parole revocation (Office of Hawaiian Affairs, 2010; see also, for a brief review, Kamehameha Schools, 2014).

- **Native Hawaiian cultural activities promote healthy lifestyles and decrease stress. More than three-quarters of Native Hawaiians believe it is important to live and practice Hawaiian culture on a daily basis.**

Multiple studies have linked stress to negative health outcomes and poor well-being for various ethnocultural groups, including Native Hawaiians (Hébert et al., 2015). In response, underserved communities are working with researchers to develop solutions and strategies to attain solutions with an emphasis on cultural activities. Health promotions grounded in evidence-based strategies, and tailored to Native Hawaiian cultural preferences as well as socio-economic circumstances, have been recommended to improve lifestyle and increase selection of healthy choices (Ka‘opua, Braun, Browne, Mokuau, & Park, 2011). Well-being is synonymous with the perpetuation of cultural traditions and activities (McGregor, Morelli, Matsuoka, & Minerbi, 2003). For example, ancestral knowledge of the land and its natural resources is often shared through subsistence practices in rural Native Hawaiian communities. Inherent in the practice is conservation to ensure availability for future generations. Cultural values, beliefs, norms, and ways of life guide thinking, decisions, and actions of individuals and families in patterned ways (Leininger & McFarland, 2006). 78.0% of Native Hawaiian adults believe it is fairly or very important to live and practice Hawaiian culture on a daily basis (e.g., honoring ‘ohana,[10] working together, and sharing food, crafts, and knowledge with others) (2004 Hawaiian Community Survey; Kana‘iaupuni, Malone, & Ishibashi, 2005). Furthermore, they expressed interest in developing their knowledge of the Hawaiian language.

- **Despite the challenges that Native Hawaiians face, there are clear protective and resiliency factors, including a strong sense of hope, and positive ‘ohana and community support.**

There has been greater awareness and effort to assess protective factors and to foster a strength-based approach to prevention and intervention (e.g., Kamehameha Schools, 2014). Despite the challenges that Native Hawaiians have faced, they have a strong sense of hope for the future. In particular, 60.8% of Native Hawaiian adults reported the belief that things will get better over the next five years, compared to 47.8% of non-Hawaiians (2011 Hawaiian Community Well-Being Survey, Kamehameha Schools, 2014).

Regarding family structure, Native Hawaiians lived in family households (91.9%) more than the Hawai‘i average (86.4%). Native Hawaiians also had the highest percentage of households where grandparents lived with and cared for their young grandchildren (10.7%) and school-age grandchildren (9.7%) compared to the Hawai‘i averages (6.9% and 5.7%, respectively) (2006-2010 American Community Survey Public Use Microdata, Kamehameha Schools, 2014).

Regarding family support, Carlton et al. (2006) found that Native Hawaiians had higher levels of family support than non-Hawaiians in Hawai‘i based on adolescent self-reports. Family support included having a very close relationship with a number of family members, having a family member to go to when the adolescent was feeling down, and having the family provide moral and emotional support. In addition, importantly, family support was found to be a robust protective and resilience factor for both internalizing (e.g., anxiety, depressive) and externalizing (e.g., conduct disorder, substance use) symptoms. Similarly, 90.6% of Native Hawaiian adults reported that during difficult times, they rely on family for the majority of support, compared to 86.9% of non-Hawaiian adults (2011 Hawaiian Community Well-Being Survey, Kamehameha Schools, 2014). This is not surprising given that Native Hawaiian families also were more likely to have households with grandparents living with and caring for their grandchildren.

Regarding family and community support, 79.0% of Native Hawaiian high school students reported that they had at least one adult outside of school with whom they could talk about things that were important to them, and 72.4% reported that they had at least one teacher or adult in school with whom they could talk if they had a problem, compared to 76.5% and 64.3%, respectively for non-Hawaiian high school students (2015 Youth Risk Behavior Survey, Hawai‘i Department of Health, cited by Kamehameha Schools, 2014). From a Hawaiian perspective, individual capabilities, such as healthy coping, practical knowledge, special talents, and persistence are rooted in family and community relationships (Kana‘iaupuni, 2005). In response, there has been greater awareness and effort to assess protective factors and to foster a

[10] family

strength-based approach to prevention and intervention (e.g., Kamehameha Schools, 2014).

Effective and Promising Approaches

We use the term "promising approaches" to include evidence-based and evidence-informed approaches, as well as practice-based evidence approaches.

While evidence-based practices give us numbers and evidence of success, practice-based evidence also has to be considered and supported. Healing practices that are multi-generational and culturally valued build community health. And the more we integrate a person's culture into treatment, the more effective treatment will be.

Captain Jon Perez, PhD
Region 9 Administrator,
Substance Abuse and Mental Health Services Administration (SAMHSA)
(SAMHSA, 2016)

- **Commonalities among wellness, substance abuse treatment, and mental health treatment programs for Native Hawaiians that have been shown to be effective include a focus on strengths, community, and indigenous and culturally informed approaches.**

Selected programs underscore the importance of program commonalities, including a focus on strengths, community, and indigenous and culturally informed approaches. The following are several examples demonstrating effectiveness. Hui Mālama o ke Kai ("The Caring Group from the Ocean") is a culturally grounded Native Hawaiian program based on prevention, positive youth and family development, and respectful utilization of natural resources (i.e., mountain, land, ocean) (Akeo et al., 2008; Hishinuma et al., 2009). The mission of Hui Mālama o ke Kai, founded in 1998, is to develop community pride and foster leadership in youth living in Waimānalo. The core afterschool program for 5th and 6th graders provides activities that integrate the Native Hawaiian cultural values of connecting the youth to their family, land, community, and spirituality through experiential learning. Five core values central to the curriculum and activities are: aloha,[11] mālama,[12] 'ohana,[13] kuleana,[14] and mahalo[15] (Sy, 2009). There is also a strong family-bonding component that includes Ho'oikaika i ka 'Ohana[16] ('Ohana Strengthening Program [n.d.], http://www.huimalamaokekai.org/ohana-programming.html). This project provides parent sessions and trainings (e.g., on communication, positive discipline, problem-solving, health promotion) and family-based activities (e.g., monthly weekend activities, monthly 'ohana nights, retreats). The results of formal program evaluations of Hui Mālama o ke Kai have been very positive (Hishinuma et al., 2009; Takeshita & Takeshita, 2002, 2003). For example, positive pre-post increases were found for (1) youth self-reports on Native Hawaiian values, school success, self-esteem, anti-drug use, violence prevention strategies, healthy lifestyle, and family cohesion; and (2) parent self-reports on family cohesion, and children's knowledge and practice of Native Hawaiian values, school success, and violence prevention strategies (Hishinuma et al., 2009). The afterschool program expanded to include intermediate and high school students who "serve as alaka'i[17] to their younger counterparts and have the opportunity to practice aloha 'āina[18] by getting involved with community service projects, perpetuating a cycle of social responsibility and instilling confidence in themselves" (http://www.huimalamaokekai.org/after-school-programs.html).

The heuristic method remains the initial process by which Western-trained clinicians treat patients and assess response to treatment. Case study reports document treatment responses. When there is a pattern of successful treatment responses, effective evidence-based practice is demonstrated, and treatment protocols are documented. Empirical studies commonly follow to identify the factors that explain and predict treatment responses. Many mental health practitioners recognize the importance of culture and have begun to apply a heuristic approach to demonstrate the efficacy of cultural interventions. 'Imi ke Ola Mau[19] is a community collaboration formed in 2005 through the Co-occurring State Incentive Grant (COSIG). Partners communicated a common vision to ensure that Native Hawaiians, their families, and communities have access to substance abuse and mental health services that honor culturally responsive treatment (Papa Ola Lōkahi & 'Imi ke Ola Mau, 2007). Practitioners shared their experiences and the role of culture in healing. In order for Native Hawaiians to heal, "[They] need a sense of self,

[11] love, affection, compassion, mercy, sympathy
[12] to care for
[13] family
[14] responsibility
[15] gratitude, respect
[16] Strengthen the family.
[17] mentors, leaders
[18] love and care for the land
[19] to perpetuate a life of health and healing

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 to our 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" (Papa Ola Lōkahi & ʻImi ke Ola Mau, 2007).

Hawaiian health is about Hawaiian culture.

ʻImi ke Ola Mau

Another program demonstrating the heuristic effectiveness of Native Hawaiian culture is Ola Kino Maikaʻi (translated loosely as "good health and/or well-being"), within the Women's Way program at Salvation Army Family Treatment Services (Office of Hawaiian Affairs, 2017). This is the only program in the State of Hawaiʻi to serve women and their children in a residential substance abuse treatment setting (Gill, 2015; Kate Leilani Kahoano, personal communication, August 3, 2017; Office of Hawaiian Affairs, 2017). Participants engage in Native Hawaiian cultural practices, including a weekly culture class, lomilomi,[20] establishment of a mala,[21] papa hula,[22] huakaʻi[23] to culturally significant sites, mele,[24] ʻoli,[25] and moʻolelo.[26] By serving entire families rather than individuals, this program increases the likelihood of Native Hawaiian families "actively improving lifestyle choices by engaging in health programs and supportive family development." Most anecdotal reflections on the program indicate that it offers inspiration and maintenance of positive behavioral change around improving lifestyle choices. With the tools, support, and education provided by this program, women and their families gain the ability to select healthier or better-informed choices. Most reports of change experienced by clients since entering the program have revolved around increased active play with their children, greater knowledge about how to prepare healthy meals for their families, and improved self-esteem and self-worth in response to renewed health and healthy coping tools and practices.

The Hoʻopono Mamo Civil Citation Initiative, a juvenile justice diversion program, is designed to guide youth toward a pathway of supportive programs to help them address issues that may lead to risky or harmful behavior (Hoʻopono Mamo, 2013, 2017). Historically, once youth enter the juvenile justice system, many sink even deeper into the system. Hoʻopono Mamo provides immediate assessment and intervention services, and focuses on strengthening teens' connection to their families and community, including using cultural values. The original concept of the Hoʻopono Mamo diversion process consisted of four phases that guided youth in charting a pono[27] path. The process begins when a youth is arrested and issued a civil citation. Eligible youth are brought to a Family Assessment Center where they are informed of the program and invited to participate. A counselor and kupuna[28] will "talk story" with them to assess their situation, strengths, challenges, resources, and interests. The program focuses on six key dimensions: peers, family, community, school, spiritual values, and the youth's mind and body. Service providers then help the youth develop an action plan to address any issues that they may be confronted with. The youth's action plan may include a variety of pathways, including making an apology, the Wahi Kanaʻaho (healing arts and hoʻoponopono or conflict resolution), an ʻāina[29]-based curriculum reconnecting to family and school, Hoʻala Conferencing Circles (facilitating dialogue with the youth's chosen network of support, including immediate family, extended family, and other members of their support system), mental health and substance abuse treatment programs (e.g., residential, outpatient, emergency shelters), and a variety of community-based programs (e.g., education, recreation, culture, meditation). Subsequent to program completion, there is a follow-up visit to the Family Assessment Center for a second "talk story" assessment, for an updated plan to be developed, if needed, and for feedback and evaluation. The goal is to offer youth the avenues to overcome challenges underlying their actions and to realize their own kuleana[30] as valuable and gifted members of their communities. As a result, not only are youth offenders' lives transformed, but also the lives of their entire families.

Although not all of the program components have been successfully implemented, positive evaluation results have been obtained overall (Miao, Umemoto, Hishinuma, & Smith, 2017). Randomly selected parents who consented to participate in a qualitative evaluation expressed that Hoʻopono Mamo helped provide them with different types of support that made

[20] traditional massage
[21] garden
[22] hula dance class
[23] excursions
[24] songs
[25] chants
[26] stories and history
[27] balanced, righteous
[28] elder
[29] land
[30] responsibility

a positive difference for themselves and their families in the following areas: coping and decision-making skills, understanding the social and legal consequences of their actions, accountability and resources to reach their goals, youth involvement in positive activities, parent self-reflection and parenting skills, and parent and child relationships. Quantitative evaluation found a lower rate of recidivism for Hoʻopono Mamo participants compared to a matched sample of non-participants, with a 7.7% lower re-arrest rate for participants. There was also a trend that when police transported the youth directly to the Assessment Center with "warm hand-offs," the positive difference for those cited for misdemeanors (with no prior offenses) was 3-4 times greater (i.e., 28.1% vs. 8.7%). Among Hoʻopono Mamo youth, those who received intervention services had a 12.2% lower re-arrest rate than those who did not receive intervention services (i.e., those who were only assessed at the Assessment Center, but did not receive intervention services). Those who completed the program had a 16.6% lower re-arrest rate. This positive effect was somewhat greater for those with first-time misdemeanors (with no prior offenses). Furthermore, the evaluation findings highlighted the importance of implementing all program components for Native Hawaiian youth with consistency and fidelity in order for the maximum benefit to be experienced.

For the Wahi Kanaʻaho[31] component mentioned above, positive qualitative and quantitative findings were obtained. Interviews of the youth revealed the following positive outcomes: learning about self and values as well as connecting to something greater than themselves (spirituality); rebuilding broken bonds with family; connection to staff; cultural basis, tools, and skills to make different choices; time and space away from problems and distractions; hands-on and outdoor activities (connecting with the ʻāina); and transition planning (Tibbetts, 2016). The quantitative survey assessed pre-post differences retrospectively and found gains with respect to the personal, family, friends, community, school, and body-mind/spirituality domains (unpublished results).

- **Most of these programs provide a balance between Western best practices and cultural teachings and activities. There is a need to experience a sense of belonging and sense of place. Integration of Native Hawaiian traditional approaches and practices is essential for developing paths for healing.**

Place is fundamental to Native Hawaiian ethnocultural identity. Place-based learning provides the learner with a rich history and stories of the land, reinforcing the connection between land and identity (Kanahele, 1986; Kanaʻiaupuni & Malone, 2006; Pukui, Haertig, & Lee, 1972; Ulukau, 2017). This accumulated knowledge is a source of spiritual strength and well-being. Conversely, ignorance of place weakens a person's identity (Kanahele, 1986). By learning the traditions of place and genealogy in connection with personal experiences, Native Hawaiians can internalize ethnocultural identity and ways of thinking (Andrade, 2006; Kekoa, 2017; Meyer, 2001). Therefore, restoring and preserving connections to the land, practices of caring for the sea, and maintaining historically significant places create space for traditional practices that foster spiritual well-being. Oneha (2001) further supports this concept that Native Hawaiian health, including mental health, is rooted in Native Hawaiian culture. She found that having a spiritual connection to one's ancestral place, and being able to relate to past, present, and future experiences with intention and understanding, resulted in openness to the flow and use of energy to create a sense of safe place or puʻuhonua. Ethnocultural identity is a central value in Native Hawaiian communities. Relationships with spiritual power inherent in every location, ancestral lineage, living family members, and obligations to the collective good of the community strengthen ethnocultural identity. This is illustrated by a simple question: In Native Hawaiian language, one asks, "Who is your name? (ʻO wai kou inoa)" and not "What is your name?" (Kawakami, Aton, Cram, Lai, & Porima, 2007), conveying a link to the past, but also to present-day ethnocultural identity. The intensity of feeling for place is imperative for health and well-being. "The mobilizing energy comes from the land itself, from the sea, from the children and from the compelling vision of a future in which indigenous Hawaiians are in our rightful place as a vibrant, thriving people" (Kanaʻiaupuni & Malone, 2006, p. 301).

Ma kēia ʻāina e pūlama mai i loko o kuʻu naʻau.

The land which has nurtured me in its depths
fills my heart.

"Mele ʻOhana"
Written by Damon Williams
Hawaiian translation by Charles Kaʻupu
Sung by Kealiʻi Reichel on album *Keʻalaokamaile*
Punahele Productions, 2003

The strategic plan for the improvement of substance abuse and mental health outcomes for

[31] healing arts

Native Hawaiians, their families, and communities identified several key components for Native Hawaiians to heal and recover (Papa Ola Lōkahi & ʻImi ke Ola Mau, 2007). Native Hawaiians need a sense of place to anchor values and balance life. Beyond Western practices, Native Hawaiians need to care for the ʻāina,[32] 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. Native Hawaiian substance abuse treatment programs (e.g., Hoʻomau ke Ola on the Leeward Coast of Oʻahu) which weave Western best practices (e.g., cognitive behavioral therapy, 12-step programs, financial literacy, life skills) with traditional practices (e.g., hula,[33] moʻokūʻauhau,[34] ʻoli[35]), to reestablish cultural foundations and connectedness, reflect promising approaches to decrease substance use prevalence among Native Hawaiians (Hoʻomau ke Ola, 2017).

Table 2
Parallel Strengths of Western and Native Hawaiian Healing Practices (Blaisdell, 2007; Kaholokula, 2007)

Western Healing Practices	Native Hawaiian Healing Practices
Focus on physical/psychological signs, symptoms, and causes	Focus on spiritual/interpersonal complaints and causes
Organic or psychological causal models	Causal models based on imbalance in relationships/life roles
Treatment involves medicine, cognitive restructuring, and lifestyle changes	Treatment involves prayers, herbs, and repairing relationships
Evidence-based	Faith-based

It is a given that many will find cultural aspects of a program healing, supportive, and meaningful—and that there is inherent value in these approaches…The challenge and the opportunity are to find ways to ensure that cultural services are afforded the same recognition and validity as "Western" services and interventions. What is needed is a harmonious and effective combination of approaches and interventions that provide a continuum of care that effectively meets diverse needs and resonates with people across the spectrum.

Edward Mersereau
Division Chief, Hawaiʻi Alcohol and Drug Abuse
(SAMSHA, 2016, p. 1)

- **Programs have increased capacity to address the growing mental and behavioral health care needs of rural Hawaiʻi through training and clinical service, integrating cultural and community-based perspectives.**

In order to improve access to primary health care in rural, underserved areas, and promote collaboration in health care delivery, the U.S. Congress passed the Rural Health Care Services Act of 1977 (U.S. Department of Health and Human Services, 2017). Clinics are also authorized to serve as an originating site for telehealth services. Kīpuka o ke Ola is an example of interested parties coming together to create collaborative health care systems in rural areas (Kīpuka o ke Ola, 2017). Rooted in the medical home

[32] land
[33] dance
[34] genealogy
[35] chant

model, they provide a variety of medical services (primary care, psychiatric, psychotherapy, and pediatric), as well as indigenous healing services, such as laʻau lapaʻau,[36] lomi lomi,[37] and hoʻoponopono.[38]

Access needs to be easier for Native Hawaiians to obtain mental health care and get the services that they need. We need to break down the barriers of stigma. Having more Native Hawaiian psychiatrists and psychologists helps…Clinics like Kīpuka o ke Ola that meld indigenous Hawaiian and Western medicine also help indigenous people and the whole community improve and progress.

Ian Chun, MD
Director, Psychiatrist and Pediatrician
Kīpuka o ke Ola (Rural Health Clinic)

Another organization, I Ola Lāhui,[39] was created by emerging Native Hawaiian scholars with a mission to provide culturally minded, evidence-based behavioral health care that is responsive to the needs of underserved and predominantly Native Hawaiian rural communities (I Ola Lāhui, 2017). This rural behavioral health program offers integrated behavioral health services to help with a variety of concerns for individuals, couples, families, and groups to promote overall health and well-being, providing behavioral health care at many of the Native Hawaiian and community health centers. The program is also increasing the number of trained psychologists available to work with Native Hawaiian and rural communities. The program conducts research and evaluation projects for programs and services related to behavioral health and service delivery to rural and underserved communities, and culturally minded interventions developed and implemented by I Ola Lāhui staff and trainees, as well as through partnerships with other organizations. For example, three substance abuse and mental health treatments using traditional Hawaiian cultural practices were evaluated as part of the 2007 Hawaiʻi Co-occurring State Incentive Grant Project (COSIG; I Ola Lāhui, 2017). Native Hawaiian cultural practices are integrated into clinical practice, training, research, and evaluation.

Telemental health can increase access to psychiatric clinical services in underserved areas. However, it is essential that telemental health providers be trained in culturally appropriate care practices and understand the culture and community that they serve (Alicata et al., 2016; Brooks, Spargo, Yellowlees, O'Neill, & Shore, 2013; Savin, Glueck, Chardavoyne, Yager, & Novins, 2011; Shore, Savin, Novins, & Manson, 2006; Yellowlees, Shore, & Roberts, 2010). The success of telemental health is contingent upon consistent communication and interactions among the clinical directors at rural sites, telemental health providers, administrative and support staff, and the institutions that commonly interact with families, including schools, primary care, social welfare, and juvenile justice agencies (Savin et al., 2011). Care coordinators and social work specialists who interact frequently and directly with families and coordinate all mental health services are central to providing cultural and community context (Alicata et al., 2016). They are the primary contact with the families to address schedules and urgent- and after-hour care, procure on-site translation services, and train families in the use of the technology. They attend all appointments and team meetings, court hearings, and home visits when transportation and other psychosocial challenges are an issue. Thus, the community-based care coordinators facilitate treatment engagement, bringing familiarity to the patients and providing insight to providers into patients' daily lives and stressors (Helm et al., 2016).

In areas of shortage, attention has centered on primary care providers to screen, diagnose, and treat mental health conditions (Guerrero et al., 2017). However, many providers reported feeling unprepared, professionally isolated, and pressured for time in their practice. Through telemental health, primary care providers may access specialists for patient care and education, allowing them to continue treating their patients and better serve their communities (Chung-Do et al., 2012). Guerrero and colleagues (2017) describe the programmatic components that operationalize and facilitate successful primary care integration using telepsychiatry in Hawaiʻi, including universal screening, telephone availability, mutually educational team rounds, and as-needed consultations. Collaborating closely to provide coordinated care to patients is efficient and results in high-quality care (Guerrero et al., 2017; Helm et al., 2016).

Project ECHO (Extension for Community Healthcare Outcomes) is another empirically based option for enhancing specialty care capacity in rural, underserved communities through regularly scheduled, facilitated case-based learning, knowledge networks, and learning loops among primary care, interdisciplinary specialists, and community-based partners (Komaromy et al., 2016; Sockalingam et al.,

[36] herbal medicine
[37] massage or soft tissue manipulation
[38] conflict resolution

[39] health of our nation

2017). In 2016, ECHO Hawai‘i launched its behavioral modules.

- **These programs, designed to optimize Native Hawaiian mental and behavioral health, are frequently initiated and led by Native Hawaiians as key stakeholders. While the focus of many of these programs is on Native Hawaiians, the individuals they serve are multicultural.**

The reclaiming of Native culture, traditions, values, and practices during the Native Hawaiian renaissance influenced many mental health providers and scholars to implement programs and research for Native Hawaiian people incorporating indigenous knowledge (McCubbin & Marsella, 2009). The two-volume *Nānā i ke Kumu: Look to the Source* (Pukui et al., 1972) described Native Hawaiian ways of living, knowing, and being, setting the stage for indigenization. Key informants acknowledged the lack of available and appropriate mental health care and adequate funding to continue to support existing services. The absence or severely limited number of Native Hawaiian providers and other providers who can adequately address the cultural aspects of mental health issues within the community was a prominent issue. Furthermore, key informant interviews and publications universally called for a change in focus from a Western mental health model with the individual at the center to one in which consideration was given to multiple generations, the extended family, and the entire community. Native Hawaiian communities, providers, and researchers who collaborate with them have designed and evaluated programs with these considerations in mind, to support education, prevention, and treatment. Such programs enable communities to introduce and assess innovative, culturally grounded prevention and care initiatives in their communities. As the host culture, programs that benefit Native Hawaiians also benefit others who call Hawai‘i their home, and ultimately, all communities in Hawai‘i. As was noted earlier, the majority of Native Hawaiians have one or more other ethnicities from Hawai‘i’s diverse immigrant groups. The term *Hapa-Hawaiian* refers to Native Hawaiian mixed with one or more immigrant ethnicities. Hapa-Hawaiians raise the additional challenge of developing cultural treatments that find the common ground within their ethnic diversity of persons, families, and communities. To address this challenge, innovative sociocultural models of mental or behavioral health assessments and interventions should be developed with guidance from community-based leaders and cultural practitioners.

Gaps

- **Data on Native Hawaiian mental and behavioral health and well-being status are challenging to find and not consistently or regularly collected and reported. Indigenous data governance can assert Native Hawaiian data rights and interests; ensure that data for and about Native Hawaiians are protected; and require quality and integrity of Native Hawaiian data and their collection.**

There are numerous challenges encountered in seeking to understand Native Hawaiian mental and behavioral health and well-being. For a more complete discussion of these issues, see Chapter 6: Data Governance. There are few sources of disaggregated data among large-scale, community-based epidemiologic studies organized in a central portal or set of documents. Disaggregated data are data that have been broken down into smaller information units, enabling us to delve more precisely into a set of results to highlight issues of interest (i.e., gender, urban vs. rural location, income, ethnocultural background, language, geographical location, or age group). We have been unable to consistently or readily find data on Native Hawaiian mental and behavioral health status. It is even more difficult to obtain specific data on kūpuna.[40]

On the one hand, the Hawai‘i Department of Health, Kamehameha Schools, the Office of Hawaiian Affairs, and the University of Hawai‘i generate helpful reports, presentations, and papers by compiling existing data. The Hawai‘i Health Data Warehouse was created to centralize data from multiple sources within a single location and to present results in a form that is easy for the public to access and utilize (Chosy et al., 2015). However, with the exception of depression, mental health is not routinely assessed in statewide surveys. Even less information is available on protective factors, which would be essential for determining optimal ways to improve well-being. Fully disaggregating data and regularly assessing key information would help to reveal hidden trends among vulnerable populations. Disaggregated data play a critical role in helping to understand not only the extent of mental and behavioral health disparities, but also the effectiveness of interventions in meeting the needs of children, families, elders, and communities from a culturally congruent point of view.

[40] elders

"Indigenous [communities], like all communities, require data to identify problems, to develop and prioritize solutions, to make strategic decisions and defensible policies, to influence external entities, and, most importantly, to bring the community's vision of a healthy and vibrant society to life" (Rainie, Schultz, Briggs, Riggs, & Palmanteer-Holder, 2017, p. 1). Indigenous communities seek to exercise their rights to information about their communities and people (Kukutai & Taylor, 2016). For example, the Waianae Coast Comprehensive Health Center's Research Committee reviews study requests from a community-engagement perspective, requiring shared data ownership. In mainstream data discussions, data sovereignty is the right of a community to collect and manage its own data (Oneha, et al., 2014; Rouse, 2013), while data governance refers to the ownership, collection, control, analysis, and use of data (The Data Governance Institute, 2015). Indigenous groups seek both data sovereignty and governance.

- **Disparities are magnified by limitation in access and availability of services, particularly in rural, primarily Native Hawaiian communities.**

Mental and behavioral health care reflects significant disparities in service access and availability, particularly in rural areas of all islands, which are medically underserved and experience health professional shortages (Helm et al., 2016). Conservative, demand-based estimates of psychiatric workforce needs indicate a shortage, with small numbers of psychiatrists, if any, on neighbor islands or working in rural communities on Oʻahu (Aaronson & Withy, 2017; Guerrero et al., 2017). Overall, there is a shortage of over 100 psychiatrists in Hawaiʻi (Aaronson & Withy, 2017).

- **While some programs have been found to be successful at improving well-being, most culturally based and culturally adapted mental health interventions for Native Hawaiians have not been formally evaluated.**

We need to be a little bit more systematic in our approach. We need to increase accountability, evaluate what we're doing, demonstrate effectiveness, and I don't mean in a Western sense where [for example] we're decreasing their depression, but are we meeting the goals that the people we serve want? Is it doing something for them and their families?...Evidence-based [has a] negative meaning in the Hawaiian communities, which [argue that] it doesn't work here; which I agree. But evidence means that it's been found to work with our people…[W]e can't just say this is Hawaiian, or what we think is Hawaiian, and assume [that it's going] to work. We need to say this is Hawaiian, this is meaningful, it is what we believe is happening, but let's evaluate it for its intended outcomes. When we can show what we're doing works, and has an effect, we can get funding.

J. Keaweʻaimoku Kaholokula, PhD
Professor and Chair
Department of Native Hawaiian Health
University of Hawai`i at Mānoa
John A. Burns School of Medicine

Programs must be evaluated with respect to processes and outcomes that incorporate an indigenous Native Hawaiian framework. Unfortunately, more Western evaluation approaches tend to place the "problem" within the individual rather than consider the context (e.g., environment) of the individual. For example, according to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013), substance use disorder is described as a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress. Grant (2008) insightfully observed that the current "diagnosis of a substance use disorder does not seem to consider social learning or cultural and environmental factors," and yet, "a change in context [residential treatment, discontinuing contact with people who use the substance, etc.] is one of the most commonly prescribed treatments of substance use disorders" (p. 2). Similar arguments can be made with respect to other mental health disorders. This type of inconsistency may contribute to Native Hawaiians' rejection of Western medicine due to distrust and lack of culturally relevant treatment protocols (Kamaka, Paloma, & Maskarinec, 2011). Without appropriate assessment and interventions, these communities are unlikely to seek treatment for illness, engage in preventive services, or report to follow-up sessions. These adverse conditions compound the difficulty of evaluating the efficacy of programs that are intended to improve Native Hawaiian well-being.

From a more indigenous approach, when the context of the individual is examined, then "interventions are holistic and not based on the problem, per se, but on the person's or family's sense of esteem and identity" (Mokuau, 2002, p. 85). By making the identity of the person a priority, the agency and treatment assess the culture and values of that person. When treatment acknowledges not only the identity of that singular person, but the entire culture

that the person identifies with, then treatment naturally becomes culturally relevant.

Culture is the shared learned meanings and behaviors that are transmitted from within a social activity context for purposes of promoting individual/societal adjustment, growth, and development. Culture has both external representations (i.e., artifacts, roles, activity contexts, institutions) and internal representations (i.e., values, beliefs. attitudes. activity contexts, patterns of consciousness, personality styles, epistemology). The shared meanings and behaviors are subject to continuous change and modification in response to changing internal and external circumstances. (Grant, 2008, as cited in Marsella & Yamada, 2010, p. 10.)

In this definition, it is necessary to highlight the two main components of culture: Culture is shared socially though meanings and values, which are represented both externally and internally; and such values and meanings change over time consequent to changing internal and external representations. This is of utmost importance when incorporating Native Hawaiian culture into practices of treating substance abuse because external factors, such as colonization, disease, alcohol, drugs, and tourism, as well as internal factors, such as loss, depression, anger, sadness, and despair, have altered Native Hawaiian culture (Grant, 2008). These changes act as chronic stressors and forms of oppression, which can translate into problems in physical health, mental health, and/or substance abuse (Morelli & Fong, 2008). The goal is that, as culture is integrated with treatment not only for possible shared meanings and values, but also to create effective treatment models of healing and recovery among Native Hawaiians, the outcome will be valid improvements in well-being. By understanding the nature of culture and its effect on health outcomes, treatment can be initiated to address more effectively not only pathologies such as substance abuse disorders, but also negative effects upon Native Hawaiian identity. Once the gap between cultural values and Western approaches is bridged through treatment, clients will be better protected against misusing substances because they will be more attuned to themselves and able to draw from the strengths of their culture (Grant, 2008; Mokuau, 2002). Therefore, "cultural strengths may be viewed as protective factors and should be the focus of prevention and treatment efforts" (Mokuau, 2002, p. 86).

Unfortunately, few studies focus on interventions that enhance resilience, and these rarely include cultural factors (Brady, 1993; Frison, Wallander, & Browne 1998; Werner, 1995). Werner conducted pioneering work in the field of resilience, examining multiple protective factors and their impact on adolescents on Kauaʻi (Werner, 1971; Werner & Johnson, 1999; Werner & Smith, 1982, 1992). However, Native Hawaiians and culture were not focus areas. In research on Native Hawaiian youth, more than 80% of those facing adversity did not exhibit high levels of psychiatric symptoms, demonstrating resilience (Carlton et al., 2006; Goebert et al., 2000). The odds increased multiplicatively with the addition of family adversity indicators among both Native Hawaiians and non-Hawaiians. Among Native Hawaiian youth, the risk for depression was most dramatic, significantly increasing from 1.8-fold with one adversity indicator to 3.1-fold with two indicators, and 9.7-fold with four indicators. While Native Hawaiian youth experienced more family adversity than non-Hawaiians, Native Hawaiians were also more likely to have higher levels of family support. The presence of strong family support significantly increased resilience. These findings support the need for intervention programs designed to promote resilience in adolescents, including highlighting the importance of the family in culturally appropriate ways.

Further, there is increasing support for a strong connection between well-being and identification with culture among non-Hawaiian indigenous people. Culture facilitates resilience for indigenous people facing adversity (Adelson, 2000; Montgomery, Miville, Winterowd, Jeffries, & Baysden, 2000; Roberts & Holmes, 1999; Wexler, DiFluvio, & Burke, 2009; Les Whitbeck, Hoyt, Stubben, & LaFromboise, 2001). Borowsky and colleagues (Borowsky, Resnick, Ireland, & Blum, 1999) found that increasing protective factors was more effective than decreasing risk factors in reducing suicide risk among indigenous youth. Building protective factors and resilience through cultural integration and ethnocultural identity are promising approaches. A strong sense of ethnocultural identity has been correlated with higher levels of psychological health for indigenous youth, including feelings of self-worth, self-efficacy, connectedness, and purpose (McCabe, 2007; Minore, Boone, Katt, & Kinch, 1991; Les Whitbeck, Chen, Hoyt, & Adams, 2004; White, 2000).

Several studies have shown that integrating culture can lead to improved program success among indigenous Native Hawaiian and minority youth (Huriwai, Sellman, Sullivan, & Potiki, 2000; Williams, Nasir, Smither, & Troon, 2006; Withy, Lee, & Renger, 2007). Two examples of programs integrating cultural components that demonstrated effectiveness are described below. The Pono Curriculum is a culture-specific, interactive substance abuse prevention program that utilizes core Native Hawaiian values, initially implemented in schools (Kim, Withy, Jackson, & Sekaguchi, 2007). The program encourages practicing and living the cultural

and spiritual principles associated with 21 values, thereby increasing cultural identity and self-worth, improving family and social communication skills, and recognizing the dangers of substance abuse. Results for 155 students who used the Pono Curriculum demonstrated significant positive effects of the curriculum on student school commitment ($p<0.007$) and self-esteem ($p<0.042$), with reduced positive perception of harmful drugs ($p<0.040$), and maintenance of low alcohol, tobacco, and other drug use (Kim, Withy, Jackson, & Sekaguchi, 2007). The curriculum also served as the basis for an effective, culturally grounded residential substance abuse intervention targeting drug-involved youth (Withy, Lee, & Renger, 2007). Therefore, the Pono Curriculum functions as a prototype for community- and Native Hawaiian-initiated, culture-based programs that are contextually relevant for both prevention and intervention paradigms (Rehuher, Hiramatsu, & Helm, 2008).

Another example is the Queen's Medical Center's Family Treatment Center, which promotes the health and well-being of Hawaii's adolescents and their families through core evidence-based strategies, including individual therapies; family strengthening; promoting physical health and well-being; developing a sense of community, such as cultural, spiritual, and social awareness; and nurturing Native Hawaiian concepts of community and relationships with people and the environment (Bell et al., 2001a, 2001b; Carlton et al., 2006). The cultural integration program at the Family Treatment Center places Native Hawaiian values at the center of well-being, providing adolescents with a foundational guide for beliefs, social behavior, and attitudes that help them to think about practical ways of expressing values about themselves, others, the community, and the world. Through the cultural integration program, youth are exposed to Native Hawaiian values in their learning environment as well as in individual and group therapy sessions and are given the time and space to reflect on their meaning (Carlton et al., 2011). Examples of values selected by youth as relevant to their treatment and healing include acceptance (āpono, hoʻāpono), change (loli, hoʻololi), responsibility (kuleana), positive attitude (ʻoluʻolu), patience (ahonui), faith (manaʻoʻiʻo), forgiveness (kala, hoʻokala), and respect (hōʻihi). By including cultural values in education and therapy, youth are provided with the principles and tools for developing the whole person physically, mentally, emotionally, and spirituality. Such integration allows the therapist to develop unique awareness and understanding of the youth's thoughts, views, and perspectives; emotional and cognitive capacities; interpersonal relatedness; and morality. By living the selected cultural values, youth become more resilient and better able to cope with adversity in the future.

More recently, the Family Treatment Center began a collaborative project on healing through art, in which murals along its walls reflect Native Hawaiian cultural values by telling the story of how Queen Emma (the founder of Queen's Medical Center) as a 26-year-old dealt with the devastating loss of her 4-year-old son, followed 16 months later by the death of her grief-stricken husband, King Kamehameha IV (Goebert et al., 2018). As the youth completed the murals, they vicariously experienced Queen Emma's mourning, journey of healing, and sublimation of her grief into advancing the mission and vision of the hospital to provide quality care to her people. Hence, the physical change in the treatment center's milieu literally and metaphorically created a place of courage and healing for the youth. Youth from the unit also went to the kalo[41] field as part of their treatment. During the process of caring for the kalo, they discussed cultural values and ancestral narratives. This heuristic healing approach that combines experiential cultural immersion, collaborative work, and artistic expression teaches adolescents on the unit to channel their suffering into positive action, increasing hope.

- **A connection between historically traumatic events (physical, emotional, social, and spiritual genocide) and contemporary stressors has been posited to impact physical and emotional well-being but has not been well-studied among Native Hawaiians.**

As described in the Introduction, historical trauma is the cumulative biopsychosocial wounding over the lifespan and across generations, emanating from massive group trauma followed by a history of oppression and colonial exploitation (Blaisdell, 1989; Blaisdell & Mokuau, 1991; Brave Heart, 1998, 1999a, 1999b, 2000; Brave Heart & DeBruyn, 1998; Brave Heart-Jordan & DeBruyn, 1995; DeCambra, Marshall, & Ono, 1998; Kanahele, 1986; Mokuau & Matsuoka, 1995; Trask, 1993, 1994). In the only study measuring the impact of historical trauma among Native Hawaiians, Pokhrel and Herzog (2014) found that the vast majority of participants (college students) reported thinking about the loss of the following at least annually or on special occasions: culture (89%), ancestral land (81%), language (87%), traditional spiritual ways (83%), respect by children for traditional ways (83%) and for elders (79%). With the

[41] taro

same frequency, they also thought about the likelihood of early death (80%). Nearly one third of participants reflected upon such losses daily. In examining the relationship with substance use, the authors found that historical trauma was linked indirectly to higher substance use through higher perceived discrimination, but was also linked directly to lower substance use. Thoughts, knowledge, or experience associated with historical trauma that increase substance use behavior via increased perceived discrimination may also, paradoxically, promote resilience. One possible explanation for this seemingly contradictory finding is that the historical-trauma component that is separated out by the correlation with perceived discrimination may be a proxy or measure of cultural identification or ethnic pride. More research in this area is needed given the limitations of this study (e.g., cross-sectional design, different measures of substance use that appeared to be differentially associated with historical trauma, definition of overall substance use).

Alameda (2005) proposed a process model for Native Hawaiian healing that (1) synthesizes the historical events that occurred during the last 200 years and how they shaped—and continue to influence—the evolution of the Native Hawaiian ethnocultural identity; and (2) provides a cultural paradigm for healing an ethnic group from the effects of generational trauma at the individual and group levels. He posited that ancestral memory and awareness of cultural values, beliefs, and practices lead to self-validation and self-worth. Furthermore, he posited that new behaviors, combined with positive reinforcement and community recognition, lead to a change in self-perception of behavior, which is necessary for an increase in resilience.

Resilience refers to the process of adapting well in spite of adversity or trauma, and the ability to increase capacity for dealing with future negative events (Carlton et al., 2006; Masten, 2007). Given the value of promoting resilience in response to historical trauma, integrating cultural values into interventions is critical. Interventions must focus on the whole person, as a cultural being connected to his/her/their ʻohana.[42] For interventions to be successful, they must target resilience, family relationships, social and interpersonal stressors, cohesion, and functioning (Beardslee & Knitzer, 2004. This is especially important for prevention and intervention programs. Programs that integrate cultural processes and encourage participation in meaningful cultural activities can lead to improved mental health and wellness for Native Hawaiians (Trinidad, 2009). Greater identification with Native Hawaiian culture is considered to be protective against risky behaviors such as substance use (Poʻa-Kekuawela, Okamoto, Nebre, Helm, & Chin, 2009). Prevention and treatment interventions that build on cultural strengths, such as resilience in the face of multiple challenges, and adaptive ways of coping (e.g., connecting with extended family, strengthening kinship ties, spirituality, creating positive meaning), can reduce symptoms.

- **While primary care integration and co-occurring disorder treatment have made significant advances, there remains a lack of a wholistic approach to well-being.**

The primary care integration model refers to programs that unify care for medical and mental health. The first such model, the medical home, originated in Hawaiʻi several decades ago as an approach to coordinating services for children with special health care needs (Sia, Tonniges, Osterhus, & Taba, 2004). Primary care integration enhances access to care by establishing an ongoing relationship with primary care, a team approach to care, coordinated or integrated care, and a commitment to quality and safety, thereby decreasing rates of crisis intervention services and emergency department use (Hogan, Sederer, Smith, & Nossel, 2010). In addition to the Affordable Care Act endorsement, this approach has been embraced by the Native Hawaiian Health System, many of the community health centers, public and private insurers, and provider networks in Hawaiʻi. By integrating physical, emotional, and spiritual needs, teams are oriented to the whole person. In practice, this is neither universal nor common.

[Mental health is] having the personal equilibrium and stability to deal with the things life brings you in a manner that's functional, effective, satisfactory and leads to personal growth and health and that part of your overall wellness. There's no health without mental health. Physical health and spiritual health and mental health all go together. A person does best when all those areas are optimally functioning.

William Sheehan, MD
Former Chief, Adult Mental Health Division
Psychiatrist, Child & Adolescent Mental Health Division
State of Hawai`i Department of Health

Co-occurring disorders refers to the co-occurrence of addiction *and* another mental illness

[42] family

(e.g. depressive disorder). In the general population, approximately half of all individuals with a substance use disorder have also been diagnosed with a mental illness, and about one third of individuals with a mental illness have also been diagnosed with a substance use disorder (Patrick, Hishinuma, & Pehm, 1999). Co-occurring disorders began receiving attention in the 1980s because treatment was less likely to be effective when only one illness was treated (Hryb, Kirkhart, & Talbert, 2007). As a result, clinical recognition was enhanced, some of the barriers to treatment were reduced, patient care was improved, and treatment outcomes were more successful. However, by its very definition, it is an illness model. A 6-year needs assessment of co-occurring substance use and mental health disorders, from 2002 through 2007, was funded by the Co-Occurring State Incentive Grant (COSIG) from the Hawai'i State Department of Health. This project assessed the state's co-occurring disorders services system, identified unmet needs and problems in the system, and collected data to develop a plan to improve services and build capacity to establish a seamless system of care. Specifically, Native Hawaiian cultural methods utilized by cultural practitioners were assessed, including interventions that incorporated Native Hawaiian spiritual practices and traditional healing practices (Hawai'i State Department of Health, 2008).

Another important form of co-occurring illness is when an individual has both a mental illness and a medical condition (i.e., comorbidity). Mental illness exacerbates morbidity from multiple chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, and cancer (Reeves et al., 2011). This increased morbidity is a result of multiple factors including delayed help-seeking, less frequent use of medical care, and reduced treatment, resulting in a higher risk for adverse health outcomes. These are conditions that have been found at higher rates, with higher morbidity, among Native Hawaiians (See Chapter 3: Medical Health). For example, Grandinetti et al. (2000) found a significant association for a Native Hawaiian sample between depressive symptoms and hemoglobin A1c (HbA1c)—the latter being an indicator of diabetes at high levels.

The models of Native Hawaiian health and well-being presented in the Introduction of this report provide different cultural approaches to co-occurring and co-morbid conditions that attempt to explain how Native Hawaiians think about and address ailments and disruptions to their health and well-being. Further work in systematically applying these models to these kinds of disorders will be vital to advancing Native Hawaiian mental and behavioral health and wellness.

- **Few studies focus on Native Hawaiians across the lifespan. We have limited information on keiki[43] and kūpuna.[44] Research needs to examine developmental trajectories of Native Hawaiian mental health, which would provide essential information on the mental health needs of all Native Hawaiians. Treatment also needs to span multiple generations.**

Intergenerational longitudinal studies over the lifespan provide valuable information for understanding the contexts and dynamic relations among family, health, and well-being (Mare, 2014; Onoye et al., 2014; Werner, 2013). Longitudinal research has demonstrated that exposure to advantage and disadvantage accumulates over the life-course, influencing epigenetic, physiological, psychosocial, and behavioral attributes among individuals, families, and communities (World Health Organization, 2014b). For example, while the Kaua'i Longitudinal Study of Resilience did not focus specifically on Native Hawaiians, it examined strengths across the lifespan starting with the perinatal period (Werner, 1993, 2004; Werner, Bierman, & French, 1971; Werner & Johnson, 1999; Werner & Smith, 1982, 1992), and found that significant adult social supports, including the extended family and beyond (e.g., aunties, uncles, grandparents, teachers), are strong protective factors for resilience.

Despite the advantages of Native Hawaiian mental health promotion programs for keiki and kūpuna, as well as longitudinal and intergenerational approaches, very little has been done in the implementation of such approaches. One exception is Hā Kūpuna: National Resource Center for Native Hawaiian Elders. Hā Kūpuna is one of three resource centers for Native elders funded by the U.S. Administration on Aging (Browne et al., 2014; Ka'opua, Braun, Browne, Mokuau, & Park, 2011). The name Hā Kūpuna derives from the Native Hawaiian cultural belief that one's life essence (spiritual energy, ancestral knowledge) is transmitted to others through the sharing of hā.[45] It is believed that such sharing allows kūpuna[46] to pass on vital knowledge and wisdom to subsequent generations, thus perpetuating valued cultural traditions and a positive sense of identity. Grounded in these and other traditional Native Hawaiian cultural values, Hā Kūpuna seeks to ensure the transmission of hā from kūpuna to younger generations by achieving parity in

[43] young children
[44] elders
[45] breath of life
[46] elders

life expectancy and good health among Native Hawaiian older adults relative to other older Americans. As a center dedicated to the health of Native Hawaiian elders, Hā Kūpuna develops and disseminates knowledge to inform policy and service innovations. This program has provided a wealth of qualitative information, reflecting the voices of kūpuna and the needs of their caregivers (Browne, Braun, Mokuau, Kaʻopua, & Higuchi, 2011). "Among discussion points were: the kuleana[47] of the family in providing care to kūpuna; elders' concerns about becoming a family burden; the importance of prayer and spirituality in providing support to nā kūpuna and caregivers; the role of nā kūpuna in the ʻohana[48] and in Native Hawaiian culture (cultural preservation); and the importance of respect and sensitivity to privacy issues in elder and ʻohana communication" (pp. 6-7). Due to limitations in health monitoring assessments, information on mental and behavioral health in this program has been limited to suicide and general mental health (Braun, Mokuau, & Browne, 2010; Braun, Yang, Onaka, & Horiuchi, 1996).

There is no beginning or end to healing. The seeking of health and healing is a process spanning from ʻōpio[49] to kūpuna and is spiritually understood as the essence of healing and health.

Aunty Malia Craver, Kupuna
Hoʻoponopono Cultural Practitioner

❖ **Systems of care remain in silos, resulting in fractured and inadequate coordination.**

He waiwai nui ka lōkahi.

Unity is a precious possession.

ʻŌlelo Noʻeau #977
(Pukui, 1983, p. 105)

The above ʻōlelo noʻeau[50] captures the Native Hawaiian value of being in harmony with one another. Ancestral Native Hawaiians developed a system of beliefs and practices for the purpose of promoting and maintaining unity, harmony, and balance (Blaisdell & Mokuau, 1991). Our mental health system is out of harmony. Too many Native Hawaiians are not receiving needed mental health care.

In Hawaiʻi, as in other jurisdictions, agencies have developed separate models of care with differing mandates that often result in a "silo" effect and fragmented care (Slavin & Suarez, 2013). Behavioral health and well-being are the responsibility of many organizations, including but not limited to Papa Ola Lōkahi; community health centers; hospitals and medical centers; university schools of medicine, nursing, pharmacy, psychology, social work, and other allied health programs; insurers; Aliʻi[51] trusts; the Office of Hawaiian Affairs; the Hawaiʻi State Departments of Education, Health, Human Services, Public Safety, and Justice; county departments; and many nonprofit organizations. Attaining mental and behavioral wellness requires an integrated systems of care approach. There is not one single entity responsible for the behavioral and mental health of Native Hawaiians in Hawaiʻi.

"E ʻimi i ke ola mawaho" means "Seek life outside!" It's an ʻŌlelo Noʻeau that points out when someone is very sick and slow in healing—often because of complex and complicated illnesses and stressors—you can't stay home and isolate yourself; you have to get out of your house and go seek help from a kahuna or clinician with the expertise to help you.

Naleen Andrade, MD
Professor, Department of Psychiatry
Director, Native Hawaiian & Pacific Peoples
Behavioral Health Research Programs
University of Hawaiʻi at Mānoa
John A. Burns School of Medicine

Given the complexity and challenging determinants of mental health disparities, multidimensional, multifaceted approaches that address individual, community, program, system, and policy levels are needed (Safran et al., 2009). Such approaches are challenging to existing systems because they cut across so many policy and service areas (Keast, Mandell, Brown, & Woolcock, 2004).

Systems of care approaches align with models of Native Hawaiian well-being, sharing core values which strive to be family-focused, community-based, and culturally competent (Cook & Kilmer, 2004; Slavin & Suarez, 2013). Embedded systems of care principles reflect (1) strength-based services; (2) readily available services in least restrictive environments; (3) collaborative, integrated, and coordinated services; and (4) early identification and intervention (Slavin & Suarez, 2013; VanDenBerg, Bruns, & Burchard, 2003).

One example of a systems-approach for girls from diverse background in Hawaiʻi is Project Kealahou.

[47] responsibility
[48] family
[49] youth
[50] proverb, poetic saying
[51] royal

This project works to address the gaps in our current system for girls with histories of trauma on two levels: (1) At the direct service level, Project Kealahou works to develop and enhance mental health services for traumatized girls. (2) At the broader system level, Project Kealahou works to improve the degree of integration, collaboration, and shared understanding of trauma among major state agencies involved in caring for these girls (Slavin & Suarez, 2013). However, such approaches have been demonstrative in nature and are not universal.

Recommendations for Impact

Recommendations for this report were derived from review of related literature, key informant interviews, and committee input.

- **Promulgate Effective Community Engagement Programs.**

Of the women in the correctional center, 95% are there because of drugs or drug-related crimes, and 75% have suffered some traumatic event in their life—not so much a singular event but a series of events, usually between the ages of 5 and 16. Substance abuse and truancy emerge as these young teens cope with trauma. Realizing the traumatic and criminal pathway of the women housed at WCCC, I sought the counsel of Kahuna Pule David Kaupu. These women committed crimes, but there were issues prior to them violating the law. How can they be healed and not just put in a cell? In considering our ancestors and pu'uhonua:[52] *How do we create a sanctuary for healing? Kahu said when a woman enters WCCC, she is told that she is forgiven for what she has done to the community and her family. She is then instructed on how to live a forgiven life. The first step in the journey of forgiveness is to chip away at the internal walls that inhibit the female from seeing the source of the issue. These walls were built as protection from pain. The walls are thick and built up over years of trauma. When the walls are finally stripped away the process of cleaning out all the 'opala*[53] *can begin. From here, her journey is about her. Her family and children come later. This begins healing of self. The start of a lifelong journey of forgiveness. At the Hawaii Youth Correctional Facility focus has become increasingly important when a ward's family is still intact. We have created Halau Maluhia - "A gathering of Ha for peace" on the campus. This place is for family engagement. Originally two large cells that held sixteen wards but have been renovated to function as a family living room and a dining room. We have created a "safe" place for families to engage with community facilitators. A place where families can rediscover themselves. Within this space, families learn to communicate, share, and most important, listen. When peace is established within a family, a new journey begins.*

Mark Kawika Patterson
Former Warden,
Hawai'i Youth Correctional Facility and Women's
Community Correctional Facility
Konohiki (Administrator),
Kawailoa Youth & Family Wellness Center
Pū'ulu, Mana i ka Leo

Patterson describes a few ways for healing to begin. Such healing is essential for the well-being of individuals, their families, their communities. Programs that promote community engagement can improve mental health status for more than just one individual; such programs can also improve reintegration and social networking. Community participation in all parts of participatory research is key when striving toward community acceptance of the results of the intervention (Matsunaga et al., 1996). 'Ohana[54] is highly valued in Native Hawaiian communities. When programs engage families instead of individuals, they have the potential to be more effective. Several of our interviewees mentioned that social networks and supports help decrease rates of admission and readmission into medical and mental health facilities. It is important that the community engagement program be culturally based, as 'ohana is a central value in Native Hawaiian culture.

- Programs that promote community engagement improve reintegration and social networking.

Community-engaged programs are integral in ensuring reintegration and social networking, thereby improving community well-being. For examples, in the Statewide Needs Assessment of Co-Occurring Substance Use and Mental Disorders (Hawai'i State Department of Health, 2008), clubhouse programs are mentioned specifically by participants as providing a structured venue for social interaction, where consumers are "treated with respect." The need for more clubhouse programs in specific high-risk and rural areas was also noted. Another example is Hawaii's Caring Communities Initiative (HCCI) for

[52] place of refuge, peace, safety; sanctuary
[53] trash, refuse
[54] family

Youth Suicide Prevention, which partnered with six community organizations primarily serving Native Hawaiian youth in rural communities across the State of Hawai‘i. The goal was to integrate evidence-based practices into youth-led community awareness activities that were grounded in each community's strengths and needs (Chung-Do et al., 2014, 2015, 2016a, 2016b; Goebert et al., 2018). This resulted in improved integration and social networking. For instance, aspects of social capital are essential determinants of mental health (Herrman, Saxena, Moodie, & World Health Organization, 2005). According to Schaefer-McDaniel's (2004) framework, there are four dimensions of social capital: 1) Social Networks and Sociability; 2) Trust and Reciprocity; 3) Sense of Belonging/Place Attachment; and 4) Investment. HCCI was successful in building social capital among the youth, their supportive adult partners, and their communities.

To me, that's the biggest impact that we've made—that people know we're here and that we're willing to help and that we care. That's a big, I don't know—I feel like that's one thing that could save a life—just knowing that people care.

Youth Leader
Hawaii's Caring Communities Initiative
for Youth Suicide Prevention

- ❖ When programs can engage families instead of individuals, programs are more effective and can improve mental health status for more than just one individual.

Multigenerational approaches recognize the role of being "disadvantaged," including due to historical trauma, in shaping health and well-being in families and across generations (Cheng, Johnson, & Goodman, 2016). National studies and best practices indicate that a multigenerational model of service delivery is more effective than one that separately addresses individuals' needs (e.g., Hawai‘i Department of Human Services, ‘Ohana Nui Program; "Strategic Intention," 2016). These approaches address the needs of children, parents, and grandparents early and concurrently, attaining better outcomes for the entire family. While multigenerational programs are costly and labor-intensive—especially for the most vulnerable families—the long-term benefits in social-emotional, physical, and economic well-being far outweigh the costs (Golden, Loprest, & Mills, 2012). Examples of such programs, described in the section on Promising Practices, include Ola Kino Maika‘i and the Ho‘opono Mamo Civil Citation Initiative.

- ❖ Communities want to help shape the direction and focus of research and evaluation efforts through collaborations.

As stated earlier, Native Hawaiian communities seek data governance and data sovereignty to ensure that data collected from studies in their communities are not exploited and are used for the purposes that they have determined together with academic researchers. Community-based participatory practices have been recognized as the most relevant in the fields of health disparities and health promotion (Dalton, Elias, & Wandersman, 2007). Embedded within the community-based participatory research approach is the recognition that the socio-political origins of health disproportionately impact disenfranchised groups, such as rural and indigenous populations (Freire, 1998a, 1998b), including Native Hawaiians. Participatory approaches increase value through integrative processes with the potential to transfer knowledge in both directions—i.e., communities and academic institutions transferring knowledge to and from each other. Both share equally in research planning, implementation, evaluation, and dissemination of results, as well as in any resulting benefits (DeCambra, Enos, Matsunaga, & Hammond, 1992; Oneha et al., 2014). Participatory research recognizes the benefits of a partnership between those with the scientific and technical knowledge and those with the equally valuable personal and cultural knowledge of the problems, program development and implementation, and research. Participatory research begins with the assumption that minority communities can and must benefit from research. Community-based participatory research reflects and integrates Native Hawaiian cultural values, assets, and lifestyle. The community perspective determines how the cultural norms of the community relate to the intervention and research.

Increasingly, attention is placed on conducting culturally-based evaluation (Frierson, Hood, & Hughes, 2010). Culturally Responsive Evaluation and Assessment - Hawaii Chapter (CREA-HI), a group of 20 Native Hawaiian evaluators hosted by the Consuelo Foundation, is laying the groundwork in these efforts by exploring what are important concepts, values, and practices of a Native Hawaiian evaluation framework (see https://www.creahawaii.com/). CREA-HI is using a Native Hawaiian lens to offer empowering, values-based evaluation approaches that promote equity and justice in the diversity that is Hawai‘i by weaving together and sharing stories, tools, and practices that affirm and draw from a Native Hawaiian worldview.

The Wai‘anae Coast Comprehensive Health Center provides an example of the ways that research

has focused on community-based approaches, serving as a model for engagement in indigenous research (Chan et al., 2002; DeCambra, Enos, Matsunaga, & Hammond, 1992; Matsunaga et al., 1996; Oneha & Beckham, 2004; Shoultz et al., 2006). Research has focused on cultural models of care, sense of place, health disparities, and interventions (Chandler & Bell, 1995; Crabbe, 1998; Custodio, Gard, & Graham, 2009; Magnussen et al., 2004; Magnussen, Shoultz, Oneha, Hla, & Brees-Saunders, 2007; Oneha, 2001; Oneha, Magnussen, & Shoultz, 2009, 2010; Okihiro et al., 2017). Braun and colleagues (Braun, Tsark, Santos, Aitaoto, & Chong, 2006) have also demonstrated successes with culturally based and culturally adapted programs using community-based participatory research to ensure sustainability and future collaboration, particularly for empirical studies of intervention effectiveness.

- **Expand Effective Culturally Based and Culturally Adapted Prevention and Interventions.**

Ua lehulehu a manomano ka ʻikena a ha Hawaiʻi.

Great and numerous is
the knowledge of the Hawaiians.

ʻŌlelo Noʻeau #2814
(Pukui, 1983, p. 309)

This ʻōlelo noʻeau serves as a reminder that, despite the many challenges facing Native Hawaiians, culture encapsulates a wealth of multi-layered knowledge that can support Native Hawaiian individuals, families, and communities in achieving wellness (Duponte, Martin, Mokuau, & Paglinawan, 2010). Culturally based prevention and intervention programs enhance communities, strengthen relationships, and contribute to healthy and resilient community members (Goebert et al., 2018; Rasmus, Charles, & Mohatt, 2014). Through the advancement of production, teaching, and acquisition of cultural knowledge and social voice, indigenization can occur (Trinidad, 2009).

Indigenization represents a paradigm shift in developing indigenous programs by linking interventions to a sense of community and cultural grounding (Kanahele, 1986; Meyer, 2001; Trinidad, 2009). When communities tell their stories and share their traditions and cultural practices, both communities and practices become sources of hope and inspiration (Grande, 2004; Smith, 1999; Trask, 1993; Trinidad, 2009). Through indigenization, communities can invoke their history and tradition, and then develop—utilizing technical consultation with academic researchers and community advisors—culturally relevant, locally directed healing interventions that integrate scientific principles to improve effectiveness and efficacy. Prevention and intervention efforts for Native Hawaiians must be culturally guided.

The cultural adaptation of interventions for specific cultural populations can increase their effectiveness in addressing mental health issues. Griner and Smith (2006) conducted a meta-analytic review and found that interventions adapted for a specific cultural group were four times more effective than interventions provided to more varied cultural backgrounds. Culturally appropriate substance use interventions were one of four priority areas identified by the 2016 Hawaiʻi Advisory Commission on Drug Abuse and Controlled Substances for prevention and treatment of substance use in Hawaiʻi (Alcohol and Drug Abuse Division, 2016). Many of the Native Hawaiian interventions described earlier – e.g., evidence-based substance abuse programs addressing co-occurring and comorbid issues – have applied overarching Native Hawaiian cultural concepts and practices recommended by Native Hawaiian cultural practitioners and experts. These programs did not, however, systematically use indigenization as a paradigm – i.e., culturally adapting interventions to the population(s) they served, and then empirically assessing their effectiveness. Although cultural adaptation has been shown to be effective in addressing adolescent substance use prevention and treatment, youth suicide prevention, intimate partner violence, postpartum activity, teen pregnancy, elder health, cancer, and chronic diseases among Native Hawaiians, it has not been applied and evaluated for other mental health interventions (Albright et al., 2012; Braun, Fang, Kaanoi, Kamaka, & Gotay, 2005; Chung-Do et al., 2014, 2015, 2016a, 2016b; Helm et al., 2008, 2013; Hishinuma et al., 2009; Kaholokula et al., 2012; Kaʻopua, Park, Ward, & Braun, 2011; Manaseri, Uehara, & Roberts, 2014; Mau et al., 2010; Mokuau, Braun, & Daniggelis, 2012; Mokuau, Browne, Choy, & Braun, 2008; Okamoto, Helm, Poʻa-Kekuawela, Chin, & Nebre, 2009; Okamoto, Kulis, Helm, Lauricella, & Valdez, 2016; Shoultz et al., 2015; Sinclair et al., 2012; Withy, Lee, & Renger, 2007).

For cultural adaptation to be successful, there must be a balance between fidelity to evidence-based and culturally informed applications. In a critical review of culturally aligned interventions, those interventions tailored to address barriers within existing practices were found to improve care and patient outcomes (Baker et al., 2010). However, there have been only four studies focused on Native American populations, and only a single study

including Pacific Islanders (McFarlane, Burrell, Duggan, & Tandon, 2016). Cultural adaptation has the potential to improve delivery of services to underserved populations, and thus enhance health care and reduce health disparities.

- ❖ There is a need for programs using cultural and wholistic approaches that are designed to optimize Native Hawaiian mental and behavioral health, and that prevent mental/behavioral health challenges before they occur.

There are a number of Native Hawaiian cultural activities that promote healthy lifestyles and, if implemented correctly, can be used as valuable tools to encourage healthy behavior that will, in turn, improve not only mental but overall health. For example, surfing, canoe paddling, and dancing hula are physical activities that promote active lifestyles and social networking.

The Hale Mua initiative, which has established hale mua[55] in at least three Native Hawaiian communities on Oʻahu and Hawaiʻi island, is another sociocultural preventive intervention (ʻAha Kāne, 2017). The hale mua was the traditional Native Hawaiian social institution within which boys who were weaned from their mothers, male youth, and adult men learned from esteemed elders who served as role models, teachers, and mentors, about the social skills and mores of being responsible, contributing citizens. In contemporary times, the Hale Mua initiative provides Hawaiian men—from youth to adulthood—with culturally adapted gender roles, social mores, intergenerational traditions, empowerment by the effective use of mana,[56] and kuleana[57] for their personal and communal conduct. In addition, the Native Hawaiian transgender role, i.e., mahu, is also taught within this initiative. Thus, the Hale Mua initiative helps to shape social and gender roles in the context of ethnocultural identification, offering a place of support and mentoring by esteemed cultural practitioners and elders—all protective factors against threats to mental and behavioral health and wellness.

A prominent theme among the responses of the interviewees for this report was that the Native Hawaiian cultural and wholistic approach involves a complementary dualism whereby the same method or intervention can defend against adversity (i.e., serve as prevention) or provide treatment and healing, depending on the circumstances. The literature describes additional Native Hawaiian perspectives that include: the use of a shared language (Pidgin and various Native Hawaiian words), the integration of place and environment (aloha ʻāina[58]), the practice of hoʻoponopono,[59] and, finally, "deep cultural therapy" (Morelli & Fong, 2000). Preventive and treatment interventions for Native Hawaiians emphasize common experience and understanding. Each of the aforementioned perspectives—language, aloha ʻāina, hoʻoponopono, and deep cultural therapy—contain the complementary dualism in which preventive and treatment interventions can be developed to fit the need of the person(s) being served.

For example, Pidgin English used by staff seems to "increase the meaning behind the interactions of the participants" (Grant, 2008, p. 32) and serves as an empathic tool to strengthen the relationship required for health and wellness. Similarly, aloha ʻāina, or caring for the land through gardening or loʻi[60] work, deepens the meaning of recovery and resilience through physical discipline, cognitive attention and comprehension, and connection to a broader spiritual significance (Mokuau, 2002). Hoʻoponopono can be implemented in treatment to help clients resolve past transgressions that may be contributing to their poor health conditions and lack of progress in treatment; furthermore, it can provide clients, and more importantly their families, with a preventive process that can help them address conflict before it is repressed or suppressed and festers. Lastly, deep cultural therapy, typically conducted by experienced kūpuna, consists of multiple sessions up to six hours long. The sessions are based on vicarious learning via role-playing and reenacting of Native Hawaiian legends and mythic figures, followed by a discussion and reflection about the client's response to this material. The legends are often sacred stories of Native Hawaiian male and female heroes with human vulnerabilities and strengths, who face trials and adversity which they are able to address systematically with the help of other people, ancestral guardians, and divine intervention. The hero in the story typically grows—often painfully—from the experience, gaining maturity, wisdom, and empowerment. A study of deep cultural therapy by Morelli and Fong (2000) found two recurring themes in the reflections of their participants (who were all women): "lack of self-appreciation and internalized oppression" (2000, p. 38). These intrapersonal insights may be selection indicators to identify individuals who would benefit from deep cultural therapy. The use of legend or sacred stories may also have benefit for building

[55] men's eating houses
[56] spiritual and self-actualizing power
[57] responsibility
[58] caring for the land
[59] process for setting things right; conflict resolution
[60] irrigated terrace used for growing taro

resilience and promoting vicarious and anticipatory play in children and adolescents. Empirical studies of these interventions in different age groups will help define their effectiveness and indications for use.

- ❖ Such interventions bridge gaps that Native Hawaiians may experience between their behavior and their values.

When denied access to participation in cultural activities and healing practices, as well as hindered from living cultural values, Native Hawaiians will be challenged to determine what is right—what is pono. Consistent with the projects described under Effective and Promising Practices, ʻImi ke Ola Mau identified five key cultural components as helpful for Native Hawaiians from a community perspective: integration of kūpuna,[61] use of land- and sea-based sites, use of cultural values and traditional practices, incorporation of family and community into treatment, and use of a language consultant (ʻImi ke Ola Mau, 2009; Lee, 2012). Culturally based programs provide learning environments that immerse youth and their families in their values, heritage, cultures, landscapes, opportunities, and experiences, which are fundamental prerequisites for nurturing healthy and responsive citizens and contribute to the growth and harmony of the community (Office of Youth Services, 2016).

- ❖ **Decrease Stigma and Ensure Access to Services.**

  - ❖ The stigma of mental illness and behavioral health challenges adversely impacts all levels of well-being, including prevention, help-seeking, access, recovery, and resilience.

Stigma refers to a mark of disgrace that sets a person aside from others based upon misinformation and differences in understanding due to culture or religion (Byrne, 2000, 2001). It often results in prejudice and discrimination based on negative stereotyping (Papish et al., 2013). For example, due to stigmatizing attitudes, the public may be hesitant to employ or rent property to people with mental illness or a history of substance abuse (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). Many of those suffering from mental illness or substance abuse may not seek the treatment, resources, support, and advocacy that they need for fear of what others may think (Cutler et al., 2009). Those who seek psychiatric or substance abuse treatment are sometimes discouraged by family, friends, care providers, and clergy from receiving help, believing that the person can "get over it" (Schmetzer & Lafuze, 2008). While over half of Native Hawaiians (56.8%) strongly agreed that treatment can help people with mental illness lead normal lives, the proportion was significantly lower than for Whites (69.3%; Reyes-Salvail, Liang, & Gross, 2009). Furthermore, Native Hawaiians with mental illness were two-fold less likely to receive treatment. Locally, organizations such as Mental Health America of Hawaiʻi, the National Alliance for Mental Illness - Hawaiʻi Chapter, and Native Hawaiian and community health centers, are working with families and communities to decrease stigma.

When you talk about behavioral health, [community members] think it's more about mental disability. So [to] a lot of the people I shared with in the community, I say, "You know what, sometimes it's just there to talk story with somebody that you don't know and you going to feel more comfortable with talking about your problems." That's all it is. It has nothing to do with mental illness; it has nothing to do with that. So by all means, you like talk story to somebody [about] any hardship that you're going through, do it, because sometimes I do. You know, I mean, I talk to them all the time about all kind stuff, but you know, and of course it's about services that we render here…it's always good to talk about it.

Komela Horner, MA
Community Health Worker
Na Puʻuwai
(Native Hawaiian Health Care System)

Behavioral health problems such as being overweight or obese, both conditions in which Native Hawaiians are overrepresented, are also heavily influenced by stigma. McCubbin and Antonio (2012) conducted a study using the Hawaiian Health Survey to examine stigma, as measured by perceived discrimination among Native Hawaiians ($N = 118$ men and 249 women). Their study used the Everyday Discrimination Scale, which is comprised of two subscales: overt and covert discrimination. Overt discrimination is measured by four items ("perceptions of being dishonest, one to be afraid of, called names or insulted, and harassed or threatened") and covert discrimination by five items ("receiving poorer services than other people at restaurants and stores, being treated with less respect than other people, being treated with less courtesy than other people, people act as if they don't think you are as good as they are, and people act as if they think you are not smart"). They found that for Native Hawaiian men age 35-54 years, with household incomes of

[61] elders

$35,000 or less, and living in Hawai‘i 6-20 years, overt discrimination was positively associated with being overweight or obese. Among Native Hawaiian women age 18-34 years, with household incomes of $35,000-$74,000, whether with some college education or with a high school diploma or less, covert discrimination was negatively related to being overweight or obese. They posited that these results may indicate an "at-risk profile" for Native Hawaiian men who face overt discrimination. For Native Hawaiian women, they proposed a "profile of protective factors" that may be related to the ability to cognitively reframe covert discrimination into new meanings that generate resilience. The McCubbin and Antonio study shows the complexity of stigma surrounding mental and behavioral health problems, and the necessity of investigating such stigma in order to develop meaningful preventive and treatment strategies.

- ❖ A responsive system of care will improve access to mental health treatment and will eliminate health disparities for Native Hawaiians, their families, and communities.

With the deinstitutionalization movement during the Kennedy Administration initiated by the Community Mental Health Act of 1963, states began to close "asylums" or mental health institutions, transitioning patients from hospital settings to community settings (Safran et al., 2009). However, the more complicated task of creating effective community mental health systems remains unfulfilled. Consequently, emergency rooms, jails and prisons, and homeless camps and shelters have become the destinations of individuals manifesting disturbing behavioral symptoms in public settings. Native Hawaiian and community health centers and rural health clinics have made significant advances in wholistic, intergenerational, integrated health practices. A newly envisioned health care system that also substantively addresses behavioral and mental health is needed to improve access and eliminate health disparities.

- ❖ An effective behavioral health system must be capable of providing an array of prevention and treatment options in multiple settings, including services that are culturally responsive and contribute to improvement of treatment outcomes.

The Cultural Influences on Mental Health framework is a useful approach to characterize cultural factors in the relationship that develops among patients, their family, and the mental health care system (Jimenez, Bartels, Cardenas, Dhaliwal, & Alegría, 2012). This model suggests that cultural differences may contribute to the prevalence and experience of mental disorders, influence beliefs about the causes of mental illness, and subsequently impact treatments and interventions. Treatment preferences shape the manner in which everyone seeks help, and from whom help is sought. Therefore, the greater the availability of culturally responsive options, the greater the likelihood that Native Hawaiians will seek and receive services. Integrated treatment approaches can benefit from personalization because they involve matching diverse treatment options to unique profiles based on individual, family, and community need (Spaulding & Deogun, 2011). With growing awareness of health disparities and integrated systems of care, greater attention is placed on socioecological approaches and providing services at various levels. Once fragmentation is eliminated, the comprehensive array of programs and services offered can become a major strength of the system.

- ❖ **Increase Workforce Development and Training for Behavioral Health Providers.**

Indigenous and more integrated Western models of training are needed to meet behavioral health workforce demands. Traditional medicine in Hawai‘i was founded on centuries of evidence-informed practices (Smith & Ma, 2016). However, such practices became illegal in 1865. While the law may have been well-intended, it set up the obstacle of requiring all practitioners to obtain a license. With the Native Hawaiian renaissance, traditional healers and kahuna[62] were again permitted to practice legally in 1973. The Native Hawaiian Health Care Act (1988) also recognized traditional healers of Native Hawaiian ancestry. Act 162, the "Healer's Law," assigns certification to the traditional Hawaiian healing community with several councils across the State determining their own criteria, such as the Kupuna Council which recognized Papa Ola Lōkahi. Yet, with so many impediments to providing legal, reimbursable care, access is limited and continues to be marginalized.

There are a number of Western programs offered in Hawai‘i with the potential to expand the behavioral health workforce, including but not limited to: allopathic medicine and residency training at the University of Hawai‘i (UH); clinical psychology at UH; community health worker certification at UH;

[62] healer, master, sorcerer, priest

nursing programs at UH, Chaminade University, Hawai‘i Pacific University (HPU), and University of Phoenix; osteopathic medicine at A.T. Stills University (based at the Wai‘anae Coast Comprehensive Health Center); public health at UH; social work at UH and HPU; and certification in substance abuse counseling and management from the Hawai‘i Department of Health.

Nursing programs began in Hawaii more than 75 years ago. Nursing programs are offered at the University of Hawai‘i (UH), Chaminade University, Hawai‘i Pacific University, and University of Phoenix (LeVasseur & Qureshi, 2015). All of the nursing programs' curricula emphasize culture (including Native Hawaiian, Pacific Islander, and Asian culture) and its influence on health and healing. Nursing programs in the state also weave lessons on transcultural care throughout core classes such as community health, complex nursing care, and mental health in the undergraduate programs. The UH nursing program requires coursework in culturally competent research methods for its doctoral students and houses the ‘Ike Ao Pono program, which aims to recruit and support Native Hawaiian nursing students (‘Ike may be translated as “a shared vision held and nurtured by all,” Ao as “the everlasting quality of continuation,” and Pono as “well-being in life”). Chaminade’s program engages students in community outreach projects, service learning, and supervised clinical experiences (Thompson, Jarvis, Sparacino, Kuo, & Genz, 2012). However, while they have a community focus, none of these programs offer advanced practice nursing with a mental health specialization.

Established in 1920, the UH Psychology Department provides training in behavioral neuroscience, community and culture, experimental psychopathology, and clinical, cognitive, developmental, and social psychology (http://www.psychology.hawaii.edu/index.html#). Its Clinical Studies Program offers the Doctor of Philosophy (PhD) in Clinical Psychology and has been accredited by the American Psychological Association since 1972.

UH has offered training in social work since 1936 (http://www.hawaii.edu/sswork/). In 2008, the UH Board of Regents unanimously approved the naming of The Myron B. Thompson School of Social Work. Myron "Pinky" Thompson, who received his MSW from UH in 1953, went on to become a noted humanitarian and leader in the struggle for the preservation of Native Hawaiian culture. The school naming reflects not only its commitment to Native Hawaiians but also to providing services anchored in cultural values and culturally based models of practice (Mokuau, Garlock-Tuiali'i, & Lee, 2008). Hawai‘i Pacific University also offers a social work program.

Established in 1962, the UH Department of Public Health has undergone many iterations (http://manoa.hawaii.edu/publichealth/). It is currently housed in the Myron B. Thompson School of Social Work. The Office of Public Health Studies strives to advance the health of the peoples of Hawai‘i through knowledge, discovery, innovation, engagement, inclusion, and leadership. It considers community diversity a strength, providing a supportive learning environment for students, staff, and faculty to serve community needs, and to understand and utilize strengths to promote healthy and thriving communities. Because knowledge of history, policy, health determinants, and ethics is essential to address and eliminate the inequities faced by Indigenous people, the department created a specialization in Native Hawaiian and Indigenous Health. Many faculty members conduct community-engaged research on mental and behavioral health and well-being, including research pertaining to Native Hawaiian communities.

In 1973, the ‘Imi Ho‘ōla[63] Program was established at UH under the leadership of Dr. Benjamin Young, a Native Hawaiian psychiatrist (DeCambra & Lee, 2011; Lee, Lee, & Carpenter, 2014; Young, 1998). This program increases the number of physicians trained in Hawai‘i, including psychiatrists, through a 12-month pre-medical program that addresses disadvantaged students’ academic and social-emotional needs.

In 1991, UH established the Native Hawaiian Center of Excellence at the John A. Burns School of Medicine. This program has demonstrated on multiple levels its commitment to indigenous people and native knowledge, educating Native Hawaiians in the field of medicine while also conducting research to address and reduce the health disparities affecting this population. In 2002, the Department of Native Hawaiian Health was established to develop a comprehensive program that addresses the health care status of Native Hawaiians through research and education (Izutsu et al., 2012). This department also currently houses other divisions related to Native Hawaiian health and welfare including the Imi Ho‘ōla Program, the Native Hawaiian Center of Excellence, and the Center for Native and Pacific Health Disparities Research. The Imi Ho‘ōla Program has been instrumental in expanding the number of Native Hawaiian psychiatrists (for one Native Hawaiian psychiatrist’s journey, see J. K. Andrade, 2017).

[63] those who seek to heal

To promote the expansion of services to connect people to the resources they need to stay healthy, the Community Health Worker/Health Navigator Certificate Program was established at UH Maui College in 2015 (http://maui.hawaii.edu/communityhealth/). The program recruits trusted members of the community to be vital members of health care or social services teams by providing health education, care coordination, and supportive counseling; as well as helping to improve access to services and ensure that services are culturally appropriate.

There are several community- and school-based pathway programs that support and encourage Native Hawaiians to become healers and/or enter health careers. Peer support workers with lived experience in recovery may be more successful than professionally qualified staff in promoting hope and belief in the possibility of recovery; empowerment and increased self-esteem; self-efficacy and self-management of difficulties; and social inclusion, engagement, and enhanced social networks (Repper & Carter, 2011). Two certification programs, for substance abuse counselors and peer specialists, are operated by the Hawai‘i State Department of Health. Requirements include multicultural competency. The Hawai‘i Certified Peer Specialist program, a program of the Adult Mental Health Division, certifies individuals to provide direct peer-to-peer support services to others diagnosed with mental illness and co-occurring disorders. Peer specialists can use their life experiences to inspire hope and provide support. Their certification requirements include training in cultural differences and beliefs and the role of culture in recovery.

Additionally, a kūpuna[64] workforce for health care (i.e., as navigators for culture, community, and health) can help bridge gaps identified by Native Hawaiians in the existing health care system.

The National Center for Indigenous Hawaiian Behavioral Health (formerly the Native Hawaiian Mental Health Research Development Program; Andrade et al., 1994) was established in 1990 by Dr. Naleen N. Andrade, the first Native Hawaiian female psychiatrist, at the Department of Psychiatry in the UH John A. Burns School of Medicine (Guerrero, 2015; Andrade et al., 1994). The program’s strategic aim and purpose are to develop and conduct a comprehensive program to improve the mental health and well-being of Native Hawaiians through: (a) epidemiological, translational, community-based, clinical, and preventive intervention and neuroscience research; (b) clinician-educator-researcher education and training; and (c) culturally effective diagnostic and treatment protocols (Andrade et al., 1994, 2006). The National Center for Indigenous Hawaiian Behavioral Health has also been instrumental in supporting other teaching, research, and clinical efforts, including those within the Department of Psychiatry. In total, over 100 peer-reviewed journal articles have been published with support from the program (for a list of Department of Psychiatry publications, see N. N. Andrade, 2017; for review article, see Choi-Misailidis & Kaulukukui, 2004). These publications include not only some of the prevalence results reported earlier, but also results related to psychiatric symptoms (e.g., Yuen, Nahulu, Hishinuma, & Miyamoto, 2000) and protective factors (e.g., Carlton et al., 2006).

Collectively, these units, centers, and programs clearly demonstrate the shift toward Native Hawaiians reclaiming their identity and knowledge and utilizing these assets in the perpetuation of their people and culture, and an expansion of training and research programs to increase the workforce of mental health providers and scholars. However, the numbers remain insufficient. (See also Chapter 7: Workforce Development.)

- ❖ Shortages of mental health providers disproportionately impact residents on neighbor islands and other rural communities.

The 2017 Behavioral Health Workforce Planning Meeting was sponsored by the Healthcare Workforce Advisory Board of the Hawai‘i Department of Labor and Industrial Relations. An estimated 153 representatives from education, industry, government, non-profit, and practice sectors were invited to this meeting, and 85 participants attended from more than 50 public and private agencies across the state. Four goals guided the process (see Table 3): (1) Summarize priorities from prior workforce reports that address development of the behavioral health workforce in Hawai‘i; (2) Identify behavioral health workforce needs and recommendations; (3) Prioritize recommendations and explore ways to optimize current resources; and (4) Develop collaborative action plans among participating stakeholders. The group selected ten strategies for action planning, and prioritized next steps. Needs were greatest in rural communities. For example, most of Hawai‘i County, Waimea on Kaua‘i, Hana on Maui, Moloka‘i, and all areas served by community health centers and Papa Ola Lōkahi have been designated Mental Health Professional Shortage Areas (Health Resources and Services Administration, 2017). Therefore, all of

[64] elders

these recommendations are relevant for serving Native Hawaiians and their communities.

Table 3
Work Force Development Strategic Priorities

FOUR CATEGORIES AND THEIR STRATEGIES (prioritized by individual and group voting)	
EDUCATION AND TRAINING • Increase continuing education: using learning collaboratives, distance learning, online training, SBIRT (screening, brief intervention, referral and treatment) training and cultural competency to build behavioral health skills • Expand paraprofessional training (community health worker, case worker, peer counselor, certified nursing assistants, health care navigators, etc.)	**POLICY** • Create statewide group to create feasible plans and share resources across silos to decrease duplication of efforts and implement long term solutions to build the behavioral health workforce • Obtain community input into local needs/resources to balance with workforce statistics to determine the ideal mix of behavioral health workers and share information on resources with community • Create payment reform that encourages care coordination, integration of behavioral health into primary care, screening, brief interventions
COLLABORATIVE PRACTICE • Integrate behavioral health into primary care (requires education, payment reform, etc., and cooperation among physicians, mental health providers, social care workers, and health care navigators) • Create robust telehealth network	**RECRUITMENT, HIRING, AND RETENTION** • Increase incentives to practice in areas of need-scholarships/loan repayment • Facilitate hiring process (particularly in state system) • Increase payment for behavioral health conditions, especially via Medicaid

(Condensed from the Behavioral Health Workforce Planning Meeting Report, April 5, 2017.)

Table 3 does not include traditional Native Hawaiian cultural practitioners and kupuna, yet a major part of this chapter has focused on the need for Native Hawaiian cultural approaches. Creating opportunities for well-trained Native Hawaiian cultural practitioners, particularly kūpuna with expertise at the kahuna[65] level and their mo'olono[66] and haumana,[67] to work within a Native Hawaiian health community network, performing their distinct assessments and interventions, is imperative. This would also provide Western-trained clinicians with a grounding and fundamental proficiency in comprehending the application of Native Hawaiian cultural approaches within indigenous Hawaiian communities. Workforce development of this cadre of cultural practitioners is addressed in Chapter 1: Historical and Cultural Perspectives.

❖ Treatment for Native Hawaiians can have lasting effects if the provider uses treatments or skills that are relevant to the beliefs and values of the person being treated.

It is important for mental health and substance abuse treatment providers to be well trained in serving the Native Hawaiian community. This particular community has values and cultural practices that are different from mainstream American values and cultural practices. Among the responses given during our interviews, there emerged a common theme of differentiating Native Hawaiian culture from Western culture. In order for any type of treatment to be optimally effective, treatment providers need to have a solid understanding of the cultural beliefs and values of the persons they treat. Treatment for Native Hawaiian community members may not have lasting or long-term effects if the provider uses treatments or skills that are irrelevant to the beliefs and values of the persons being treated.

[65] master
[66] apprentices who are qualified practitioners
[67] student learners

'Āina[68]*-based, community-based, 'ohana*[69]*-based, spiritual-based. That's the difference.*

Uncle Wayde Lee
Director/Cultural Practitioner
Wahi Kana'aho (A Healing Place for Youth)

- Native Hawaiian practitioners, mental health care providers, community health workers, and educators have direct linkages to appropriate resources that make them essential wellness navigators for the Native Hawaiian community.

It is of vital importance that Native Hawaiian behavioral health programs be initiated and led by Native Hawaiians, as they are stakeholders. Native Hawaiian practitioners, social workers, psychologists, psychiatrists, and educators have direct linkages to appropriate mental health resources which make them essential health navigators for the Native Hawaiian community. Having access to programs implemented by these key leaders will help to encourage use of these valuable resources to improve mental health. Having Native Hawaiians lead programs can also encourage more Native Hawaiian community engagement.

When you have a well-informed, educated, culturally grounded Hawaiian health professional, that will make the greatest influence in helping a Hawaiian individual change…The Western way wants to know what the Hawaiian understanding is, because they have a template. In Hawai'i, for native people, for indigenous Hawaiians, there is another way and perhaps we need to understand the native indigenous way, perspective, to contextualize how Hawaiians not only live, survive in today's world in Hawai'i, but also may have a greater understanding of our historical, cultural past that has contributed to our ill state of being. So we should focus on our own traditional concepts of assessment, diagnosis, treatment development, and healing frameworks to help our own people adapt, adjust in Hawai'i under a whole set of factors of Western intrusion. The greatest impact is when we use our own heritage, our own cultural practices, rituals, language, proverbs, mo'olelo[70] *in helping to heal the individual…I've had more success developing that technique…And it's much more powerful.*

Kamana'opono Crabbe, PhD
Chief Executive Officer
Office of Hawaiian Affairs

- **Enhance Funding and Resources for Mental Health.**

The vast majority of the promising programs and approaches described in this report were implemented as pilot or demonstration projects with grant funding. While in most cases this allowed for examination of their effectiveness, there is a need to ensure accessibility and availability to all Native Hawaiians through more sustainable forms of funding. This requires funding and resources from multiple sources, including all levels of government, trusts, foundations, and non-profit organizations. We must also recognize that resources expended in one domain (e.g., education) may benefit other areas (e.g., health, justice, labor) many times over and, therefore, a system-wide approach to resources, funding, and cost-benefit analysis is necessary.

- Native Hawaiian community-engaged and culturally based programs led by well-trained providers require funding.

Culturally based programs focused on specific communities are more likely to address the complex, multi-layered challenges and obstacles faced by Native Hawaiians, and are better equipped to form essential relationships to engage their communities in the creation and implementation of prevention and intervention services relevant to their diverse and unique needs. Programs developed by and with Native Hawaiian communities help to establish the necessary stakeholder base for sustainability. However, resources and funding streams are needed to ensure that providers are well-trained and effective programs are maintained.

- More funding and resources in health, education, justice, and other systems are needed to have sustainable effects.

There are insufficient funds and resources to reach all Native Hawaiian communities and provide effective services to improve well-being across the lifespan. Given the multiple determinants of health, it is crucial that resources and financial support not be limited to health. For example, resources to enact education, justice, labor, and economic improvements are also needed to create healthy Native Hawaiian communities. In addition, evidence-based interventions and studies of successful programs that show improved outcome measures set by Native

[68] land
[69] family
[70] stories, history

Hawaiian communities could sharpen the focus of how future funding is directed.

- **Incorporate a Systems Approach that Utilizes the Socioecological Model and Focuses on Long-Term Sustainability.**

When there is a cooperative, interorganizational integration of activities, programs, and services through a network of organizations linked through referrals, case management, and joint programs, Native Hawaiians and their families will experience less fragmentation and enhanced coordination of services, leading to greater efficiency and increased utilization of such services. Integrated systems can provide the full range of health and human services needed by Native Hawaiian communities in a way that focuses on well-being and ensures continuity of care.

- The socioecological model considers the complexity of well-being and mental health, including interdisciplinary factors at various levels: individual, family, social, community, and societal.

A social-ecological systems paradigm accentuates the interactional and relational processes among and between individuals and their social environments, including families, neighborhoods, communities, and society (Bronfenbrenner, 1979). From this perspective, a problem in any member of a family or the community can affect all other members. Furthermore, family and community functioning fluctuate over time, with crises and their resolution, and with various highs and lows that presumably relate to stressors and successes impinging on the system. Emphasizing and building upon community and cultural strengths have been shown to increase resilience, promote healing, and build community-based participatory research among Native Hawaiians (Braun et al., 2006; Perez, 2016). At the societal level, the degree to which equity and social justice exist is reflected in the distribution of resources and magnitude of health disparities. This encompasses a variety of indicators, such as neighborhood living conditions; opportunities for learning and training, community development, and employment opportunities; social cohesion, civic engagement, and collective efficacy; multigenerational trauma and discrimination; health promotion; disease and injury prevention priorities; and health care opportunities (Anderson, Scrimshaw, Fullilove, Fielding, & Task Force on Community Preventive Services, 2003; Kaholokula, 2014; Liu & Alameda, 2011; see also the section on Determinants of Health in the Introduction).

- Effective leadership will be crucial to develop, implement, and evaluate efforts and plans to address mental and behavioral health from a systems and sustainability approach.

The recommendations contained in this chapter, while not all new, can be perceived as revolutionary because they require extensive and comprehensive changes to core conceptualizations within existing systems. Central to the theory of diffusion of innovation is the concept of leadership and decision-making, and the rate of adoption at which point innovation reaches critical mass and becomes self-sustaining (Lee, 2012; Rogers, 1995). The implementation process connects these important stages. From a Native Hawaiian epistemology, this process will need to center on "relationships based on support, generosity and equality; identity as life giving and pre-determined; and blending of Western and Hawaiian knowledge" (Lee, 2012, p. 164). Leadership qualities that have emerged from indigenous systems indicate: (1) shared commitment by leaders to serve their communities by creating positive social change; (2) courage to take risks and take action for and with their communities; (3) recognition that education is key to cultural survival and self-determination; (4) ability to travel across boundaries and bridge relationships with others different from themselves; (5) foresight to envision new possibilities for the future; and (6) sense of balance in their lives, so that their life and work have meaning and purpose (Johnson, Benham, & VanAlstine, 2003). Not surprisingly, these qualities have been emulated by the leaders that have laid the groundwork for improving Native Hawaiian mental health and well-being and advancing the recommendations of the *E Ola Mau* report.

Conclusion

Some of the recommendations made in this report are similar to those suggested in the original *E Ola Mau* report of 1985, implying that more needs to be done to decrease the health disparities and inequities affecting the Native Hawaiian community. Progress has been hard-won, given the traumatic clash followed by the insidious effects of 240 years of European-American colonialism and oligarchy; the death of over 90% of Hawaii's native population by the early 20th century, followed by robust population growth in the 21st century with a majority of *Hapa-Hawaiians* (Native Hawaiians mixed with one or more immigrant ethnicities); the oppression of Native Hawaiian culture, identity, and mores; and modest to meager economic resources. Continued progress requires sustained will and perseverance spanning the next

generation. Supporting the growth and sharpening the focus of the promising approaches that we reviewed in the previous sections of this chapter are key to the future advancement of Native Hawaiian mental and behavioral health and wellness. Implementation of these recommendations should maintain our progress and result in further significant improvements to the mental and behavioral health of Native Hawaiians. We offer this *mele pale*, a chant for protection and spiritual clearance at the start of a difficult task, calling upon our ancestors to guide our path to the future.

Nā ʻAumākua

(Adapted from Native Hawaiian Antiquities by David Malo)

Nā ʻaumākua mai ka lā hiki a ka lā kau	*Ancestral guardians from the rising to the setting of the sun*
Mai ko hoʻokui a ka hālāwai	*From the zenith to the horizon*
Nā ʻaumākua iā ka hina kua, iā ka hina alo	*Ancestral guardians at our back and front*
Ia kaʻa ʻakau i ka lani	*At the right side of the heavens*
ʻO kiha i ka lani, ʻowe i ka lani	*A whisper in the heavens, a rustling in the sky*
Nunulu i ka lani, kāholo i ka lani	*A voice reverberating in the heavens*
Eia ka pulapula a ʻoukou ʻo ka poʻe Hawaiʻi	*Here are the descendants, the Hawaiians*
E mālama ʻoukou iā mākou.	*Take care of us*
E ulu i ka lani	*That we may flourish in the heavens*
E ulu i ka honua	*That we may flourish on earth*
E ulu i ka pae'āina 'o Hawai'i.	*That we may flourish in the Hawaiian Islands.*
E hō mai i ka ʻike	*Grant us knowledge*
E hō mai i ka ikaika	*Grant us strength*
E hō mai i ke akamai	*Grant us intelligence*
E hō mai ka maopopo pono	*Grant us the right understanding*
E hö mai ka ʻike pāpālua	*Grant us the insight/intuition*
E hō mai i ka mana	*Grant us spiritual power*
ʻAmama ua noa.	*The prayer is lifted, it is free.*

References

Aaronson, A., & Withy, K. (2017). Does Hawai‘i have enough psychiatrists? Assessing mental health workforce versus demand in the Aloha State. *Hawai'i Journal of Medicine & Public Health*, *76*(3 Suppl 1), 15.

Adelson, N. (2000). *"Being alive well": Health and the politics of Cree well-being* (Vol. 16). University of Toronto Press.

‘Aha Kāne. (2017, March). Hale Mua Initiative. Downloaded from: https://www.ahakane.org/events/hale_mua_initiative

Akeo, N. P., Bunyan, E. S., Burgess, K. N., Eckart, D. R., Evensen, S. L., Hirose-Wong, S. M., …Vasconcellos, C. G. (2008). Hui Mālama o ke Kai: Mobilizing to prevent youth violence and substance use with passion, common goals, and culture. *American Journal of Preventive Medicine, 34*(3S), S67–S71. doi:10.1016/j.amepre.2007.12.013

Alameda, C. K. (2005). *Cultural competency for nursing, sociology, and psychiatry students.* Presentation to the John A. Burns School of Medicine (JABSOM), University of Hawai‘i at Mānoa, Honolulu, HI.

Albright, C. L., Steffen, A. D., Novotny, R., Nigg, C. R., Wilkens, L. R., Saiki, K., ...Brown, W. J. (2012). Baseline results from Hawaii's Nā Mikimiki Project: A physical activity intervention tailored to multiethnic postpartum women. *Women & Health*, *52*(3), 265-291.

Alcohol and Drug Abuse Division. (2016). *Annual Report to the Legislature.* State of Hawai‘i, Department of Health, Alcohol and Drug Abuse Division.

Alicata, D., Schroepfer, A., Unten, T., Agoha, R., Helm, S., Fukuda, M., ...Michels, S. (2016). Telemental health training, team building, and workforce development in cultural context: The Hawaii experience. *Journal of Child and Adolescent Psychopharmacology*, *26*(3), 260-265.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Task Force on Community Preventive Services. (2003). The Community Guide’s model for linking the social environment to health. *American Journal of Preventive Medicine*, *24*(3), 12-20.

Andrade, J. K. (2017). Improving health equity through minority psychiatry trainees: One journey to becoming an academic psychiatrist of indigenous ancestry. *Academic Psychiatry*, *41*(3), 427-429.

Andrade, N. N. (2006, November). *Indigenous Hawaiian ethnocultural identification.* Keynote address at Ku‘i Ka Lono – 2006 Conference: Hawaiian Indigenous Education, Research, and Well-being: “Holomua – Research to Action,” Honolulu, HI.

Andrade, N. N. (2017). National Center on Indigenous Hawaiian Behavioral Health. Retrieved August 21, 2017 from: http://blog.hawaii.edu/dop/research/ncihbh/nhmhrdp/

Andrade, N. N., & Hishinuma, E. S. (2000, July). *Native Hawaiian mental health research development program.* Presentation at the Native Hawaiian Education Association Conference, Kahalui, Maui, HI.

Andrade, N. N., Hishinuma, E. S., McDermott, Jr., J. F., Johnson, R. C., Goebert, D. A., Makini, Jr., G. K., …Waldron, J. A. (2006). The National Center on Indigenous Hawaiian Behavioral Health study of prevalence of psychiatric disorders in Native Hawaiian adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(1), 26-36. doi.org/10.1097/01.chi.0000184933.71917.f4

Andrade, N. N., Johnson, R. C., Edman, J., Danko, G. P., Nahulu, L. B., Makini, Jr., G. K., …McDermott, Jr., J. F. (1994). Non-traditional and traditional treatment of Hawaiian and non-Hawaiian adolescents. *Hawai‘i Medical Journal*, *53*, 344–347.

Antonio, M. C. K., Ahn, H. J., Ing, C. T., Dillard, A., Cassel, K., Kekauuoha, B. P., & Kaholokula, J. K. (2016). Self-reported experiences of discrimination and depression in Native Hawaiians. *Hawai‘i Journal of Medical and Public Health, 75*(9), 266-272. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5030789/pdf/hjmph7509_0266.pdf

Baker, K. K. (2013, November). *Suicide ideation, adults: Questions added to the Hawai‘i Health Survey (HHS) by the Adult Mental Health Division.* Honolulu, HI: Office of Health Status Monitoring, Department of Health, State of Hawai‘i.

Baker, R., Camosso-Stefinovic, J., Gillies, C., Shaw, E. J., Cheater, F., Flottorp, S., & Robertson, N. (2010). Tailored interventions to overcome identified barriers to change: Effects on professional practice and health care outcomes. *The Cochrane Database of Systematic Reviews, 3*, CD005470. doi:10.1002/14651858.CD005470.pub2

Beardslee, W. R., & Knitzer, J. (2004). Strengths-based family mental health services: A family systems approach. In K. Maton, C. Schellenbach, B. Leadbeater, & A. Solarz (Eds.), *Investing in children, youth, families, and communities: Strengths-based research and policy* (pp. 157–171). Washington, DC: American Psychological Association.

Bell, C. K., Goebert, D. A., Andrade, N. N., Johnson, R. C., McDermott, Jr., J. F., Hishinuma, E. S., …Miyamoto, R. H. (2001a). Sociocultural factors influencing adolescent preference and use of Native Hawaiian healers. *Complementary Therapies in Medicine, 9*, 224–231.

Bell, C. K., Goebert, D. A., Miyamoto, R. H., Hishinuma, E. S., Andrade, N. N., Johnson, R. C., …McDermott, J. F. (2001b). Sociocultural and community factors influencing the use of Native Hawaiian healers and healing practices among adolescents in Hawaii. *Pacific Health Dialogue, 8*(2), 249–259.

Blaisdell, K. (1989). Historical and cultural aspects of Native Hawaiian health. *Social Process in Hawai‘i, 32*, 1–21.

Blaisdell, K. (2007, January). Inaugural lecture at the Conference on Healing and Wellness: "Bridging Western and Traditional Native Hawaiian Practices," Ko Olina, O'ahu, Hawai'i.

Blaisdell, K., & Mokuau, N. (1991). Kānaka maoli: Indigenous Hawaiians. In N. Mokuau (Ed.), *Handbook of social services for Asian and Pacific Islanders.* New York, NY: Greenwood Press.

Borowsky, I., Resnick, M., Ireland, M., & Blum, R. (1999). Suicide attempts among American Indian and Alaska Native youth: Risk and protective factors. *Archives of Pediatrics & Adolescent Medicine, 153*, 573-580.Brady, M. A. (1993). Health issues for Aboriginal youth: Social and cultural factors associated with resilience. *Journal of Paediatrics and Child Health*, *29*, S56-S59.

Braun, K. L., Fang, M., Kaanoi, M. E., Kamaka, M. L., & Gotay, C. C. (2005). Testing a culturally appropriate, theory-based intervention to improve colorectal cancer screening among Native Hawaiians. *Preventive Medicine, 40*(6), 619.

Braun, K. L., Mokuau, N., & Browne, C. V. (2010). *Life expectancy, morbidity, and health practices of Native Hawaiian elders: A review of Hawaii surveillance data.* Honolulu, HI: Myron B. Thompson School of Social Work.

Braun, K. L., Tsark, J. U., Santos, L., Aitaoto, N., & Chong, C. (2006). Building Native Hawaiian capacity in cancer research and programing: A legacy of ʻImi Hale. *Cancer Supplement, 107*(8), 2082-2090.

Braun, K. L., Yang, H., Onaka, A., & Horiuchi, B. Y. (1996). Life and death in Hawaiʻi: Ethnic variations in life expectancy and mortality. *Hawaiʻi Medical Journal, 55,* 278–283.

Brave Heart, M. (1998). The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota through a psychoeducational group intervention. *Smith College Studies in Social Work, 68,* 287–305.

Brave Heart, M. (1999a). Gender differences in the historical grief response among the Lakota. *Journal of Health and Social Policy, 10,* 1–21.

Brave Heart, M. (1999b). Oyate Ptayela: Rebuilding the Lakota Nation through addressing historical trauma among Lakota Parents. *Journal of Human Behavior in the Social Environment, 2,* 109–126.

Brave Heart, M. Y. H. (2000). Wakiksuyapi: Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare, 21-22,* 245-266.

Brave Heart, M., & DeBruyn, L. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research, 8,* 60–82.

Brave Heart-Jordan, M., & DeBruyn, L. (1995). So she may walk in balance: Integrating the impact of historical trauma in the treatment of Native American Indian women. In J. Adleman & G. Enquidanos (Eds.), *Racism in the lives of women: Testimony theory and guides to anti-racist practice* (pp. 345–368). New York: Haworth Press.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge: The Harvard University Press.

Brooks, E., Spargo, G., Yellowlees, P., O'Neill, P., & Shore, J. (2013). Integrating culturally appropriate care into telemental health practice. In K. M. Myers & C. L. Turvey (Eds.), *Telemental health: Clinical, technical, and administrative foundations for evidence-based practice* (pp. 63-82). Elsevier Press.

Browne, C., Braun, K., Mokuau, N., Kaʻopua, D. L. S., & Higuchi, P. (2011). *Listening to the voices of nā kūpuna and ʻohana caregivers in Hawai ʻi: Discussions on aging, health, and well-being.* Honolulu, HI: Myron B. Thompson School of Social Work.

Browne, C. V., Mokuau, N., Lana, S., Kim, B. J., Higuchi, P., & Braun, K. L. (2014). Listening to the voices of Native Hawaiian elders and ʻohana caregivers: Discussions on aging, health, and care preferences. *Journal of Cross-Cultural Gerontology*, *29*(2), 131-151.

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment, 6*(1), 65-72.

Byrne, P. (2001). Psychiatric stigma. *The British Journal of Psychiatry, 178*(3), 281-284.

Carlton, B. S., Goebert, D. A., Miyamoto, R. H, Andrade, N. N., Hishinuma, E. S., Makini, G. K., …Nishimura, S. T. (2006). Resilience, family adversity, and well-being among Hawaiian and non-Hawaiian adolescents. *International Journal of Social Psychiatry, 52*(4), 14-31.

Chan, D. S., Callahan, C. W., Beckham, S., Kishaba, G., Yamamoto, K., Boychuk, R., …Takafuji, E. (2002). Report of the First Hawai'i Annual Research Consortium. *Hawai'i Medical Journal*, *61*, 184-187.

Chandler, S., & Bell, S. (1995). Implementing change for community care for persons with severe mental illness. In R. Schulz & J. Greenley (Eds.), *A culturally sensitive model of mental health care in an ethnically diverse, rural community*. New York: Praeger.

Cheng, T. L., Johnson, S. B., & Goodman, E. (2016). Breaking the intergenerational cycle of disadvantage: The three-generation approach. *Pediatrics*, e20152467.

Choi-Misailidis, S., & Kaulukukui, C. M. (2004). Kukulu i na hulili: Building bridges to the understanding of Native Hawaiian mental health. *Multidisciplinary Research on Hawaiian Well-Being*, *1*(1), 223-239.

Chosy, J., Benson, K., Belen, D., Starr, R., St. John, T. L., Starr, R. R., & Ching, L. K. (2015). Insights in public health: For the love of data! The Hawaiʻi Health Data Warehouse. *Hawai'i Journal of Medicine & Public Health*, *74*(11), 382.

Chung-Do, J. J., Bifulco, K., Antonio, M., Tydingco, T., Helm, S., & Goebert, D. A. (2016a). A cultural analysis of the NAMI-NH Connect Suicide Prevention Program by rural community leaders in Hawaiʻi. *Journal of Rural Mental Health*, *40*(2), 87.

Chung-Do, J., Goebert, D., Bifulco, K., Tydingco, T., Wilcox, S., Aea, D., …Alvarez, A. (2015). Mobilizing communities at-risk to prevent youth suicides. *Journal of Health Disparities Research and Practice, 8*(4), 108-123.

Chung-Do, J. J., Goebert, D. A., Bifulco, K., Sugimoto-Matsuda, J., Balberde-Kamali'i, J., Ka'ae, D., ... Walter, L. (2016b). Insights in public health: Safe messaging for youth-led suicide prevention awareness: Examples from Hawai'i. *Hawai'i Journal of Medicine & Public Health, 75*(5), 144.

Chung-Do, J., Helm, S., Fukuda, M., Alicata, D., Nishimura, S., & Else, I. (2012). Rural mental health: Implications for telepsychiatry in clinical service, workforce development, and organizational capacity. *Telemedicine and e-Health*, *18*(3), 244-246.

Chung-Do, J. J., Napoli, S. B., Hooper, K., Tydingco, T., Bifulco, K., & Goebert, D. (2014, August 12). Youth-led suicide prevention in an indigenous rural community. *Psychiatric Times.* http://www.psychiatrictimes.com/cultural-psychiatry/youth-led-suicide-prevention-indigenous-rural-community. Accessed 08/12/2014

Cook, J. R., & Kilmer, R. P. (2004). Evaluating systems of care: Missing links in children's mental health research. *Journal of Community Psychology*, *32*(6), 655-674.

Cook, W. K., Chung, C., Ve'e, T., & Sousa, A. (2010). *Native Hawaiian and Pacific Islander health disparities.* San Francisco, CA: Asian & Pacific Islander American Health Forum.

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services, 63*(10), 963-973.

Crabbe, K. M. (1998). Etiology of depression among Native Hawaiians. *Pacific Health Dialogue*, *5*(2), 341– 345.

Custodio, R., Gard, A. M., & Graham, G. (2009). Health information technology: Addressing health disparity by improving quality, increasing access, and developing workforce. *Journal of Health Care for the Poor and Underserved*, *20*(2), 301-307.

Cutler, J. L., Harding, K. J., Mozian, S. A., Wright, L. L., Pica, A. G., Masters, S. R., & Graham, M. J. (2009). Discrediting the notion "working with 'crazies' will make you 'crazy'": Addressing stigma and enhancing empathy in medical student education. *Advances in Health Sciences Education. Theory and Practice. 14*(4), 487-502.

Dalton, J. H., Elias, M. J., & Wandersman, A. (2007). *Community psychology: Linking individuals and community* (2nd ed). Belmont, CA: Thomson-Wadsworth.

The Data Governance Institute. (2015). Definitions of data governance. Retrieved from http://www.datagovernance.com/adg_data_governance_definition/

DeCambra, C. C., & Lee, W. K. (2011). 'Imi Ho'ola program: Producing primary care physicians for Hawai'i and the Pacific. *Hawaii Medical Journal, 70*(11, Supplement 2), 25–26.

DeCambra, H., Marshall, W. E., & Ono, M. (1998). Ho'omau ke Ola: "To perpetuate life as it was meant to be." In N. Mokuau, L. G. Epstein, G. Pacheco, & J. W. Quinlan (Eds.), *Responding to Pacific Islanders: Culturally competent perspectives for substance abuse prevention* (pp. 73-96). U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration.

DeCambra, H. O., Enos, R., Matsunaga, D. S., & Hammond, O. W. (1992). Community involvement in minority health research: Participatory research in a native Hawaiian community. *Cancer Control Research Reports for Public Health*, 2-9.

Department of Business, Economic Development & Tourism. (2015). 2015 Population Estimate Summary Data [Data file]. Retrieved from http://files.hawaii.gov/dbedt/census/popestimate/2015_state_pop_hi/2015_popest_sumtab.pdf

Duponte, K., Martin, T., Mokuau, N., & Paglinawan, L. (2010). Ike Hawai'i: A training program for working with Native Hawaiians. Retrieved from https://scholarspace.manoa.hawaii.edu/bitstream/handle/10125/15115/v1i1_02duponte.pdf?sequence=1

Freire, P. (1998a). *Pedagogy of the oppressed* (20th-anniversary ed.). New York: The Continuum Publishing Company.

Freire, P. (1998b). *Pedagogy of freedom. Ethics, democracy, and civic courage.* Lanham, MD: Rowman & Littlefield Publishers, Inc.

Frierson, H. T., Hood, S., & Hughes, G. B. (2010). A guide to conducting culturally-responsive evaluations. In J. Frechtling (Ed.), *The 2010 user-friendly handbook for project evaluation* (pp. 75-96). National Science Foundation.

Frison, S. L., Wallander, J. L., & Browne, D. (1998). Cultural factors enhancing resilience and protecting against maladjustment in African American adolescents with mild mental retardation. *American Journal on Mental Retardation*, *102*(6), 613-626.

Galinsky, A. M., Zelaya, C. E., Simile, C., & Barnes, P. M. (2017). Health conditions and behaviors of Native Hawaiian and Pacific Islander persons in the United States, 2014. *Vital Health Statistics, 3*(40). Washington, DC: National Center for Health Statistics. https://www.cdc.gov/nchs/data/series/sr_03/sr03_040.pdf

Gill, L.E. (July 24, 2015). Office of Hawaiian Affairs awards $224K to substance abuse and weight treatment program for women. *Pacific Business News.*

Goebert, D., Alvarez, A., Andrade, N. N., Balberde-Kamalii, J., Carlton, B. S., Chock, S., ... & Kaulukukui, G. (2018). Hope, help, and healing: Culturally embedded approaches to suicide prevention, intervention and postvention services with native Hawaiian youth. *Psychological Services*, *15*(3), 332.

Goebert, D., Nahulu, L., Hishinuma, E., Bell, C., Yuen, N., Carlton, B., …Johnson, R. (2000). Cumulative effect of family environment on psychiatric symptomatology among multiethnic adolescents. *Journal of Adolescent Health, 27*, 34–42.

Golden, O., Loprest, P. J., & Mills, G. B. (2012). *Economic security for extremely vulnerable families: Themes and options for workforce development and asset strategies.* Washington, DC: The Urban Institute. http://www.urban.org/publications/412699.html.

Grande, S. M. A. (2004). *Red pedagogy: Native American social and political thought*. Lanham, MD: Rowman & Littlefield Publishers, Inc.

Grandinetti, A., Kaholokula, J. K., Crabbe, K. M., Kenui, C. K., Chen, R., & Chang, H. K. (2000). Relationship between depressive symptoms and diabetes among Native Hawaiians. *Psychoneuroendocrinology, 25*, 239–246.

Grant, H. (2008). American Indians: Working with American Indians and historical trauma. *Illness, Crisis, & Loss, 16*, 125–136.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 531-548. doi:10.1037/0033-3204.43.4.531

Guerrero, A. P. (2015). Medical School Hotline: The University of Hawai'i John A. Burns School of Medicine Department of Psychiatry: Past, present, and future. *Hawai'i Journal of Medicine & Public Health*, *74*(2), 63.

Guerrero, A. P., Takesue, C. L., Medeiros, J. H., Duran, A. A., Humphry, J. W., Lunsford, R. M., ... & Hishinuma, E. S. (2017). Primary care integration of psychiatric and behavioral health services: A primer for providers and case report of local implementation. *Hawai'i Journal of Medicine & Public Health*, *76*(6), 147.

Hawai'i Health Data Warehouse. (2016). *Youth Risk Behavior Survey module: Suicide attempts in the past year in Hawai'i, Years 2005-2015.* Honolulu, HI: Hawai'i Health Data Warehouse, Office of Public Health Studies, University of Hawai'i at Mānoa.

Hawai'i State Department of Health. (2008). *Statewide needs assessment of co-occurring substance use and mental disorders for the state of Hawaii; phase I, II, and III – final report* (pp. 24-25).

Hawai'i State Department of Health. (2012). *Hawai'i injury prevention plan: 2012-2017.* Honolulu, HI: Injury Prevention Advisory Committee, Injury Prevention and Control Section, Emergency Medical Services and Injury Prevention System Branch, Department of Health, State of Hawai'i. http://www.sprc.org/sites/default/files/Hawaii_Injury_Prevention_Plan_2012_to_2017_4mb.pdf

Health Resources and Services Administration, U.S. Department of Health and Human Services (2017). Data Warehouse: Health Professional Shortage Areas Find. https://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx

Hébert, J. R., Braun, K. L., Kaholokula, J. K. A., Armstead, C. A., Burch, J. B., & Thompson, B. (2015). Considering the role of stress in populations of high-risk, underserved Community Networks Program Centers. *Progress in Community Health Partnerships: Research, Education, and Action*, *9*, 71.

Helm, S., Kissinger, D., Goebert, D., Agoha, R., Tanabe, R., & Alicata, D. (2016). Child and adolescent telepsychiatry in an academic-community partnership: Providers' perceptions on teamwork. *Journal of Rural Mental Health*, *40*(2), 103.

Helm, S., Okamoto, S. K., Maddock, J., Hayes, D., Lowery, T., & Rajan, R. (2013). Insights in public health: Developing the Ho'ouna Pono Substance Use Prevention Curriculum: Collaborating with Hawaiian youth and communities. *Hawai'i Journal of Medicine & Public Health*, *72*(2), 66.

Helm, S., Okamoto, S. K., Medeiros, H., Chin, C. I., Kawano, K. N., Poa-Kekuawela, K., ...Sele, F. P. (2008). Participatory drug prevention research in rural Hawaii with Native Hawaiian middle school students. *Progress in Community Health Partnerships: Research, Education, and Action*, *2*(4), 307.

Herrman, H., Saxena, S., Moodie, R., & World Health Organization. (2005). *Promoting mental health: Concepts, emerging evidence, practice.* Report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne.

Hishinuma, E. S., Chang, J. Y., Sy, A., Greaney, M. F., Morris, K. A., Scronce, A. C., …Nishimura, S. T. (2009). Hui Mālama o ke Kai: A positive prevention-based youth development program based on Native Hawaiian values and activities. *Journal of Community Psychology, 37*(8), 987-1007. doi:10.1002/jcop.20344

Hixson, L., Hepler, B., & Ouk Kim, M. (2012). Native Hawaiian and other Pacific Islander population: 2010. 2010 Census Briefs. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-12.pdf

Hogan, M. F., Sederer, L. I., Smith, T. E., & Nossel, I. R. (2010). Peer reviewed: Making room for mental health in the medical home. *Preventing Chronic Disease*, *7*(6).

Ho'omau ke Ola. (2017). http://www.hoomaukeola.org/

Ho'opono Mamo. (2013). Student report. http://manoa.hawaii.edu/durp/files/2016/10/2013_Fall_Hoopono_mamo.pdf

Ho'opono Mamo. (2017). http://www.hooponomamo.org/

Hryb, K., Kirkhart, R., & Talbert, R. (2007). A call for standardized definition of dual diagnosis. *Psychiatry (Edgmont)*, *4*(9), 15.

Huriwai, T., Sellman, J. D., Sullivan, P., & Potiki, T. L. (2000). Optimal treatment for Maori with alcohol and drug-use-related problems: An investigation of cultural factors in treatment. *Substance Use & Misuse, 35*(3), 281-300.

I Ola Lāhui. (2017). *I Ola Lāhui: Rural Hawai'i behavioral health*. Retrieved 8/21/2017 from: http://www.iolalahui.org/index.html

'Imi ke Ola Mau. (2009, May). *Community best practices for cultural base recovery programs.* Paper presented at the first seminar of 'Imi ke Ola Mau, Waimea Valley, Hawai'i.

Insel, T. (2011). Post by former NIMH Director Thomas Insel: The global cost of mental illness. National Institute of Mental Health. Retrieved from: https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2011/the-global-cost-of-mental-illness.shtml

Izutsu, S., Kaholokula, K. J., Lee, W., Mau, M. K., Look, M., Carpenter, D. A., …Coen, L. (2012). Medical School Hotline: The Department of Native Hawaiian Health at the John A. Burns School of Medicine. *Hawaii Journal of Medicine and Public Health, 71*(11), 329–331.

Jimenez, D. E., Bartels, S. J., Cardenas, V., Dhaliwal, S. S., & Alegría, M. (2012). Cultural beliefs and mental health treatment preferences of ethnically diverse older adult consumers in primary care. *The American Journal of Geriatric Psychiatry*, *20*(6), 533-542.

Johnson, V., Benham, M. K., & VanAlstine, M. J. (2003). Native leadership: Advocacy for transformation, culture, community, and sovereignty. In M. K. P. Benham & W. J. Stein (Eds.), *The renaissance of American Indian higher education: Capturing the dream* (pp. 149-166). Mahwah, NJ: Lawrence Erlbaum Associates.

Kaholokula, J. K. (2007, January 24). *Aia i hea ka la'au? Western impact on Native Hawaiian health.* Paper presented at the Healing and Wellness Conference: "Bridging Western and Traditional Native Hawaiian Practices," Ko Olina, O'ahu, Hawai'i.

Kaholokula, J. K. A. (2014). Achieving social and health equity in Hawai'i. In A. Yamashiro & N. Goodyear-Ka'opua (Eds.), *The value of Hawai'i 2: Ancestral roots, oceanic visions* (pp. 254-264). Honolulu, HI: University of Hawai'i Press.

Kaholokula, J. K., Grandinetti, A., Keller, S., Nacapoy, A. H., Kingi, T. K., & Mau, M. K. (2012). Associate between perceived racism and physiological stress indices in Native Hawaiians. *Journal of Behavioral Medicine, 35*(1), 27-37. doi:10.1007/s10865-011-9330-z

Kaholokula, J. K., Iwane, M. K., & Nacapoy, A. H. (2010). Effects of perceived racism and acculturation on hypertension in Native Hawaiians. *Hawai'i Medical Journal, 69*(Supplement 2), 11-15. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3158444/pdf/hmj6905_suppl2_0011.pdf

Kaholokula, J. K. A., Mau, M. K., Efird, J. T., Leake, A., West, M., Palakiko, D. M., ...Gomes, H. (2012). A family and community focused lifestyle program prevents weight regain in Pacific Islanders: A pilot randomized controlled trial. *Health Education & Behavior, 39*(4), 386-395.

Kaholokula, J. K. A., Nacapoy, A. H., & Dang, K. O. (2009). Social justice as a public health imperative for Kanaka Maoli. *AlterNative: An International Journal of Indigenous Peoples, 5*(2), 117-137.

Kamaka, M. L., Paloma, D. S., & Maskarinec, G. G. (2011). Recommendations for medical training: A Native Hawaiian patient perspective. *Hawaii Medical Journal*, *70*(11 Suppl 2), 20.

Kamehameha Schools. (2014). *Ka Huaka'i: Native Hawaiian educational assessment, 2014*. Honolulu, HI: Kamehameha Schools.

Kanahele, G. (1986). *Kū kanaka: Stand tall: A search for Hawaiian values.* Honolulu, HI: University of Hawai'i Press.

Kana'iaupuni, S. M. (2005). Ka 'akālai Kū Kanaka: A call for strengths-based approaches from a Native Hawaiian perspective. *Educational Researcher*, *34*(5), 32-38.

Kana'iaupuni, S. M., & Malone, N. (2006). This land is my land: The role of place in Native Hawaiian identity. In J. W. Frazier & E. L. Tettey-Fio (Eds.), *Race, ethnicity and place in a changing America* (pp. 291-305). Binghamton, NY: Global Academic Publishing.

Kana'iaupuni, S. K., Malone, N., & Ishibashi, K. (2005). *Ka Huaka'i: Native Hawaiian educational assessment, 2005.* Honolulu, HI: Kamehameha Schools. http://www.ulukau.org/elib/collect/nhea/index/assoc/D0.dir/book.pdf

Ka'opua, L. S., Braun, K. L., Browne, C. V., Mokuau, N., & Park, C. B. (2011). Why are Native Hawaiians underrepresented in Hawaii's older adult population? Exploring social and behavioral factors of longevity. *Journal of Aging Research*, *2011*. doi: 10.4061/2011/701232

Ka'opua, L. S., Park, S. H., Ward, M. E., & Braun, K. L. (2011). Testing the feasibility of a culturally tailored breast cancer screening intervention with Native Hawaiian women in rural churches. *Health & Social Work, 36*(1), 55–65.

Kassebaum, G., Lau, C. W. S., Kwack, D.-G., Leverette, J., Allingham, E., & Marker, N. (1995a). *Identifying disproportionate representation of ethnic groups in Hawaii's juvenile justice system: Phase One* (Publication #380). Honolulu, HI: Center for Youth Research, Social Science Research Institute, University of Hawai'i at Mānoa.

Kassebaum, G., Marker, N., Lau, C. W. S., Kwack, D.-G., Shera, W., Leverette, J., …Kato, D. (1995b). *Assessing disproportionate representation of ethnic groups in Hawaii's juvenile justice system: Phase Two* (Publication #384). Honolulu, HI: Center for Youth Research, Social Science Research Institute, University of Hawaii at Manoa.

Kawakami, A., Aton, K., Cram, F., Lai, M., & Porima, L. (2007). Improving the practice of evaluation through Indigenous values and methods: Decolonizing evaluation practice – Returning the gaze from Hawai'i and Aotearoa. *Hulili: Multidisciplinary Research on Hawaiian Well-Being, 4*(1), 319-348. Retrieved from http://www.ksbe.edu/spi/hulili/

Keast, R., Mandell, M. P., Brown, K., & Woolcock, G. (2004). Network structures: Working differently and changing expectations. *Public Administration Review, 64*(3), 363–371.

Kekoa, K. (2017). *We are from.* Retrieved Aug 20, 2017 from http://www.pupuaoewa.org/video-2/we-are-from/

Kim, R., Withy, K., Jackson, D., & Sekaguchi, L. (2007). Initial assessment of a culturally tailored substance abuse prevention program and applicability of the risk and protective model for adolescents of Hawaii. *Hawaii Medical Journal, 66*, 118-23.

Kīpuka o ke Ola. (2017). Kīpuka o ke Ola: Native Hawaiian health clinic. An accredited independent rural health clinic utilizing a Patient-Centered Medical Home Model! Retrieved from: http://kipukaokeola.com/index.html.

Komaromy, M., Duhigg, D., Metcalf, A., Carlson, C., Kalishman, S., Hayes, L., ...Arora, S. (2016). Project ECHO (Extension for Community Healthcare Outcomes): A new model for educating primary care providers about treatment of substance use disorders. *Substance Abuse*, *37*(1), 20-24.

Kukutai, T., & Taylor, J. (Eds.). (2016). *Indigenous data sovereignty: Toward an agenda* (Vol. 38). Canberra, Australia: ANU Press.

Lee, M. J. P. (2012). *An examination of the evolution and implementation of Native Hawaiian cultural practices in the treatment of adult substance use or co-occurring mental health and substance use disorders: An organization case study* (Doctoral dissertation). University of Hawai'i at Mānoa, Honolulu, HI.

Lee, W. K., Lee, M. S., & Carpenter, D. A. (2014). Medical School Hotline: Celebrating 40 years of 'Imi Ho'ōla. *Hawai'i Journal of Medicine & Public Health*, *73*(2), 66.

Leininger, M. M., & McFarland, M. R. (2006). *Culture care diversity and universality: A worldwide nursing theory*. Burlington, MA: Jones & Bartlett Learning.

Les Whitbeck, B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology, 33*, 119-130.

Les Whitbeck, B., Chen, X., Hoyt, D. R., & Adams, G. W. (2004). Discrimination, historical loss and enculturation: Culturally specific risk and resiliency factors for alcohol abuse among American Indians. *Journal of Studies on Alcohol*, *65*(4), 409-418.

Les Whitbeck, B., Hoyt, D. R., Stubben, J. D., & LaFromboise, T. (2001). Traditional culture and academic success among American Indian children in the upper Midwest. *Journal of American Indian Education*, *40*(2), 48-60.

LeVasseur, S. A., & Qureshi, K. (2015). Hawaii's nursing workforce: Keeping pace with healthcare. *Hawai'i Journal of Medicine & Public Health*, *74*(2), 45.

Liu, D. M., & Alameda, C. K. (2011). Social determinants of health for Native Hawaiian children and adolescents. *Hawaii Medical Journal, 70*(11 Suppl 2), 9–14.

MacDonald, J. M. (2003). The effect of ethnicity on juvenile court decision making in Hawaii. *Youth and Society, 35*(2), 243-263. doi:10.1177/0044118X03255038

Magnussen, L., Shoultz, J., Oneha, M. F., Hla, M. M., & Brees-Saunders, Z. (2007). Intimate partner violence: Systematic review of literature focused on the cultures of Hawai'i. *Hawaii medical journal*, *66*(5).

Magnussen, L., Shoultz, J., Oneha, M. F., Hla, M. M., Brees-Saunders, Z., Akamine, M., ...Wong, E. (2004). Intimate-partner violence: A retrospective review of records in primary care settings. *Journal of the American Association of Nurse Practitioners*, *16*(11), 502-512.

Manaseri, H., Uehara, D., & Roberts, K. (2014). Making pono choices: A collaborative approach to developing a culturally responsive teen pregnancy and sexually transmitted infections prevention curriculum in Hawai‘i. *Maternal and Child Health Journal, 18*(10), 2332-2340.

Mare, R. D. (2014). Multigenerational aspects of social stratification: Issues for further research. *Research in Social Stratification and Mobility*, *35*, 121-128.

Marsella, A. J., & Yamada, A. M. (2010). Culture and psychopathology: Foundations, issues, directions. *Journal of Pacific Rim Psychology, 4*, 103–115.

Masten, A. S. (2007). Resilience in developing systems: Progress and promise as the fourth wave rises. *Development and Psychopathology*, *19*(3), 921-930.

Matsunaga, D., Enos, R., Gotay, C., Banner, R., Decambra, H., Hammond, O., . . . Tsark, J. (1996). Participatory research in a Native Hawaiian community: The Wai‘anae cancer research project. *Cancer, 78*(7), 1582-1586.

Mau, M., Kaholokula, J., West, M., Leake, A., Efferth, J., Rose, C., …Gomes, H. (2010). Translating diabetes prevention into Native Hawaiian and Pacific Islander communities: The PILI ‘Ohana Pilot Project. *Progress in Community Health Partnerships: Research, Education, and Action, 4*(1), 7-16.

McCabe, G. (2008). Mind, body, emotions and spirit: Reaching to the ancestors for healing. *Counselling Psychology Quarterly*, *21*(2), 143-152.

McCubbin, L. D., & Antonio, M. (2012). Discrimination and obesity among Native Hawaiians. *Hawaii Journal of Medicine and Public Health*, *71*(12), 346-352.

McCubbin, L. D., & Marsella, A. (2009). Native Hawaiians and psychology: The cultural and historical context of indigenous ways of knowing. *Cultural Diversity and Ethnic Minority Psychology*, *15*(4), 374.

McFarlane, E., Burrell, L., Duggan, A., & Tandon, D. (2016). Outcomes of a randomized trial of a cognitive behavioral enhancement to address maternal distress in home visited mothers. *Maternal and Child Health Journal, 21*(3), 1-10.

McGregor, D. P. I., Morelli, P., Matsuoka, J., & Minerbi, L. (2003). An ecological model of well-being. In H. A. Becker & F. Vanclay (Eds.), *The international handbook of social impact assessment: Conceptual and methodological advances* (pp. 109-126). Northampton, MA: Edward Elgar Publishing.

Meyer, M. A. (2001). Our own liberation: Reflections on Hawaiian epistemology. *The Contemporary Pacific, 13*(1), 124–148.

Miao, T.-A., Umemoto, K., Hishinuma, E. S., & Smith, M. (2017). *Ho‘opono Mamo: The Hawai‘i Youth Diversion System evaluation report, Year 1, March 16, 2015 – March 15, 2016.* Honolulu, HI: University of Hawai‘i at Mānoa. http://manoa.hawaii.edu/durp/files/2016/10/2013_Fall_Hoopono_mamo.pdf

Minore, B., Boone, M., Katt, M., & Kinch, P. (1991). Looking in, looking out: Coping with adolescent suicide in the Cree and Ojibway communities of northern Ontario. *The Canadian Journal of Native Studies*, *11*(1), 1-24.

Mokuau, N. (2002). Culturally based interventions for substance use and child abuse among Native Hawaiians. *Public Health Reports*, *117*(Suppl 1), S82-S87.

Mokuau, N., Braun, K. L., & Daniggelis, E. (2012). Building family capacity for Native Hawaiian women with breast cancer. *Health & Social Work*, *37*(4), 216-224.

Mokuau, N., Browne, C. V., Choy, L. B., & Braun, K. L. (2008). Using a community-based participatory approach to create a resource center for Native Hawaiian elders. *Education for Health*, *20*(3), 1-10.

Mokuau, N., Garlock-Tuiali'i, J., & Lee, P. (2008). Has social work met its commitment to Native Hawaiians and other Pacific Islanders? A review of the periodical literature. *Social Work*, *53*(2), 115-121.

Mokuau, N., & Matsuoka, J. (1995). Turbulence among a native people: Social work practice with Hawaiians. *Social Work, 40*(4). 465-472.

Montgomery, D., Miville, M. L., Winterowd, C., Jeffries, B., & Baysden, M. F. (2000). American Indian college students: An exploration into resiliency factors revealed through personal stories. *Cultural Diversity and Ethnic Minority Psychology*, *6*(4), 387.

Morelli, P. T. T., & Fong, R. (2000). The role of Hawaiian elders in substance abuse treatment among Asian/Pacific Islander women. *Journal of Family Social Work*, *4*, 33–44. doi:10.1300/J039v04n04_04

Native Hawaiian Health Research Consortium. (1985a). *E ola mau: The Native Hawaiian health needs study.* Honolulu, HI: ALU LIKE, Inc.

Native Hawaiian Health Research Consortium. (1985b). *E ola mau: The Native Hawaiian health needs study: Mental health task force report.* Honolulu, HI: ALU LIKE, Inc. http://www.papaolalokahi.org/images/pdf-files/91985-E-Ola-Mau-The-Native-Hawaiian-Health-Needs-Study-Mental-Health-Task-Force-Report.pdf

Nguyen, D.-H., & Salvail, F. R. (2015). *The Hawai'i Behavioral Risk Factor Surveillance System: 2015 results.* Honolulu, HI: Department of Health, State of Hawai'i. https://health.hawaii.gov/brfss/files/2016/07/brfss15_results.pdf

Office of Hawaiian Affairs. (2010). *The disparate treatment of Native Hawaiians in the criminal justice system.* Honolulu, HI: Office of Hawaiian Affairs. https://19of32x2yl33s8o4xza0gf14-wpengine.netdna-ssl.com/wp-content/uploads/2014/12/ir_final_web_rev.pdf

Office of Hawaiian Affairs. (2017). *Native Hawaiian health fact sheet, 2017.* Honolulu. HI: Office of Hawaiian Affairs. https://19of32x2yl33s8o4xza0gf14-wpengine.netdna-ssl.com/wp-content/uploads/Volume-IV-Health-Status.pdf

Office of Hawaiian Affairs. (2017). The Salvation Army Family Treatment Services – Ola Kino Maika'i. *Ka Wai Ola*, *34*(8), 18.

Office of Youth Services. (2016). *Office of Youth Services Annual Reports to the Governor and the Hawaii State Legislature pursuant to section 352D-6, Hawaii Revised Statutes, Act 151, Session Laws of Hawaii 1991, Act 281, Session Laws of Hawaii 2006(1), and Section 367D-8, Hawaii Revised Statutes.* Retrieved from: https://humanservices.hawaii.gov/wp-content/uploads/2017/01/OYS-2016-Reports.pdf

'Ohana Strengthening Program. (n.d.). *Hui Mālama o ke Kai Foundation.* Retrieved from https://www.huimalamaokekai.org/ohana-programming.html

Okamoto, S. K., Helm, S., Po'a-Kekuawela, K. O., Chin, C. I., & Nebre, L. R. H. (2009). Community risk and resiliency factors related to drug use of rural Native Hawaiian youth: An exploratory study. *Journal of Ethnicity in Substance Abuse*, *8*(2), 163-177.

Okamoto, S. K., Kulis, S., Helm, S., Lauricella, M., & Valdez, J. K. (2016). An evaluation of the Ho'ouna Pono curriculum: A pilot study of culturally grounded substance abuse prevention for rural Hawaiian youth. *Journal of Health Care for the Poor and Underserved*, *27*(2), 815-833.

Okihiro, M., Duke, L., Goebert, D., Ampolos, L., Camacho, C., Shanahan, N., ...Kaholokula, J. K. (2017). Promoting Optimal Native Outcomes (PONO) by understanding women's stress experiences. *The Journal of Primary Prevention*, *38*(1-2), 159-173.

Oneha, M. (2001). Ka mauli o ka 'āina a he mauli kānaka: An ethnographic study from a Hawaiian sense of place. *Pacific Health Dialogue*, *8*(2), 299-311.

Oneha, M. F., & Beckham, S. (2004). Re-examining community-based research protocols. *Pacific Public Health*, *11*(1), 102-106.

Oneha, M. F., DeCambra, H. O., Leong, L., Song, H., Quach, T., Chang-Weir, R., ...Kagawa-Singer, M. (2014). Creating community criteria for research participation at community health centers. *AAPI Nexus: Policy, Practice and Community*, *12*(1-2), 1-20.

Oneha, M. F., Magnussen, L., & Shoultz, J. (2009). When does abuse become abuse? *Issues in Mental Health Nursing*, *30*(4), 279-280.

Oneha, M. F., Magnussen, L., & Shoultz, J. (2010). The voices of Native Hawaiian women: Perceptions, responses and needs regarding intimate partner violence. *Californian Journal of Health Promotion*, *8*(1), 72.

Onoye, J. M., Hishinuma, E. S., McArdle, J. J., Zonderman, A. B., Bumanglag, R. J., & Takeshita, J. (2014). Cohort profile: The Hawai'i family study of cognition. *International Journal of Epidemiology*, *43*(6), 1726-1735.

Papa Ola Lōkahi & 'Imi ke Ola Mau. (2007). *A strategic plan for improvement of substance abuse and mental health outcomes for Native Hawaiians, their families and communities.* Retrieved from http://www.amhd.org/Cooccurring/reports/2007%20Policy%20 Academy%20Strategic%20Plan.pdf

Papish, A., Kassam, A., Modgill, G., Vaz, G., Zanussi, L., & Patten, S. (2013). Reducing the stigma of mental illness in undergraduate medical education: A randomized controlled trial. *BMC Medical Education 13*(1), 141.

Patrick, V., Hishinuma, E. S., & Pehm, J. (1999). Trends across two time periods in the diagnosis of substance abuse comorbidity at the Hawaii State Hospital. *Hawaii Medical Journal, 58*(12), 335-340.

Perez, R. (2016, January 11). Hawaiians at risk: Healing efforts return to roots. *Honolulu Star Advertiser.*

Po'a-Kekuawela, K., Okamoto, S. K., Nebre, L. R. H., Helm, S., & Chin, C. I. (2009). 'A'ole drugs! Cultural practices and drug resistance of rural Hawaiian youths. *Journal of Ethnic & Cultural Diversity in Social Work, 18*, 242–258. PubMed: 20352019

Pokhrel, P., & Herzog, T. A. (2014). Historical trauma and substance use among Native Hawaiian college students. *American Journal of Health Behavior*, *38*(3), 420-429.

Pukui, M. K. (1983). *'Olelo no'eau: Hawaiian proverbs & poetical sayings.* Honolulu, HI: P. B. Bishop Museum.

Pukui, M., Haertig, E., & Lee, C. (1972). *Nānā i ke kumu: Look to the source* (Vols. I and II). Honolulu, HI: Queen Lili'uokalani Center.

Rainie, S. C., Schultz, J. L., Briggs, E., Riggs, P., & Palmanteer-Holder, N. L. (2017). Data as a strategic resource: Self-determination, governance, and the data challenge for Indigenous Nations in the United States. *International Indigenous Policy Journal*, *8*(2). doi: 10.18584/iipj.2017.8.2.1

Rasmus, S. M., Charles, B., & Mohatt, G. V. (2014). Creating Qungasvik (a Yup'ik intervention "toolbox"): Case examples from a community-developed and culturally-driven intervention. *American Journal of Community Psychology*, *54*(1-2), 140-152.

Reeves, W. C., Strine, T. W., Pratt, L. A., Thompson, W., Ahluwalia, I., Dhingra, S. S., ...Morrow, B. (2011). Mental illness surveillance among adults in the United States. *MMWR Surveillance Summaries*, *60*(Suppl 3), 1-29.

Rehuher, D., Hiramatsu, T., & Helm, S. (2008). Evidence-based youth drug prevention: A critique with implications for practice-based contextually relevant prevention in Hawai'i. *Hawai'i Journal of Public Health*, *1*(1), 52-61.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, *20*(4), 392-411.

Reyes-Salvail, F. R., Liang, S., & Gross, P. L. (2009). *Hawai'i BRFSS 2007: Mental health and stigma report.* Honolulu, HI: Hawai'i Department of Health. Available at: http://health.hawaii.gov/brfss/files/2013/11/MentalHealth_Stigma.pdf

Roberts, G., & Holmes, J. (Eds.). (1999). *Healing stories: Narrative in psychiatry and psychotherapy*. New York, NY: Oxford University Press - USA.

Rogers, E. M. (1995). Diffusion of innovations: Modifications of a model for telecommunications. In M. W. Stoetzer & A. Mahler (Eds.), *Die Diffusion von Innovationen in der Telekommunikation. Schriftenreihe des Wissenschaftlichen Instituts für Kommunikationsdienste*, Vol. 17 (pp. 25-38). Berlin, Heidelberg: Springer.

Rouse, M. (2013, March). *Data sovereignty.* Retrieved from http://whatis.techtarget.com/definition/data-sovereignty

Safran, M. A., Mays, Jr., R. A., Huang, L. N., McCuan, R., Pham, P. K., Fisher, S. K., ... Trachtenberg, A. (2009). Mental health disparities. *American Journal of Public Health*, *99*(11), 1962-1966.

Salvail, F. R., & Smith, J. M. (2007). *Prevalence of anxiety and depression among Hawaii's adults derived from HBRFSS 2006.* Honolulu, HI: Department of Health, State of Hawai'i. http://health.hawaii.gov/brfss/files/2013/11/PrevalenceOfAnxietyAndDepression.pdf

Savin, D., Glueck, D. A., Chardavoyne, J., Yager, J., & Novins, D. K. (2011). Bridging cultures: Child psychiatry via videoconferencing. *Child and Adolescent Psychiatric Clinics of North America, 20*, 125–134.

Schaefer-McDaniel, N. J. (2004). Conceptualizing social capital among young people: Towards a new theory. *Children Youth and Environments*, *14*(1), 153–172.

Schmetzer, A., & Lafuze, J. (2008). Overcoming stigma: Involving families in medical student and psychiatric residency education. *Academic Psychiatry, 32*(2), 127-131.

Shore, J. H., Savin, D. M., Novins, D., & Manson, S. M. (2006). Cultural aspects of telepsychiatry. *Journal of Telemedicine and Telecare, 12*, 116–121.

Shoultz, J., Magnussen, L., Kreidman, N., Oneha, M. F., Iannce-Spencer, C., & Hayashi-Simpliciano, R. (2015). Engaging Native Hawaiians and Filipinos in creating supportive and safe violence-free communities for women through a piloted "talk story" intervention: Implications for program development. *Evaluation and Program Planning*, *51*, 78-84.

Shoultz, J., Oneha, M. F., Magnussen, L., Hla, M. M., Brees-Saunders, Z., Cruz, M. D., & Douglas, M. (2006). Finding solutions to challenges faced in community-based participatory research between academic and community organizations. *Journal of Interprofessional Care*, *20*(2), 133-144.

Sia, C., Tonniges, T. F., Osterhus, E., & Taba, S. (2004). History of the medical home concept. *Pediatrics, 113*(Suppl. 5), 1473–1478.

Sinclair, K. A., Thompson, C., Makahi, E. K., Shea-Solatorio, C., Yoshimura, S. R., Townsend, C. K., & Kaholokula, J. K. (2013). Outcomes from a diabetes self-management intervention for Native Hawaiians and Pacific People: Partners in Care. *Annals of Behavioral Medicine, 45*(1), 24-32. doi: 10.1007/s12160-012-9422-1

Slavin, L. A., & Suarez, E. (2013). Insights in public health: Project Kealahou—Forging a new pathway for girls in Hawaii's public mental health system. *Hawai'i Journal of Medicine & Public Health*, *72*(9), 325.

Smith, H. W., & Ma, C. (2016). The Daniel K. Inouye College of Pharmacy scripts: Transition from traditional to Western medicine in Hawai'i (Part 2) – Western legislative impacts on traditional medical practices. *Hawai'i Journal of Medicine & Public Health*, *75*(5), 148.

Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. New York, NY: Zed Books Ltd.

Sockalingam, S., Arena, A., Serhal, E., Mohri, L., Alloo, J., & Crawford, A. (2018). Building provincial mental health capacity in primary care: An evaluation of a Project ECHO mental health program. *Academic Psychiatry, 42*(4), 451-457. doi: 10.1007/s40596-017-0735-z. Epub 2017 Jun 7.

Spaulding, W., & Deogun, J. (2011). A pathway to personalization of integrated treatment: Informatics and decision science in psychiatric rehabilitation. *Schizophrenia Bulletin*, *37*(Suppl. 2), S129-S137.

Strategic intention: DHS implementation of 'Ohana Nui. (2016, December 5). Hawai'i Department of Human Services. Retrieved from https://humanservices.hawaii.gov/blog/ohana-nui-kicks-off/

Substance Abuse and Mental Health Services Administration. (2016, August 23). *Healing in Hawaii – The role of culture in addiction recovery.* Retrieved from: https://elbiruniblogspotcom.blogspot.com/2016/09/healing-in-hawaii-role-of-culture-in.html

Sy, A. (2009, July). *Developing a measure of Hawaiian cultural values: Hui Mālama o ke Kai youth wellness programme.* Paper presented at the Aotearoa New Zealand Evaluation Association (ANZEA) Conference, Aotearoa, New Zealand.

Ta, V. M., & Chen, T. (2008). Substance abuse among native Hawaiian women in the United States: A review of current literature and recommendations for future research. *Journal of Psychoactive Drugs*, *40*(Suppl. 5), 411-422.

Takeshita, C., & Takeshita, I. (2002). *Hui Mālama o ke Kai: Impact survey results, June 2002.* Waimānalo, HI: Hui Mālama o ke Kai.

Takeshita, C., & Takeshita, I. (2003). *Hui Mālama o ke Kai: Impact survey results, June 2003.* Waimānalo, HI: Hui Mālama o ke Kai.

Thompson, L. M., Jarvis, S., Sparacino, P., Kuo, D., & Genz, S. (2013). Perceptions of health equity and subjective social status among baccalaureate nursing students engaged in service-learning activities in Hawai‘i. *Hawai‘i Journal of Medicine & Public Health, 72*(10), 339–345.

Tibbetts, K. A. (2016, March). *Preliminary findings: From Wahi Kana‘aho youth interviews.* Presentation at the Office of Youth Services, State of Hawai‘i, Honolulu, HI.

Trask, H. (1993). *From a native daughter: Colonialism and sovereignty in Hawai‘i.* Honolulu, HI: University of Hawai‘i Press.

Trask, H. K. (1994). Kupa'a 'Aina: Native Hawaiian nationalism in Hawai'i. In U. Hasager & J. Friedman (Eds.), *Hawai'i: Return to nationhood* (pp. 15-32). Copenhagen, Denmark: International Work Group for Indigenous Affairs.

Trinidad, A. M. O. (2009). Toward *kuleana* (responsibility): A case study of a contextually grounded intervention for Native Hawaiian youth and young adults. *Aggression and Violent Behavior, 14*, 488–498.

Ulukau. (2017). *Culture, innovation and promising directions in Native Hawaiian education.* Retrieved from http://www.ulukau.org/elib/collect/nhea/index/assoc/D0.dir/doc339.pdf

Umemoto, K., Spencer, J., Miao, T.-A., & Momen, S. (2012). *Disproportionate minority contact in the Hawai‘i juvenile justice system, 2000-2010: Final report, June 2012.* Honolulu, HI: Department of Urban and Regional Planning, University of Hawai‘i at Mānoa. https://humanservices.hawaii.gov/wp-content/uploads/2013/01/DMC-FINAL-REPORT-2012-for-printing.pdf

U.S. Census Bureau. (2000a). *Aloha counts: Census 2000 special tabulations for Native Hawaiians.* http://ulukau.org/elib/collect/census00/index/assoc/D0.dir/doc16.pdf

U.S. Census Bureau. (2000b). *P12, sex by age, Hawai‘i.* http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=DEC_2000_SF1_U&-mt_name=DEC_2000_SF1_U_P012&-CONTEXT=dt&-tree_id=4001&-all_geo_types=N&-geo_id=04000US15&-search_results=01000US&-format=&-_lang=en

U.S. Department of Commerce. (2015). *United States Census Bureau quick facts*. Retrieved from http://www.census.gov/quickfacts/

U.S. Department of Health and Human Services. (2017). *Rural health clinics.* Retrieved from: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf

VanDenBerg, J., Bruns, E., & Burchard, J. (2003). History of the wraparound process. *Focal Point: A National Bulletin on Family Support and Children’s Mental Health – Quality and Fidelity in Wraparound*, *17*(2), 4-7.

Werner, E. E. (1993). Risk, resilience, and recovery: Perspectives from the Kaua‘i Longitudinal Study. *Development and Psychopathology, 5,* 503-515.

Werner, E. E. (1995). Resilience in development. *Current Directions in Psychological Science*, *4*(3), 81-84.

Werner, E. E. (2004). Journeys from childhood to midlife: Risk, resilience, and recovery. *Pediatrics*, *114*(2), 492-492.

Werner, E. E. (2013). What can we learn about resilience from large-scale longitudinal studies? In S. Goldstein & R. B. Brooks (Eds.), *Handbook of resilience in children* (2nd ed., pp. 87-102). New York, NY: Springer.

Werner, E. E., Bierman, J. M., & French, F. E. (1971). *The children of Kaua‘i: A longitudinal study from the prenatal period to age ten.* Honolulu, HI: University of Hawai‘i Press.

Werner, E. E., & Johnson, J. L. (2002). Can we apply resilience? In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development. Longitudinal research in the social and behavioral sciences: An interdisciplinary series* (pp. 259-268). Boston, MA: Springer.

Werner, E. E., & Smith, R. S. (1982). *Vulnerable but invincible: A longitudinal study of resilient children and youth.* New York, NY: McGraw-Hill.

Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High-risk children from birth to adulthood.* Ithaca, NY: Cornell University Press.

Wexler, L. M., DiFluvio, G., & Burke, T. K. (2009). Resilience and marginalized youth: Making a case for personal and collective meaning-making as part of resilience research in public health. *Social Science & Medicine*, *69*(4), 565-570.

Williams, D. (2003). Mele ‘ohana. [Recorded by Keali‘i Reichel]. On *Ke‘alaokamaile* [CD, album]. Makawao, HI: Punahele Productions.

Withy, K. M., Lee, W., & Renger, R. F. (2007). A practical framework for evaluating a culturally tailored adolescent substance abuse treatment programme in Molokai, Hawaii. *Ethnicity and Health*, *12*(5), 483-496.

World Health Organization. (2003). *Investing in mental health.* Geneva: Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health Cluster, World Health Organization. Retrieved from: http://www.who.int/mental_health/en/investing_in_mnh_final.pdf

World Health Organization. (2014a). *Mental health: A state of well-being.* Retrieved from: http://www.who.int/features/factfiles/mental_health/en/

World Health Organization. (2014b). *Social determinants of mental health*. Retrieved from: http://apps.who.int/iris/bitstream/10665/112828/1/9789241506809_eng.pdf

Yellowlees, P., Shore, J., & Roberts, L. (2010). Practice guidelines for videoconferencing-based telemental health. *Telemedicine Journal and e-Health, 16*(10), 1074–1089. doi: 10.1089/tmj.2010.0148.
Young, B. (1998). A history of Imi Hoʻola. *Pacific Health Dialogue, 5*(2), 375–377.
Yuan, S., Vo, H., Gleason, K., & Azuma, J. (2016). *Homeless service utilization report: Hawai'i 2015.* Honolulu, HI: Center on the Family, University of Hawaiʻi at Mānoa.
Yuen, N. Y. C., Nahulu, L. B., Hishinuma, E. S., & Miyamoto, R. H. (2000). Cultural identification and attempted suicide in Native Hawaiian adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(3), 360-367.



Papa Ola Lōkahi

894 Queen Street | Honolulu, HI 96813 • (808) 597-6550 • www.papaolalokahi.org