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.

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE UNIVERSITY OF HAWAI‘I AT MANOA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR DEGREE OF DOCTOR OF PHILOSOPHY IN SOCIAL WELFARE MAY 2012

By
Michael John Palama Lee

Dissertation Committee:
Steven J. Onken, Chairperson
Kathryn L. Braun
Noreen Mokuau
Paula Morelli
Ernestine Enomoto
Dedication

This dissertation is dedicated to my parents, Annie Kealohanui Kanahele Palama and Edward Elia Kalama Lee, the source of my mana and mo‘okū‘auhau.

~ He mana loa ke Akua
Acknowledgements (‘Ōlelo ho‘omaika‘i)

Ke aloha aku nei ‘au i nā mea a pau. E kau ana nō ke kōkua, ke aloha nui a me ka ‘ike na‘au ao.

Ke Akua, mahalo i ka ho‘ike ‘ia ‘ana o kāu ‘ōlelo ia‘u, “mai ho‘okaumaha ‘oe i ke Akua ma ka pule, a me ke nonoi aku, a me ka ho‘omaika‘i”. Ku‘u mau mākua, i ko ‘oukou aloha, ahonui, a me hui kala ‘ana mai ia‘u. Saifoloi Aganon, i kāu ‘ōlelo wiw’a‘ole a me kou ikaika a i ka hanahana maika‘i i nā hui kūkākūkā. Dr. Steven Onken, i ke alaka‘i ana mai a me kou ho‘onani. PhD Committee, i ko ‘oukou aloha, ho‘omanawanui, a me ka ‘ike. Aloha nui loa iā Dr. Jamie Kamailani Boyd, ko‘u tita, ko‘u pilialoha, a ‘o ka‘u kāko‘o mau loa. Mahalo iā ‘Imi Ke Ola Mau, nō ho‘i! Aunty Malia Craver, i ka ho‘oulu mai ia‘u a i kāu kau ‘ana i ka inoa i kāu pepa lae‘o. Lisa Aganon, i ke kōkua ‘ana mai i nā hō‘ā‘o muā ma nā hui kūkākūkā. A mahalo i kēia mau kānaka i waele i ke a: Aunty Betty Jenkins, James Winters, Hardy Spoehr, Dr. Aunty Sita Nissanka, Poka Laenui, Dr. Nani Lee, a me Dr. Kamuela Ka‘ahanui. He wahi mahalo ho‘i kēia i nā haumāna o ka Hui Ho‘ola o Na Nahulu o Hawai‘i i kā lākou aloha, ho‘omake‘aka, nani, a me kā lākou kūpa‘a ‘ana. A palena‘ole ku‘u mahalo i ko‘u ‘ohana Kū Aloha Ola Mau: Aunty Ulu Garmon, Lisa Cook, Kelaukila Carter, Kaipo Like, Rachel Kruse, Brian Ogawa, Mariposa Blanco, Gene Abraham, Paul Takehiro, a me Aunty Lucille Chun. Ke mahalo nei ‘au ia ka‘u komike: Dr. Steven Onken, Dr. Kathryn Braun, Dr. Paula Morelli, Dr. Noreen Mokuau, and Dr. Ernestine Enomoto. No lai ila, ke ho‘omaika‘i nei ‘au ia Kaneda Scholarship, Takasaki Scholarship, Department of Hawaiian Home Lands Kuhiō Scholarship, a me Kanehe Lampson Scholarship.

I am graced by the work of many hands to assist with this endeavor.

To ke Akua for the inspiration of, “fear nothing, but have faith in the manifestation of ke Akua through prayer, asking, and gratitude”. To my parents for your love, patience, and forgiveness. To Saifoloi Aganon for your candor and strength and facilitation of all focus groups. To my Chair, Dr. Steven Onken for your leadership and grace. To my PhD Committee for your support, patience, and knowledge. With a deep aloha to my sister, colleague, and eternal supporter, Dr Kamailani Boyd. For the partnership of ‘Imi Ke Ola Mau! To Aunty Malia Craver for the inspiration and naming of my dissertation. And to the following individuals for opening up the way: Aunty Betty Jenkins, James Winters, Hardy Spoehr, Dr. Aunty Sita Nissanka, Poka Laenui, Dr. Nani Lee, Dr. Kamuela Ka‘ahanui. A very special acknowledgment to the haumāna of Hui Ho‘ola o Na Nahulu o Hawai‘i for their resilience, laughter, and beauty, and to my ‘ohana at Kū Aloha Ola Mau: Aunty Ulu Garmon, Lisa Cook, Kelaukila Carter, Kaipo Like, Rachel Kruse, Brian Ogawa, Mariposa Blanco, Gene Abraham, Paul Takehiro, and Aunty Lucille Chun. I want to thank my committee: Dr. Steven Onken, Dr. Kathryn Braun, Dr. Paula Morelli, Dr. Noreen Mokuau, and Dr. Ernestine Enomoto. Finally,
much appreciation to the Kaneda Scholarship, Takasaki Scholarship, Department of Hawaiian Home Lands Kūhiō Scholarship, and Sally Kanehe Lampson Scholarship.

...mahalo, mahalo, mahalo.
Acknowledgements

Naming

I include the origins of the name of my dissertation, ‘Imi Ke Ola Mau. I had originally asked Aunty Malia Craver to gift a name for an entity; later, I asked her to use the name for my dissertation. As is discussed in this dissertation, names carry with them identity and destiny.

She must dream

“E kupuna, i ha‘awi ai ‘oe I ko makou inoa? Ke kali nei ‘oe e Palama, a‘ole ‘au moe ‘uhane. Mahope. Aunty, have you dreamed our name yet? Palama, you must wait, it has not come.”

As a child, Aunty Malia was hanai (adopted) by her grandparents in Ke‘anae, Hawai‘i. Daily, her tutu asked her if she dreamt the night before; her tutu knew Malia had the gift of dreaming. A portal had been opened for her into where she traveled nightly to bring back stories, messages, and truths to her family.

Two days later, Aunty Malia gave birth to the name, ‘Imi Ke Ola Mau. “Palama, the kauna (hidden meanings) of ‘Imi Ke Ola Mau rests in the palm of Ke Akua (God) and refers to a life’s journey to seek God and to seek health and healing...one cannot exist without the other...in Ke Akua is life; in life is Ke Akua.” (M. Craver, personal communication, August 25, 2007).
Abstract

This case study examined the implementation of Native Hawaiian Cultural Practices (NHCPs) to understand why and how one organization identified, developed, and implemented these practices to address substance use or co-occurring mental health disorders among Native Hawaiian adults, and key factors that impact the implementation process.

Qualitative methods used included semi-structured interviews, focus groups, review of documents and archival records, and casual observation. Study participants were recruited from a community-based organization that used NHCPs and Western addiction practices in the treatment of substance use. Participants included administrative staff (n=4), program staff (n=5), and Native Hawaiian consumers (n=15).

Content analysis was used to identify 488 codes, 23 subthemes, 3 themes, and 1 overarching theme. The three themes (key factors) identified included: 1) Pilialoha or loving relationships people maintain with each other, with places, and with spirituality, 2) Koho‘ia or identity as a predestined concept, and 3) ‘Ākoakoa or organizational integration that acknowledges similarities, differences, and areas in which Hawaiian and Western cultures blend. As the overarching theme, Pili‘ana or connections characterize the Hawaiian universe as a continual movement of asking permission, engaging, and mutual benefit binding people, land, and spiritual realms together.

Other key findings included: wahi pana or place-based knowledge and resources such as the significance of cultural kūpuna or elders, relational harmony such as pono or morality and justice and lōkahi or unity, the expansive nature of values that reinforce an
individual’s connection to communal life, the transferability of a healthy code of conduct from ‘āina or land interactions to human interactions, an extended period of time to plan with communities, the influential role of organizational leadership in diffusion of an innovation, and spirituality and faith as important implementation factors.

These findings suggest social workers have an opportunity to implement novel programs responsive to the cultural needs of indigenous populations at greatest risk for substance use or co-occurring disorders by incorporating their epistemic worldview to increase program utility, improve recovery outcomes, and facilitate healing. At the same time, social workers must continually assess organizational key factors that impact the implementation of an innovation to become routine practice.
# Table of Contents

Abstract ........................................................................................................................................ vi

Opening Reflections .................................................................................................................... xiii

I. Chapter 1. Problem Statement .............................................................................................. 15
   Understanding Prevalence from a Lifespan Approach ......................................................... 16
   Understanding the Problem from an Ecological Framework .............................................. 20
   Need for Indigenous Cultural Practices .............................................................................. 23
   Gaps in the Implementation of Indigenous Cultural Practices .......................................... 25
   Purpose of This Study ........................................................................................................... 27
   Definition of Key Concepts ................................................................................................. 27
   Conclusion ............................................................................................................................ 34

II. Chapter 2. Literature Review .............................................................................................. 36
    Organizational Change Theories ...................................................................................... 36
    Holistic Healing Models .................................................................................................. 41
    Indigenous Cultural Practices ......................................................................................... 45
    Conclusion .......................................................................................................................... 48

III. Chapter 3. Methods ........................................................................................................... 50
    Research Questions .......................................................................................................... 50
    Research Design ................................................................................................................ 50
Phase One: Administration Staff ........................................................................58
Phase Two and Three: Program Staff and Haumāna ........................................60
Data Analysis Procedures ................................................................................68

V. Chapter 4. Findings ......................................................................................76

Qualitative Findings .......................................................................................76
Research Questions .........................................................................................103
Literature Review .............................................................................................114

VI. Chapter 5. Discussion ..................................................................................155

Limitations .......................................................................................................155
Implications to Social Welfare .........................................................................157
Conclusion ......................................................................................................164

VII. Chapter 6. Concluding Reflections ............................................................166

VIII. Appendices .............................................................................................168

Appendix A - Consents ..................................................................................168
Appendix B – Recruitment Protocol .................................................................179
Appendix C – Interview and Focus Group Guides .............................................182
Appendix D – Capacity Assessment ................................................................188
Appendix E – Archival Records and Documents Data Collection ....................190
Appendix F – Responses to CHS’s Request for Further Clarification .............193
List of Tables

1. Administration Staff Participant Demographic Characteristics..........................59

2. Program Staff Participant Demographic Characteristics......................................62

3. Haumāna Participant Demographic Characteristics ...........................................64

4. Subthemes...........................................................................................................93

5. Themes and Collapsed Subthemes......................................................................95

6. Themes...............................................................................................................100

7. Outcomes for 2008 of past 30 Days at 6 Month Post-Discharge Follow-Up ........152
# Table of Figures

1. Behavioral Health Care Received by Persons with Co-occurring Disorders ..........18

2. Pyramid of Evidence-Based Practices .................................................................33

3. Innovation Implementation Framework ..............................................................39

4. Recovery Paradigm ..............................................................................................43

5. Lōkahi Triad .........................................................................................................44

6. Pono Triad .............................................................................................................120

7. Innovation Implementation Framework ..............................................................137
Preface. Opening Reflections

“E hana kau hana, e waiho i ka ho‘oilina. Get a grip! Leave a legacy.”

I have been blessed in my life to be the carrier of two rich mo‘okū‘auhau or genealogies and to live under the shade of many wonderful kūpuna or elders like Aunty Malia Craver of the Queen Lili‘uokalani Children’s Center. Her words remind us of our kuleana or responsibility to leave a legacy for our Hawaiian people.

My daddy is Edward Elia Lee, the son of Noah Kahalekoa Kalama and Bella Nakila-Hanohano Keawe-kūloa, both claiming ancestry from Kaupo, Maui. My mommy’s mo‘okū‘auhau from her father, John Keliihanahulu Palama, comes from Lahaina, Maui; her mother, our big grandma, Annie Kealohanui Kanahele, is a Ka Po‘e Ao Hiwa or Carrier of the Sacred Light (Willis & Lee, 2005), from Kamalo, Molokai. I am the second child of three, and the first son. Yet, my sister Olani remains the hiapo or first born and is granted all the authority that comes with this title.

My grandfather Noah Kalama was a voyager, the first to take outrigger canoe paddling as a sport outside of Hawai‘i to Newport Beach, CA in the 1950s. Like him, I have been on a long voyage to navigate the spaces between a dominant Western system of knowledge and Indigenous systems of knowledge, spaces other Pacific scholars have traversed (Hereniko, 1995; Meyer, 2001; Nabobo-Baba, 2006). Within these spaces, ripples of tension occur; within these spaces lay the solutions for our Native people.

I use this analogy as the precipice from which to dive into the following chapters. I acknowledge that truth and knowledge are anchored in the lives and experiences of
people and in their relationships with nature and the spiritual realm. In as much, the nature of truth and knowledge is subjective, experiential, and purposeful. No one truth should prevail; instead, multiple truths must co-exist.
Chapter 1. Problem Statement

Introduction

Co-occurring mental health and substance use disorders are a debilitating set of health conditions often resulting in a higher level of distress, a lower level of functioning, and a more complicated course of treatment (Cleary, Hunt, Matheson, & Walter, 2008). In 2007, 5.4 million U.S. adults had a co-occurring disorder within the past year (SAMSHA, 2008) and the highest prevalence of co-occurring disorders is among American Indians, Alaska Natives, and Native Hawaiians (Beal, Manson, Witesell, Spicer, Novis, & Mitchell, 2005; Papa Ola Lōkahi, 2007; SAMHSA, 2005).

The literature indicates significant barriers exist in prevention and treatment services if cultural needs are not addressed for American Indians, Alaska Natives (Hodge, Weinmann, & Roubideaux, 2000) and Native Hawaiians (Braun, Mokuau, Hunt, Kaʻanoʻi, & Gotay, 2002). Yet, the co-occurring disorder literature contains no outcome and implementation studies on Native cultural practices to address co-occurring disorders among these populations. In this study, Native cultural practices refer to the use of cultural attributes such as the values, practices, and language of American Indians, Alaska Natives, and Native Hawaiians to address issues salient to that population.

This study examines co-occurring disorders with a focus on Native Hawaiian Cultural Practices (NHCPs) to address co-occurring disorders. This section is organized to cover six areas: 1) prevalence from a lifespan perspective; 2) ecological perspective on the individual, family, and healthcare system; 3) need for Native practice models for Native adults with co-occurring disorders; 4) gaps in the literature on the implementation of Native cultural practices; 5) purpose of the study; and 6) definition of key concepts.
Regarding the latter, the word *haumāna* is used in this study and refers to consumers who receive substance use treatment services from Kū Aloha Ola Mau, the organization that is the focus of the case study. *Haumāna* is a Native Hawaiian word that means a person who is the receiver of knowledge (Pukui, Haertig, & Lee, 1972). According to the organization’s staff, the term haumāna implies a reciprocal relationship exists between the teacher and the student. The haumāna is responsible to be open to receive the knowledge and the teacher is responsible to be prepared to share the knowledge. To honor the contributions made to this research by the organization’s staff and haumāna, I use the term haumāna throughout this study in lieu of the terms “consumer” or “client”. Additional implications for its use are described in the Findings and Discussion Chapters of this dissertation.

**Understanding Prevalence from a Lifespan Approach**

A lifespan approach provides a multidirectional process to understand human development across life stages influenced by social, biological, situational, and personal factors (Erickson, 1950). Although my focus is on adults, this approach offers a lens to understand the needs of specific populations from a developmental perspective. What is absent in the literature regarding co-occurring disorders are data on prenatal and infancy stages (less than one year old).

**Youth.** National prevalence data on youth (1 to 18 years of age) co-occurring disorders is unknown. However, according to the National Survey of Drug Use and Health (NSDUH), the occurrence of a major depressive episode in the past year among youth was associated with a higher prevalence of illicit drug or alcohol dependence or abuse (18.9 percent). Among youth who did not report a major depressive episode in the
past year, 6.7 percent had illicit drug or alcohol dependence or abuse during the same period (U.S. DHHS, 2007).

Mental health data on youth suggests an association between emotional, behavioral, and mental health disorders and substance use (U.S. DHHS, 1999). For example, Moran linked the earlier onset of conduct disorder to the later development of anti-social personality disorder and substance use (Moran, 1999). Depression studies of youth found that depression co-occurs with numerous mental health disorders including substance use (Orton, Riggs, & Libby, 2009). Geller, Zimmerman, Williams, Bolhofner, & Craney (2001) report that at least 20% of youth with an early on-set of a depressive disorder (starting in childhood or adolescence) are at risk for developing a bipolar disorder, especially if present in the family history. Suicide is closely associated with depression. Adolescent girls are more likely to attempt suicide and boys are more likely to complete suicide (Brent & Birmaher, 2002). The National Institute of Alcohol Abuse and Alcoholism (2003) reports that adolescent binge-drinking is a significant predictor of suicide attempts.

For youth who used illicit substances, the rate of mental health treatment was higher than for youth who did not use illicit substances (U.S. DHHS, 2002). Kessler, Nelson, and McGonagle (1996) found that while the onset of mental disorders generally occurred in adolescence, substance use followed 5 to 10 years after onset. While this early study provided data on patterns of use, it also indicated the importance of early detection and prevention of co-occurring disorders.
**Adults.** A sizeable number of U.S. adults (18 years and older) suffer from a mental health or substance use disorder and a large proportion have co-occurring disorders (U.S. DHHS, 2002). In 2007, the National Survey on Drug Use and Health findings indicated 24.3 million adults had a serious psychological distress (SPD) in the past year. Among the 24.3 million adults with SPD in 2007, 5.4 million had both SPD and substance abuse within the past year (SAMHSA, 2008). Adults with co-occurring disorders often have higher rates of relapse and re-hospitalization, report more social isolation (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998a; U.S. DHHS, 1999; U.S. DHHS, 2002), and have worse treatment outcomes (Drake, & Wallach, 1989; Margolese, Malchy, Negrete, Tempier, & Gill, 2004) than adults with only a mental health or a substance use disorder. If untreated, under-treated, or undiagnosed, then adults are at greater risk for serious medical problems, victimization, and hospitalization; the most devastating preventable consequence is suicide (U.S. DHHS, 2003).

*Figure 1.* Behavioral health care received by persons with co-occurring disorders (2007).
Yet, as Figure 1 indicates, the number of adults who receive treatment is low with 53.5 percent receiving no treatment, 33.3 percent receiving only mental health care, 10.4 percent receiving both mental health care and specialty substance use treatment, and 2.8 percent receiving only specialty substance use treatment (SAMHSA, 2008). For adults, mental health and substance use disorders are the leading cause of combined disability and death for women, and second leading for men (Kessler, Demler, Frank, Olfson, Pincus, Walters, et al., 2005).

**Elderly.** Prevalence data on the elderly (65 years and older) with co-occurring disorders are limited. Yet, what is known is that the elderly with mental disorders are particularly vulnerable to the negative effects of substance use due to age, co-morbidity with other health issues, and interaction with other prescribed medications. According to Bartels, Blow, Brockmann, & Van Citters (2005), older adults tend to underutilize mental health and substance use services. The reasons for underutilization may relate to negligence on the part of healthcare professionals or stigma. The elderly tend to rely heavily on their primary care physician to meet their healthcare needs. Physicians may overlook assessing the elderly for co-occurring disorders (U.S.DHHS, 2002). Furthermore, health care providers may attribute symptoms of co-occurring disorders to dementia or side effects of pharmacology for other medical conditions. In both situations, providers contribute to the underreporting of these disorders. Underutilization may also be due to feelings of shame and stigma, causing older adults not to seek appropriate care (U.S. DHHS, 1999). In general, it is likely prevalence data on the elderly is underreported.
Prevalence data provide a snapshot of the rate of co-occurring disorders among youth, adults, and the elder. What is presented next is an examination of the problem from different system levels.

**Understanding the Problem from an Ecological framework**

An ecological framework can be used to understand the problem from multiple levels such as an individual-level as well as other levels in which the individual interacts and transacts (Onken et al., 2007). An analysis of the three levels of individual, family, and healthcare system follows.

**Individual.** The presence of co-occurring disorders makes interventions more complicated as each disorder interacts differently within the individual. Individuals with co-occurring disorders may not receive treatment due to issues of stigma and discrimination (U.S. DHHS, 1999; U.S.DHHS, 2002). Subsequently, they may access inpatient care and emergency room services and require costlier care than individuals with a primary mental or substance use health disorder (U.S. DHHS, 2002). As a system of social support, family members often provide care to the consumer, especially during periods of crises (Lincoln, Wilhelm, & Nestoriuc, 2007).

**Family.** Families are the primary provider for individuals with a mental illness and/or a substance use disorder (U.S. DHHS, 2002). Defined from the perspective that family is an inclusive term constructed by the individual, family may include biological and extended members as well as peers and service providers. Families deal with the daily interactions and behaviors of a member with a co-occurring disorder, including behaviors that promote social bonding and cohesion to those of isolation,
decompensation, and violence. The responsibility of caring for the individual falls on the family and particularly, the women of the family (Clark, 2001; Thurer, 1983).

More often than not, families are faced with challenges inherent in fragmented services, lack of empathetic providers, and stigma (U.S. DHHS, 1999). Stigma can affect the entire family. Past etiological theories blamed the parents as the cause of their child’s mental illness; although this is not the normative belief, it still may influence a family’s involvement especially in advocacy work with public visibility (U.S. DHHS, 1999). Additionally, the policy of deinstitutionalization of the 1960s challenged the family system as consumers of mental health hospitals were discharged to the streets, often without appropriate community services (Sands, 2001). Although the policy intended to divert hospitalization and develop community-based services, it was unsuccessful at developing the latter. Today, the issue of insufficient available community–based re-integration services continues (U.S. DHHS, 2003). Without community services, families find themselves lacking the appropriate education, training, and skills to support their family members in the community (Sands, 2001).

**Healthcare System**

A fundamental problem exists in how healthcare is funded in the U.S. that creates barriers to accessible and acceptable services. The first issue relates to accessibility. The healthcare system in the U.S. is compartmentalized into silos (U.S. DHHS, 2002; Mueser, Drake, Sigmon, & Brunette, 2005) that create problems for individuals with co-occurring disorders and their family members. Mental health and addiction services generally have been funded by the federal government as separate block grants to states (Buck, 1984; Bukoski, 1986) that encourages a division between these two systems of
care. Individuals attempting to access treatment for co-occurring disorders often are bounced back and forth between two separate treatment systems (U.S. DHHS, 2002). Each system maintains separate eligibility criteria, is reimbursed according to one disorder rather than both, and is driven by different treatment philosophies. An individual eligible in one system (e.g., mental health) may not be eligible in the other (e.g., substance use).

The second issue relates to acceptability of services. Federal funding to states emphasize the use of Evidence-Based Practices (EBPs) in the treatment of co-occurring disorders (Cleary et al., 2008; Drake, O’Neal, & Wallach, 2008; Horsfall, Cleary, Hunt, & Walter, 2009; Mueser, Kavanagh, & Brunette, 2007). The Substance Abuse Mental Health Services Administration (SAMHSA), the lead federal agency on co-occurring disorders (U.S. DHHS, 2002) established the National Registry of Evidence-based Practices and Programs (NREPP) to forward EBPs for mental health and co-occurring disorders. A review of NREPP indicates that no interventions listed as EBPs include indigenous cultural practices to address co-occurring disorders among indigenous peoples. When we consider that the U.S. co-occurring disorder prevalence is highest among Native peoples as compared to other ethnic populations, it is critical to develop interventions congruent with the cultural needs of Native peoples aimed to decrease this health disparity.

The literature suggests services that do not match the cultural needs of consumers may lead to early termination or underutilization (Niemeyer & Arango-Lasprilla, 2007, Ta, Juon, Gielen, Stenwachs, & Duggan, 2008; Takeuchi, Mokuau, & Chun, 1992). Similarly, if treatment systems offer culturally incongruent services that do not address
the problem, then the system may unintentionally contribute to the high prevalence among certain ethnic and cultural populations.

**Need for Indigenous Cultural Practice Models**

Multiple factors influence the prevalence of co-occurring disorders across populations such as ethnicity and culture. Ethnicity and cultural background play a vital role in health and health care practices for populations within the United States (U.S. DHHS, 2002; Sands, 2001). Culture influences how health is conceptualized and the level to which health interventions are acceptable (Jackson, 2006) and impacts how individuals describe a symptom, seek treatment, and address stigma associated with both a mental health and substance use disorder (U.S. DHHS, 2002). Similarly, the level of acculturation or the extent to which individuals embrace the values, worldviews, and language of the “mainstream” culture affects health service utilization and treatment effectiveness (Niemeier & Arango-Lasprilla, 2007). For individuals who do not embrace a “mainstream” culture, problems arise when accessing human service interventions.

According to Mokuau (2002), human service interventions in the U.S. are primarily based on Western theories and methodologies or what Brave Heart (2005) refers to as the “dominant cultural model” (p. 184). Practice models based on a “dominant cultural model” often marginalize the knowledge and experiences of other cultures, thus compromising the utility of the intervention (Manson, 2009). While interventions based on a “dominant cultural model” are beneficial for certain populations, other ways of dealing with issues may be more effective for ethnic and cultural groups (Mokuau, 2002).
Understanding cultural norms provides an opportunity for social workers who are sensitive to the cultural dynamics of the consumer to craft practice models that are more suitable to the values, preferences, and worldviews of the consumer to maximize health outcomes (Mokuau, 1999). These practices may rely more on indigenous intuitive intelligence, wisdom from elders, and traditional ways and less on Western defined practices and evidence that may reflect cultural biases (Matsuoka, 2007).

Manson (2009) describes a mental health practice model that integrates both Western and Alaska Native cultural practices. The Therapeutic Village of Care (TVC) is an adaptation to the Therapeutic Community, an EBP model utilized in the mental health field. The TVC integrates Native village decision making processes for “family members” or clients. Alaska Native cultural practices and Western treatment approaches are integrated with a treatment completion rate of 69%, exceeding national treatment outcomes of Therapeutic Communities of 35%. Other holistic types of outcomes are also noted including an increase in employment, reduction in alcohol use, and improvement in housing placements. The findings suggest that adapting a Therapeutic Community model by incorporating values and cultural practices of Alaska Natives have benefit for Alaska Natives.

Considering the high prevalence of co-occurring disorders among indigenous peoples, a model using indigenous cultural practices that are congruent with the values, norms, and epistemic perspective of indigenous peoples is needed in the treatment of co-occurring disorders.
**Gaps in the Implementation of Indigenous Cultural Practices**

The noticeable gap exists in the literature on indigenous cultural practices to address co-occurring disorders for both outcome and implementation studies. Most of the literature focuses on EBPs. The question thus arises as to whether treatment programs, programs primarily based on EBPs, are sufficiently responsive to the emotional, social and cultural needs of indigenous peoples.

The efforts of the NREPP to establish evidence may contribute to this gap in two ways. First, the NREPP is a resource database available to individuals, families, and communities on EBPs in the prevention and treatment of mental health and substance use disorders. Toolkits or guidelines on how to implement these EBPs to encourage national adoption are also provided by the NREPP (SAMHSA, 2006). Toolkits are not available from SAMHSA for co-occurring practices that do not qualify as evidenced-based, such as indigenous cultural practices. Second, several indigenous authors have criticized the NREPP process to establish EBPs. Manson (2009) suggests that the process used by the NREPP follows a Western epistemological framework and therefore creates challenges for indigenous communities that do not share the same values and norms. Brave Heart (2005) describes the many challenges American Indian and Alaska Native communities face to move interventions to the level of evidence required that include limited resources, criteria to become an EBP that may violate the privacy and sacredness of the indigenous practice, and distrust of research. A similar distrust of research has been cited for Native Hawaiians (Fong, Braun, & Tsark, 2003). Nevertheless, a groundswell movement to establish a process to recognize Indigenous Evidence Based Cultural Practices based on an indigenous epistemological perspective is growing (Naquin,
Manson, Curie, Sommer, Daw, Maraku, et al., 2008). In short, federal efforts to support
EBPs may inadvertently contribute to gaps in the literature as well as the availability of
implementation guidelines (e.g., toolkits) for public use. Yet, in Hawai‘i, changes in
State funding of substance use services has created an opportunity to assist community
providers with implementing Native Hawaiian Cultural Practices (NHCPs) to address
substance use or co-occurring mental health disorders.

In 2009, for the first time, the State of Hawai‘i reimbursed substance abuse
treatment providers for the use of NHCPs. This change resulted in an interest by
community providers in how to implement NHCPs into substance use or substance use
and mental health treatment services (J. Yurow, personal communication, August 17,
2009). During this period to assist community providers, ‘Imi Ke Ola Mau, a community
partnership developed a conceptual framework that identified five Native Hawaiian
Community Best Practices for Cultural-Based Recovery Programs (CBPCBRPs) in the
treatment of co-occurring disorders. A panel of experts (consisting those with expertise
at implementing NHCPs to address substance use or co-occurring disorders),
reviewed five years of statewide archival reports and documents and identified the
themes or concepts (the five CBPCBRPs). The panel included treatment providers,
policy makers, and Native Hawaiian cultural practitioners. Because of the subsequent
interest in the implementation of the CBPCBRPs, ‘Imi Ke Ola Mau hosted a conference
to discuss how three organizations used them in treatment (‘Imi Ke Ola Mau, 2009).
While this event described what NHCPs were offered in treatment, more was needed to
describe the process of how organizations identify, develop, and implement NHCPs in
the treatment of co-occurring disorders and the impact of these practices on consumer engagement, retention, and outcomes.

**Purpose of the Study**

The four main objectives of this study are: 1) to describe the process of identification, development, and implementation of NHCPs at one organization, 2) to examine these practices in relation to ‘Imi Ke Ola Mau’s identified five Native Hawaiian CBPCBRPs, 3) to describe how participation in NHCPs hindered or helped consumers’ in their recovery outcomes, and 4) to identify key factors and lessons learned to guide other organizations interested in incorporating these practices.

**Definition of Key Concepts**

Key concepts in the topic of co-occurring disorders include the following: a) co-occurring disorders, b) mental health and mental illness, c) substance use disorders, d) culture and indigenous cultural practices, e) evidence-based practices and thinking, and f) indigenous evidence-based effective practices model.

**Co-occurring disorders.** Co-occurring disorders are the co-morbidity of a serious mental illness or serious psychological distress and a substance use disorder. Co-occurring disorders are not a single disorder with one set of defined clinical parameters of symptoms, level of functioning, and degree of distress; instead, co-occurring disorders encompass a wide range of co-morbid mental health and substance use conditions. The DSM TR-IV of the American Psychological Association (2000) provides diagnostic categories for all serious mental illnesses and substance-related disorders.

The literature on co-occurring disorders spans over 20 years as the fields of mental health and addiction gradually acknowledged co-morbidity (Sands, 2001; U.S.
Co-occurring disorders were recognized by clinicians who noticed a high prevalence of both mental illness and substance use in consumers in treatment. Early studies focused on one disorder as primary (e.g., depression) and described how the other disorder (e.g., substance use) interacted. Studies now focus on the co-occurrence of both mental health and substance use disorders as separate but interactive. It is now accepted in the treatment field that both disorders must be addressed simultaneously (U.S. DHHS, 2002).

**Mental health and mental illness.** The best way to understand mental health and mental illness is to define them as points on a continuum rather than opposing conditions (U.S. DHHS, 1999; Pollett, 2007). In general, mental health refers to a combination of factors that indicate an individual's ability to maintain well-being (Pollett, 2007). Specifically, mental health is the successful performance of mental functions that result in engaging in productive activities, fulfilling relationships with other people, adapting to change, and coping with adversity (APA, 2000). From early childhood to later life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem (U.S. DHHS, 1999). While mental illness can be understood as a point on a continuum, in the psychiatric field it has been referred to as all diagnosable mental disorders as described in the Diagnostic and Statistical Manual Text Revision IV (APA, 2000). Mental illness is a term that refers collectively to health conditions that are characterized by singular or combined alterations in thinking, mood, or behavior associated with distress and/or impaired functioning (U.S. DHHS, 1999; APA, 2000).
As a construct, mental health is influenced by cultural factors which may differ across groups making a precise definition difficult to pinpoint (Mayo Clinic, 2007). Each cultural group expresses dimensions of well-being and distress differently. Culture influences how well-being is conceptualized and expressed, acceptable ways to cope, and available family and community supports. For instance, certain American Indian tribes have no word for depression; however, this does not negate that depression exists for these tribal members (Kokanovic, Furler, May, Dowrick, Herrman, Evert, et al., 2009). Cultural groups may express depression in other ways that do not directly correspond with clinical terms to formulate a DSM IV-TR diagnosis (Tseng, 2006).

The DSM IV-TR includes a section on culture-bound syndromes as cultural explanations of disorders that go beyond a diagnostic interpretation of mental and substance-related disorders. Culture-bound syndromes also may be systematically described by an indigenous practitioner within the context of how the local society expresses emotions, behaviors, and language. Examples of culture-bound syndromes include locura which is experienced among Latinos in the U.S. as a severe form of psychosis (APA, 2000). Among Native Hawaiians, kaumaha syndrome has been described as a collective form of sadness and grief due to multiple experiences with historical and personal losses (Rezentes, 1996; Hoshmand, 2005). Culture bound syndromes are useful in the field of psychiatry because they bring to the forefront the importance of culture in making a diagnosis, especially when a health professional is trained in another culture. They also provide another framework in which to understand the strengths of the individual (e.g., how they perceive the origins of their distress) and may lead to the identification of culturally appropriate interventions to resolve the
Substance use disorders. In general, substance use disorders are a collection of substance-related disorders that involve taking or exposure to a chemical substance (e.g., illicit, over the counter, toxin exposure). According to the National Institute for Drug Abuse (NIDA), substance use disorders are a complex disease of the brain consisting of several characteristics such as craving, compulsive behaviors, seeking, and continued use despite negative outcomes. Substances cause changes in certain areas of the brain; these are the same areas affected by other types of mental disorders such as depression, schizophrenia, and anxiety (NIDA, 2008).

The DSM IV-TR classifies all substance disorders into an overarching category of substance-related disorders (APA, 2000). Within this category, there are two subcategories of disorders: substance use and substance induced. Within each subcategory, a wide range of disorders exist. The clinical pattern of substance-related disorders range in type (e.g., disorder, chemical used or exposed to), physical features (e.g., dependency and/or withdrawal), psychological markers (e.g., cravings and/or expectations), and level of impairment (social, economic, familial). For purposes of this study, I will be discussing substance use disorders and not substance induced disorders; furthermore, the definition of substance use disorders will adhere to the DSM IV-TR (APA, 2000).
**Culture and indigenous cultural practices.** Culture is a broad term used in a variety of ways. According to Kagawa-Singer and Chung (1994), culture is “a tool which defines reality for its members” (p. 198). Sands (2001) asserts that “cultures are communities that have a common history, knowledge, language, values, and behavior” (p. 72), and Marsella (2005) describes culture as “shared learned behavior and meanings that are socially transferred in various life-activity settings for purposes of individual and collective adjustment and adaptation” (p. 657). What these authors seem to suggest is that *culture* plays a significant role in shaping the meaning of mental health and substance use, and from culture is drawn the attributes used in the resolution of problems experienced among a cultural group. Thus, indigenous cultural practices are defined as the use of cultural attributes (e.g., values, norms, and traditional practices) based on a particular U.S. indigenous population to address issues salient to that population. Because this case study focuses on an organization in Hawai‘i, there will be an emphasis on Native Hawaiian Cultural Practices.

**Evidence-based practices and thinking.** Evidence based practices refer to programs and practices with a proven record of effectiveness by using scientific methodology that produced consistently positive outcomes (SAMHSA, 2006). Through research studies, EBPs have shown the greatest generalizability across populations and have been implemented as a “gold standard” by many federal programs. EBPs are often required by funding agencies (Anderson, Brownson, Fullilove, Teutsch, Novick, Fielding, et al., 2005).

The literature on EBPs in mental health and substance use fields has primarily emphasized scientific types of research over consensus, global subjective judgment, and
other forms of non-rigorous research. Recently, discourse is growing around the emphasis of scientific-only approaches in determining EBPs. Claxton, Sculpher, McCabe, Briggs, Akehurst, Buxton, et al., (2005) assert the true performance of an intervention remains unclear even in the light of available research evidence. Reed (2005) posits that certain interventions are more amenable to scientific-type approaches and are therefore more likely to be supported by research evidence. Reed suggests that separating scientific-only approaches from all other approaches restricts the definition of evidence and dismisses other forms of knowledge based on non-experimental research, clinician judgment, and experiences of individuals served. Furthermore, Mueser (2005) suggests that the definition of a successful outcome is not universally shared, particularly in the fields of mental health and substance use.

SAMHSA (2006) describes evidence as levels that rank according to their strength of research evidence (Figure 2). Lower-level evidence includes observational experience, established clinical practices, and descriptive writing. Higher-level evidence, as indicated at the apex of the evidence-based pyramid, includes expert panel reviews. The evidence-based pyramid is offered as a way to capture the extent of what can be considered evidence. However, when considering definitions, the question becomes 'by whose standards is this a model or "best"-practice?' I raise this question as a way of considering cross-cultural applications and efforts to establish indigenous models of evidence.
Figure 2. Pyramid of evidence-based practices.


**Indigenous Evidence-Based Effective Practices model.** In 2007, the Cook Inlet Tribal Council established the Indigenous Evidence-Based Effective Practices model consisting of three levels of evidence with each level building upon the other in developing scientific rigor (Naquin & Sommer, 2008). The purpose of establishing this model was to integrate indigenous knowledge and evidence, examine issues of validity, and promote funding for this model. Level one is client-based evidence and requires at least 3 of the identified 8 criteria to be met. Client level criteria include case studies, discharge interviews, and focus groups. The second level of practice-based evidence requires 4 of the 11 criteria to be met. Practice level criteria include personal testimonies,
indigenous spiritual ceremonies (e.g., sweat lodge), and process evaluations. Level three, research-based evidence, requires the use of local data such as participatory research or single group pretest/posttest, and at least 2 of the remaining 5 criteria to be met such as peer reviewed journal or indigenous review panel (Naquin, 2007). Bringing forward other types of external standards to evaluate evidence recognizes contextually-based knowledge and efforts to transfer knowledge to other locations and populations.

**Conclusion**

Millions of individuals in the U.S. have co-occurring disorders which cuts across their lifespan. Within the lifespan, some populations are at greater risk for co-occurring disorders due to factors of developmental stage, coping mechanisms, and social determinants of health. Multiple ways to understand the concept of mental health and substance use exist, especially when culture and ethnicity are considered. A body of literature exist examining EBPs to address co-occurring disorders; however, the co-occurring literature does not include studies on indigenous cultural practices with the adult population. Considering indigenous populations of American Indian, Alaska Natives, and Native Hawaiians have the highest adult co-occurring disorders prevalence, an exploration of indigenous cultural practices that are congruent with the values, norms, and worldviews of these populations are needed in the literature on co-occurring disorders. Of particular interest is the need for studies on the process of implementing indigenous cultural practices to address co-occurring disorders among U.S. indigenous populations.

This chapter provided a broad understanding of the nature of the problem. The next chapter will focus on literature germane to the study. Since my two aims are to
understand why and how an organization implemented NHCPs to address co-occurring disorders among Native Hawaiian adults, and to describe key factors influencing this process, I review the literature on organizational change theories, holistic healing models, and indigenous cultural practices.
Chapter 2. Literature Review

Organizational Change Theories

Organizational development. The precursor to most modern day theories of organizational change was posited by Lewin (1951) and is referred to as the theory of organization development (Glanz, Rimer, & Lewis, 2002). Organizational development applies the behavioral sciences to improve organizational performance and the quality of work life. Often a consultant is employed to initiate the change process through directed interventions focused on organizational processes and structures (Cummings, 2008).

Lewin posited that change occurs in three phases: 1) unfreezing includes facing a dilemma, becoming aware of the need to change, and creating motivation and change readiness, 2) moving includes diagnosing the dilemma, exploring new models, and making behavioral movement towards a change goal, and 3) refreezing includes practicing the change in the organization, evaluating its application, and adopting it into routine practice (Cummings, 2008). Lewin identified two underlying variables as barriers to change that include status quo and resistance as the organization attempts to return to a state of equilibrium (Cummings, 2008). He suggested that organizations address these barriers in their change strategy by assessing worker perceived value of the change and motivation to change. Several other models have been proposed subsequent to Lewin’s work (Argyris, Putnam, and Smith, 1985; Beckhard and Harris, 1987; Bridges, 1980; Lippitt, Watson, and Westley, 1958; Simpson & Flynn, 2007) and many are stage- or phase-based models. Prior to Lewin’s work, organizational theories focused on effectiveness, authority, and division of labor with scant attention to worker needs (Glanz et al., 2002), humanism, and democracy (Cummings, 2008). While Lewin was a
strong proponent of understanding behavior as a function of individuals and their environment, his three-phase model has been criticized for ignoring certain contextual factors that influence change such as organizational culture, past experience, and resources.

Modern day organizational development theorists include environmental factors to understand how norms and values are changed in the organization (Glanz et al., 2002). For example, the theory now includes the concepts of organizational climate or its members’ perceptions, attitudes, and beliefs about the organization (Hoy & Miskel, 1987), organizational culture or the unconscious assumptions about the organization by its members (Schein, 1985), and organizational capacity or the efficient and effective functioning of an organization’s subsystems (Katz & Kuhn, 1978). In my study, I used organizational development theory to help me understand how staff and consumers perceive the organization (e.g., its climate, culture, practices) and the extent to which organizational change factors influence the implementation of NHCPs.

**Diffusion of innovation.** The theory of diffusion of innovation examines how and why certain innovations or ideas, products, and objects are communicated through channels to members of a social system (Rogers, 1995). Central to the theory is the concept of decision-making which influences whether an innovation is accepted or rejected. Decision making within organizations to adopt an innovation generally is done collectively by the entire system or by a small group in positions of authority. A five-stage model is proposed by the theory: 1) innovation development or the activities to bring an idea to production, 2) dissemination or the communication channels to move the innovation to a given audience, 3) adoption or a multifaceted stage assessing the uptake
of an innovation, 4) implementation or the initial use of the innovation, and 5) maintenance or the continual implementation of the innovation into regular practice (Oldenburg & Parcel, 2002). The rate of adoption or the speed at which an innovation reaches critical mass and becomes self-sustaining is another important concept.

The literature on diffusion of innovation with organizations indicates its usefulness in the areas of health promotion and disease prevention such as safe sex practices (de Vroome, Paalman, Dingelstad, Kolker, & Sandfort, 1994) and smoking cessation (Cooke, Mattick, & Campbell, 1998). However, the theory has been criticized for not considering how organizational structure influences change.

**Innovation implementation framework.** Simpson and Flynn (2007) provide a stage-based innovation diffusion framework (Figure 3) to understand organizational change. The framework incorporates both individual-level and organizational-level factors that influence the adoption and implementation of an innovation. Included in this framework are three general stages: 1) strategic planning, 2) preparation, and 3) implementation process. The implementation process stage is the focus of the framework and includes three additional steps: 1) training, 2) adoption (decision making and action), and 3) implementation. The implementation process connects the decision to adopt an innovation with it becoming a routine practice and serves as a critical stage (Klein & Knight, 2005). Furthermore, each stage is influenced by individual key factors. For example, the decision step is shaped by leadership support, perceived quality and utility of the innovation, and adaptability or compatibility of the innovation with the existing culture or values within the treatment program. Likewise, organizational factors such as motivation, resources, staff attributes, program climate, and costs shape the
implementation process. Over time, as an innovation is successfully implemented, it becomes a routine practice.

Figure 3. Innovation implementation framework.

Note. This figure represents a stage-based approach to understand the adoption and implementation process of an innovation. Simpson, D., & Flynn, P. (2007). Moving innovations into treatment: A stage-based approach to program change. Journal of Substance Abuse Treatment, 33, 111-120.

In my study, I used the conceptual framework to help me interpret and discuss the findings related to the adoption and implementation of NHCPs and the multiple change factors that influenced these processes. Additionally, as Simpson and Flynn (2007) assert, the conceptual framework is a working model and continual refinements are expected. Therefore, it holds a degree of flexibility and openness to what emerged from the data. It also provides a holistic approach to understand how change occurs from factors inside and external to the organization. Also, the stages are not strictly linear;
instead, organizations may experience challenges that require them to cycle back to a previous stage. Last, it should be noted that the conceptual framework was developed with an emphasis on innovations that are EBPs. While NHCPs may be considered best practices (‘Imi Ke Ola Mau, 2009), they are not EBPs, as noted earlier. I raise this point as a caution because the framework may have been developed from an epistemological orientation that values certain aspects of planning and decision-making. Cross-cultural application of the framework should be done with the understanding that a step-by-step process and an orientation toward action may not fit every organization’s culture and values. Additionally, other change factors and stages may exist that have yet to be identified.

**Summary.** Lewin’s theory of organizational development shed light on worker behavior and motivation as factors impacting organizational change but was limited to internal organizational factors. Roger’s theory of innovation diffusion expanded Lewin’s work to include additional variables to understand organizational change and emphasized decision making and enhanced knowledge. Both theories provided me with a way of understanding overarching concepts in organizational change. Simpson and Flynn (2007) offered a conceptual framework that considers both individual key factors and organizational factors that influence organizational change and was useful in my case study to interpret the findings.
Holistic Healing Models

Recovery. Recovery has been defined as many things: an intervention, an overarching philosophy, and a social movement (U.S. DHHS, 1999; Davidson, O’Connell, Tondora, Styron, & Kangas, 2006; Gold 2007; Onken, Craig, Ridgeway, Ralph, & Cook, 2007). Recovery first emerged in the substance abuse field then crossed over to the mental health field. Recovery in addiction has a particular history spanning more than 250 years. Models of addiction recovery are often based on a 12-step model that recognizes individual power, spirituality, and affiliation (Galanter & Kleber, 2008). Recovery in the field of mental health has recently been recognized as a principle of well-being; however, for nearly a century consumers have written about the challenges and celebrations of living with mental illness (U.S. DHHS, 1999; Gold, 2007). Recovery as a principle took hold in the 1980s when consumer testimonials, family advocacy, and deinstitutionalization merged to form a movement that was recognized in the mental health field (Davidson et al., 2006). In this study, the theory refers to recovery from both substance use and mental health disorders, though the two processes are not identical, nor interchangeable.

Recovery is well documented in the literature as an important ingredient of positive well-being (U.S. DHHS, 2002; Galanter, 2007; Gold, 2007; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Onken et al., 2007). Recovery is built on the principle that individuals can recover from mental illness and substance use, even though they may still have co-occurring disorders. Recovery is often expressed in the personal narratives of individuals to give voice to their challenges and the capacity to grow and restore their
lives. Described as a journey rather than a destination, recovery is descriptive of consumer movements that are forward, backwards, and sideways (Davidson et al., 2006).

In this study, I use the definition of recovery proposed by Onken et al. (2007) as multidimensional, holistic, and complex that influences the individual’s life context and is linked to the larger community and society in which the individual interacts and transacts. Recovery is the process towards gaining and maintaining positive well-being. Onken et al. (2007) offer a recovery paradigm that emphasizes holistic well-being that includes three levels of change in order to build personal capacity as well as develop community capacity for inclusion. The three levels of recovery include the person-centered, the exchange-centered, and community-centered. On the person-centered level, concepts of recovery include hope, sense of agency, self-determination, meaning and purpose, awareness and potentiality, and the re-authoring of coping, healing, wellness, and thriving. The exchange-centered level emphasizes the person in their community and includes the qualities of partnership such as shared decision-making and risk taking, secure relatedness, interdependence, and cultural responsiveness. Community-centered level recovery includes basic materials that support meaningful activities (e.g., citizenship); habitat; rights and freedoms; integration; and social circumstances, connectedness, and opportunities.
### Figure 4. Recovery paradigm


**Lōkahi Triad.** Recovery, as a holistic approach to mental illness and substance use, aligns with indigenous conceptualizations of health and well-being which are described as a balance of the spiritual, physical (environment/earth), and personal/community (Kameʻeleihiwa, 1996; Rezentes, 1996; Takini, 2009, Warne, 2009). For Native Hawaiians, lōkahi means unity, balance, and relational harmony (Pukui & Elbert, 1986). The Lōkahi Triad (Figure 5) suggests that when all three dimensions of *Ke Akua* or spirituality, *Na Kānaka* or humankind, and *Ke Ao Nei* or nature are in harmony,
then a relational balance is achieved. Relationships for Native Hawaiians are approached with respect, reciprocity, and duty. The concept of health, therefore, is embedded within the worldview of relationships. Health is a holistic concept for Native Hawaiians who do not view health as something that is pursued per se; instead, good health and well-being are the result of a balanced life as harmony is maintained among the dimensions of spirituality, humankind, and nature (Pukui, Haertig, Lee, & McDermott, 1979; Rezentes, 1996). When illness arises, the remedy and process of healing are restoration of balance through cultural practices of *pule* or prayer; *la‘au lapa‘au* or traditional medicinal herbs; and *ho‘oponopono* or resolving relational conflicts (Pukui et al., 1979).

Integrating both a recovery paradigm and the Lōkahi Triad allowed me to approach this study from a holistic perspective to understand Hawaiian well-being.

![Lōkahi Triad Diagram](image)

*Figure 5. Lōkahi triad.*

Summary. In order for interventions to be effective with indigenous populations, they need to be holistic to address the multidimensional needs of indigenous peoples. Onken et al. (2007) offer a holistic recovery paradigm to consider the interaction of the person in their environment as one way to identify how to build personal and community capacities to optimize well-being. A recovery theory provides a holistic approach to well-being and aligns with indigenous conceptualizations of health and healing such as the Lōkahi Triad (Rezentes, 1996). Concepts from the Lōkahi Triad and recovery paradigm were used in the development of the interview questions.

Indigenous Cultural Practices

A review of interventions that use indigenous cultural practices to address adult co-occurring disorders reveals a gap in the literature. Brave Heart (2005) suggests that indigenous clients and native practices are not typically included in the literature on co-occurring disorders. As a population, the Office of Surgeon General (2001) acknowledges that indigenous peoples are seldom included in studies focused on the development of EBPs in mental health. The use of indigenous cultural practices appears to be utilized more in the field of substance use than mental health, and none appear to exist in the literature for co-occurring disorders.
**Mental health.** In the mental health literature, Manson (2009) reports positive outcomes of a Therapeutic Community model adapted to incorporate Alaska Native values and traditional practices. The model is the Therapeutic Village of Care (TVC) based on an Alaska Native village with a traditional structure of governance by a tribal council. Alaska Native cultural practices are integrated with Western treatment services. TVC completion rates exceed national Therapeutic Community completion rates, and positive psychosocial outcomes have been reported in alcohol reduction, employment, and housing.

**Substance use.** In the substance use literature, Segal (2001) finds that Alaska Native cultural practices such as traditional healing are important to substance use treatment outcomes with Alaska Natives. A few studies have been conducted with indigenous populations that are worth mentioning. These studies lack strong empirical designs and do not address co-occurring disorders per se; however, considering the high rate of mental health disorders among the substance use population, these studies provide models of incorporating indigenous cultural practices that could be used to address co-occurring disorders. Crabbe (1997) conducted a pilot project with adult Native Hawaiian males to heal problems of substance use and family violence by using a cultural model emphasizing traditional Native Hawaiian male identity and roles. While Crabbe found no significant difference in self-reported symptoms of distress, he noted a positive change in participants’ association with Hawaiian identity. A three month qualitative follow-up indicated all participants maintained sobriety and reported no accounts of family violence. In another study, Nebelkopf and King (2004) reported that in an urban substance use treatment residential program for adults, two recovery models of trauma-
resolution and self-esteem incorporated traditional American Indian spirituality. However, findings were not reported at the time as the evaluation was on-going. Mills (2004) found that Alaska Native healing practices in adult behavioral health treatment were beneficial for that population, and Yellow Horse and Brave Heart (2004) described several best practice models used to address mental health and substance use among American Indian and Alaska Native youth and parents.

**Co-occurring disorders.** In the co-occurring disorders literature, a gap exists on studies that utilize indigenous cultural practices with indigenous populations. While no published studies exist, communities are addressing the issue by forwarding knowledge to address specific needs such as the work done by ‘Imi Ke Ola Mau (2009).

**Community Best Practices for Cultural Based Recovery Program.** ‘Imi Ke Ola Mau (2009), a community partnership in Hawai‘i, reviewed three State of Hawai‘i reports on co-occurring disorders to identify what the community cited as key elements needed in cultural programs to be helpful to Native Hawaiians with co-occurring disorders. The three reports were produced under the State of Hawai‘i’s five year Co-Occurring State Incentive Grant (Hawai‘i State Department of Health, 2006a; Hawai‘i State Department of Health, 2006b; Hawai‘i State Department of Health, 2007). The five Community Best Practices for Cultural Based Recovery Programs (CBPCBRPs) include the following: 1) integration of kūpuna or elders, 2) use of land and sea base sites, 3) use of cultural values and traditional practices, 4) incorporation of family and community into treatment, and 5) use of a language consultant. In addition, ‘Imi Ke Ola Mau provided an explanation of how each Native Hawaiian cultural practice might be incorporated into an organization.
Because the key elements are broad concepts, the boundaries between them are fluid. For instance a kupuna could be integrated into the program as an advisory council member, as the teacher of Native Hawaiian language, and as a practitioner of traditional healing practices. In order to address the need by community providers in how to incorporate NHCPs into treatment, ‘Imi Ke Ola Mau held a symposium to discuss the five Native Hawaiian CBPCBRPs and to describe how three organizations used them in treatment (‘Imi Ke Ola Mau, 2009). The conceptual framework was used in my study to assist me in interpreting the findings. While this was the first conference held in Hawai‘i to discuss how NHCPs are used in the treatment of co-occurring disorder with adults, a gap in knowledge exists on studies that examine the implementation of NHCPs in the treatment of co-occurring disorders among adults.

**Summary.** More attention is needed to promote culturally appropriate practices and research that includes indigenous populations to address co-occurring disorders among these populations at highest risk. Models and frameworks from indigenous communities are needed to inform research on how best to implement these practices within an organization. ‘Imi Ke Ola Mau (2009) provided such a framework to understand how five indigenous cultural practices can be incorporated into an organization to address co-occurring disorders among Native Hawaiians.

**Conclusion**

Because my inquiry focuses on one organization’s journey to adopt and implement NHCPs, I reviewed theories on organizational development (Lewin, 1951; Rogers, 1995) to understand concepts that shape the process of organizational change. Simpson and Flynn (2007) provided a conceptual model as a mechanism to understand
specific factors that influence change within an organization from multiple levels. This conceptual model fits well with the embedded design of my case study and was used to assist in the interpretation of findings.

The theory of recovery was selected to provide a more holistic view of how to develop and maintain well-being by examining various levels of change and the interaction between these levels. The theory of recovery aligns well with Native Hawaiian conceptualizations of health and well-being (Rezentes, 1996). Yet, what was needed was a holistic framework that described how cultural practices are used as interventions to address co-occurring disorders. ‘Imi Ke Ola Mau (2009) offered such a framework in the five Native Hawaiian CBPCBRPs.

Approaching this study from a holistic perspective, integrating recovery theory with Native Hawaiian frameworks, and utilizing organizational change theories provide an opportunity to generate new knowledge as well as cautions in understanding how one organization implemented NHCPs to address substance use or co-occurring disorders among Native Hawaiians. In Hawaiʻi, a growing interest in how to adopt and implement NHCPs in the treatment of substance use or co-occurring mental health disorders has emerged and has contributed to the need for this study. In the next section, the research questions and the methodology are described.
Chapter 3. Methods

Research Questions

The two aims of this study are: 1) to describe the process one organization underwent that led to the implementation of NHCPs to address substance use or co-occurring substance use and mental health disorders, and 2) to describe the key factors influencing this process. Given these two aims, the research questions follow.

1. Why and how did an organization identify, develop, and implement NHCPs in the treatment of substance use or co-occurring mental health disorders?
   a. What NHCPs were implemented and where did they come from?
   b. What key factors influenced the identification, adoption, and implementation of these NHCPs?
   c. How has participation in NHCPs helped and/or hindered haumāna in their recovery outcomes?
   d. How are NHCPs related to the five Native Hawaiian CBPCBRPs identified by ‘Imi Ke Ola Mau (2009) in the treatment of co-occurring disorders?

Research Design

The research design is a non-experimental, exploratory study that used a qualitative method and an embedded case study strategy to understand the research questions. The embedded case study strategy examined three sub-units of analysis from an administration level, program staff level, and haumāna level.

Human subjects procedures. The University of Hawai‘i’s Committee on Human Studies (CHS) approved the research through two applications. The first application was approved by expedited review on April 13, 2010 and included the
administration and program staff sub-units of analysis. The second application was approved by full review with further explanations (see Appendix F.1) on June 21, 2010 and included the haumāna sub-unit of analysis. In 2011, CHS re-approved the study for an additional 12 months since it extended beyond the initial approval period.

**Research methods.** A qualitative method was the most appropriate approach to obtain in-depth and rich data to understand the factors that influence organizational change as well as to obtain life experiences of haumāna in recovery. A qualitative method provided the advantage of studying a phenomenon with openness, depth, and detail without being constrained to predetermined categories of analysis (Patton, 2002). I did not employ a quantitative method because the study’s intention was not to understand the implementation of NHCPs across a large number of organizations to produce a broad, generalizable set of findings; by contrast, the focus was to gather in-depth and rich data about one organization.

According to Austin (2005), a qualitative method also lends well when working with indigenous communities, communities with mistrust and frustration toward outside researchers. For indigenous communities, interviews and focus groups convey respect for the perspectives of community members and can build a sense of investment in the project by these members. Community members are more likely to participate in subsequent meetings to vet preliminary findings if they feel the person conducting the research is genuine and sincere about investing in their community (Austin, 2005).

The study included multiple sources of data such as semi-structured key informant interviews (Rubin & Babbie, 2009), focus groups (Krueger & Casey, 2000), reviews of archival records and documents (Yin, 2003), and casual direct observations
(Patton, 2002; Yin, 2003). Reviews of archival records and documents were important evidentiary sources of data and were used to corroborate and expand evidence from other sources (Yin, 2003). Direct casual observation provided me with first-hand experience of the setting, the people, and their interaction (Patton, 2002). These observations were documented procedurally after conducting each data collection method, and have been maintained in the case study database.

**Research strategy.** The research strategy I used was a case study with an embedded design. A case study fit well with the qualitative method as it allowed for an in-depth description of three sub-units of analysis as embedded within the design: 1) the *administration* staff described why and how NHCPs were identified, developed, and implemented as well as the factors that influenced this process, 2) the *program* staff described why and how NHCPs were implemented and the factors that influenced implementation, and 3) the *haumāna* described their recovery outcomes in participating in the program and the extent to which they identified and connected their participation in NHCPs to their recovery outcomes. The study met the three conditions for a case study as posited by Yin (2003) as: 1) focused on “how” and “why” types of research questions, 2) did not require control over behavioral events, and 3) examined a contemporary phenomenon. Furthermore, a case study of an organization allowed for a focused examination of how NHCPs are localized, anchoring them within a particular context.

The description of this context is provided in detail as a way to cast light on the phenomenon, illuminating its use, how it is perceived, and the setting in which it occurs. Contextual information includes the protocol I used to engage the organization, a rich description of the data collection settings, and my positionality as a Native Hawaiian and
a researcher. This information will likely have relevance to other organizations interested in adopting and implementing NHCPs.

**Research setting.** “Sometimes we need to stand tall in order to perpetuate healing and restore healthy lives” is how the executive director of Kū Aloha Ola Mau translates the Hawaiian name of her organization. Kū Aloha Ola Mau is the organization or “case” of my study. The administrative office and methadone treatment facility is located in Honolulu, HI with additional substance use treatment programs in the districts of Hilo and Puna on Hawai‘i Island. Kū Aloha Ola Mau was selected because it is exemplar as it: a) provides NHCPs in the treatment of substance use for over 15 years; b) serves over 50% of haumāna with co-occurring disorders; c) serves a sizeable number of Native Hawaiian haumāna, d) was funded for NHCPs by the State of Hawai‘i prior to the state’s 2009 procurement change to make such practices available to all contracted providers; and e) has an established and trusted relationship with this researcher through previous community-based work.

**Engagement.** I believe developing and maintaining positive and helpful encounters are at the nexus of the relationship between the researcher and the individual, organization, and/or community. This is a standard cultural practice among Native Hawaiians as expressed in this ‘ōlelo no‘eau (Hawaiian proverb), “‘ike aku, ‘ike mai, kōkua mai; pela iho la ka nohona ʻohana. Recognize others, be recognized, help others, be helped; such is a family relationship” (Pukui, 1983). When working with indigenous peoples, it is critical that the researcher be mindful, respectful, and thoughtful about how to best engage the community since mistrust of researchers is a longstanding issue for
many indigenous communities (Austin, 2005; Brave Heart, 2005; Fong, Braun, & Tsark, 2003).

The method I used to engage Kū Aloha Ola Mau and its Puna program was based on Native Hawaiian protocol. I used my identity as a Native Hawaiian researcher and the Native Hawaiian values taught to me by my family to inform my method of engagement of recognizing the hierarchy in relationships, acknowledging the familial and reciprocal nature of relationships, interacting with respectful humor and at times informal conversations, emphasizing commonalities, and acknowledging interrelationships of place, genealogy, and spirituality.

I first called the poʻo or executive director of Kū Aloha Ola Mau in September 2009 to ask for permission and to review the intent of my study. After her approval, I asked if I could contact their substance use treatment program in Puna, Hui Hoʻola o Na Nahulu o Hawaiʻi. I wanted to request permission from the kākoʻo or assistant to the kupuna of the program, and then the kupuna. The executive director conferred the protocol. My experience working with kūpuna who have kākoʻo instructs me to first approach the kākoʻo to gain access to the kupuna; it may be disrespectful to inquire directly to a kupuna since their kākoʻo often serves as a gatekeeper. Prior to approaching the kākoʻo and kupuna, I needed to prepare myself. The values of respect and reciprocity in relationships, especially in hierarchal ones (e.g., the kupuna possessing a higher status than I) means that I need to prepare for questions from the kupuna and her kākoʻo, questions related to the proposed study and to me as a Native Hawaiian. For example, why, as a Native Hawaiian, am I conducting this study? What are my kuleana or responsibilities in this study as well as in life? How would this study benefit the lahui or
Hawaiian nation? What is my family’s genealogy and how is it related to Hawai‘i Island, the island where most of the study would be conducted? Cultural preparation can be daunting. This was my kuleana when I approached the kupuna.

“‘A‘ohe ‘ulu e loa‘a i ka pokole o ka lou. No breadfruit can be reached when the picking stick is too short. There is no success without preparation” (Pukui, 1983). My request of the kupuna is part of a larger understanding of mutual exchange. Specifically, as I ask of her, she asks of me. Not understanding this manner of exchange means that a researcher may be caught off guard because s/he did not prepare to enter into this relationship understanding her/his kuleana. Once I received the permission from the kāko‘o, I contacted the kupuna at her home in September 2009. As expected, she had a few questions, most related to the study and its aims. The kupuna gave me her approval. When I followed-up with the executive director in November 2009, she suggested that I visit Hui Ho‘ola o Na Nahulu o Hawai‘i, the program in Puna, Hawai‘i. I know that he alo a he alo or face to face (Pukui & Elbert, 1986) conversations are important to initiate and maintain relationships with Native Hawaiians, especially when a researcher is working in a Native Hawaiian community. During my visit in December 2009, the program staff, kupuna, and I talked about my progress with the proposal, reviewed my conceptual map, and discussed my timeline. The staff had no questions about the study or about me. I left my phone number in case they had questions or wanted to talk-story. The meeting was informal, friendly, and at times humorous. As is culturally practiced, I brought food for the program and a makana or offering to the kupuna. The meeting lasted approximately three hours. This began a reciprocal relationship between me and
the organization – I refer to it as a Hawaiian cultural code of conduct in research – one of mutual exchange of knowledge, talents, and resources.

It is worth noting that my position as a researcher working with a Native Hawaiian community required me to accept this reciprocal relationship. The expectancy of mutual exchange permeated my role as a researcher warranting me to assume an active role. For example, I was asked to assist the organization to interpret cultural information for presentations, then to present with them. They trusted my opinion and input as a researcher and as a Native Hawaiian. A researcher who misunderstands her/his role and declines the organization’s invitation will violate this cultural law of mutuality. As a result, the organization will mistrust the researcher, and/or terminate the study early. If my aim as a qualitative researcher is to watch, listen, engage, and immerse myself to draw out rich descriptions of what is happening and illicit narratives of lived experiences with culture, I must give deeply of myself when asked by the organization and those who have walked with me in this long journey. To this end, during my data collection phase, the organization asked me to assist with three statewide presentations and to co-present in two of them. I was honored to assist and present as a researcher and as a Native Hawaiian. For me, no conflict of interest existed; it was expected of me as dictated by a cultural code of conduct, one of the many navigational stars I used to paddle the space between Western knowledge and Native knowledge that was voyaged before by other Pacific scholars (Hereniko, 1995; Meyer, 2001; Nabobo-Baba, 2006).

**Research team.** The research team consisted of three individuals and was divided by research task. In addition to me, our team consisted of a researcher who assisted with data collection and a researcher who assisted with data analysis. The
researcher who assisted me with data collection facilitated all focus groups in Puna, Hawai‘i. He is experienced in facilitation and shares similar characteristics with the study’s Puna sample in that he is male, raised in Puna, speaks both Hawaiian and local ‘Puna Pidgin English’, is in recovery, and is approximately 34 years old. The researcher who assisted me with data analysis has her PhD, extensive experience in the Native Hawaiian culture, has fluency in the Hawaiian language, and has conducted qualitative studies with Native Hawaiians. In addition to these qualities that made them ideal research colleagues, I also selected them because I have an intimate relationship with them, solidified by 12 years of shared experiences, trust, and dependability. And I knew, when the research activities would require us to schedule flights, take time off from work to conduct the research or analyze the data, they would come through. And, they did.

**Participant recruitment.** The executive director of Kū Aloha Ola Mau assisted in the recruitment of participating administration staff. During our initial meeting, we agreed to the recruitment protocol of administration staff (Appendix B.1) and she provided me with a list of individuals who met the inclusion criteria (Appendix B.1). The clinical coordinator of Hui Hoʻola o Na Nahulu o Hawaiʻi assisted in the recruitment of program staff by posting three recruitment announcements in the staff offices. The recruitment protocol of program staff is found in Appendix B.2. Last, the Clinical and Program Coordinators of Hui Hoʻola o Na Nahulu o Hawaiʻi assisted in the recruitment of haumāna after receiving training on the haumāna recruitment protocol (Appendix B.3). We recruited participants for each data collection phase of administration staff, program staff, and haumāna, and a description follows. Because phase two and three were similar in method and setting (e.g., focus group and conducted in Puna, Hawaiʻi), these phases
are described together. Since most of the data collection occurred in Puna, a fuller description of the physical environment is provided to offer a “sense of place”.

**Phase One: Administration Staff**

**Setting.** To provide a sense of Puna, both settings of the key informant interviews are described by the types of rains that fall in that district. “*Ka ua kaulana Kukala-hale*” meaning the rains that rattle the roof top depicts the famous rains of Honolulu (Elbert, 1970), and “*I ka ua kanilehua,*” the rains that rustle the lehua blossoms describe the rains of Hilo (Elbert, 1970). One interview was conducted in Honolulu, O‘ahu and three in Hilo, Hawai‘i.

**Participants.** Four key informants participated in the interviews from May 5, 2010 to May 16, 2010. Participant inclusion criteria are found in Appendix B.1 and focused on recruiting individuals who worked with the organization during the implementation of the program innovation. Thus, participants were recruited from within the organization (e.g., administration) and community representatives from the Policy Steering Committee responsible for implementing the program. A total of 12 individuals were identified from which we drew our administrative sample of four (33%). Participants ranged in age from 55 to 68 years with a mean age of 59 years. Seventy five percent (3/4) of participants were female and 25% (1/4) male. Seventy five percent (3/4) reported their primary ethnicity as Native Hawaiian; 25% (1/4) reported being Japanese.
Table 1

*Administration Staff Participant Demographic Characteristics*

<table>
<thead>
<tr>
<th>Age</th>
<th>Range</th>
<th>Years</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td></td>
<td>4</td>
<td>75%</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>55-68</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>59</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>Primary Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td></td>
<td></td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Japanese</td>
<td></td>
<td>1</td>
<td>1</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Materials.** The materials used in Phase One included the following: 1) Consent Form Administration/Staff (Appendix A.1), and 2) two audio digital recorders.

**Semi-structured interview questions (Appendix C.1).** I asked eight questions of each participant. Each question included one to seven probing questions. The key informant interview questions were developed from the literature (Rezentes, 1996; Yin, 2003; Onken, 2007; Simpson & Flynn, 2007) and focused on the process of why and how NHCPs were identified, developed, and implemented at Kū Aloha Ola Mau as well as the factors that influenced the process. Participants responded orally to the questions, and were invited to contact me later if they wanted to expand or clarify an answer. Interviews were recorded using audio digital recorders and the recordings were transcribed verbatim. To protect confidentiality, participants were assigned unique codes instead of using their names. All identifying information was removed to protect their identity. Participant codes are stored in a separate location from the participant names. Data collection in
phase one also included organizational documents and archival records (see Appendix E.1 for a list of organizational documents).

**Procedure.** “O ke aloha ke kuleana o kâhi malihini. Love is the host in strange lands. In old Hawai‘i, every passerby was greeted and offered food whether he was an acquaintance or a total stranger” (Pukui, 1983). Sharing food and good intentions with others facilitated the interview process. While we had distinct roles as the ‘interviewer’ and ‘interviewee’, our behavior was often governed by what is expected of Native Hawaiians in social interactions. For example, during data collection with a kupuna, I would refer to her as “Aunty” as a sign of respect and wait for her behavioral cues indicating she was ready to move to the next question and/or defer to her own self-regulation if she appeared to move off point. To be directive such as, “Aunty, can you tell me how what you just described relates to the question?” may be taken as disrespectful, corrective, and demeaning. On average, each interview lasted between 1.5 to 2 hours and opened with a pule or prayer.

**Phase Two and Three: Program Staff and Haumāna**

**Setting.** “Puna paia ‘ala, i ka paia ‘ala i ka hala. Puna with the fragrant bowers, fragrant are the blossoms of the pandanus tree (Naumu, 1925). Data were primarily collected in Puna at the organization’s outpatient substance abuse program that integrates cultural practices. Aunty Abbey Napeahi, a Native Hawaiian traditional practitioner of ho’oponopono or the Hawaiian practice of resolving relationship conflicts, named the program “Hui Ho’ola o Na Nahulu o Hawai‘i” to mean “the group that gives life and healing to the people of Hawai‘i” (L. Cook, personal communication, September 10, 2007). Hui Ho’ola o Na Nahulu o Hawai‘i’s facility is a free standing home located on
30th St. in the Maku‘u district of Puna, Hawai‘i. As you enter the front door, you enter into a spacious living room that opens to a large kitchen and a dining room. The dining room is used as an office. The home has a large carport where most of the group activities occur and a sizeable back yard for informal meetings. The house has three bedrooms that are used as offices and two restrooms. The first time I entered, haumāna and staff were laughing. The smell of simmering food filled the air; it felt like a home.

Puna is located on the Southwest part of Hawai‘i Island and is the second most populated Hawai‘i Island district, after Hilo, with 31,335 or 21% of the population spread out over a rural area that is twice the size of O‘ahu (The State of Hawai‘i, 2002). Most of the district exists without paved roads, electricity, telephone service and running water. Puna is a fast growing area with large numbers of newcomers. The predominant ethnic populations of Puna include Caucasian, those reporting two or more races, Native Hawaiians, Filipinos, and Japanese with about 60% of the population between the ages of 18 and 64 (U.S. Census, 2000). R. Keli‘iho‘omaluh, a longtime Kalapana resident, claims that Puna is a less populated, rural area, where many families still engage in traditional Native Hawaiian practices that promote self-subsistence, family and social bonding, and spirituality (personal communication, September 24, 2010).

Participants. Phase two participants included program staff of Hui Ho‘ola o Na Nahulu o Hawai‘i, and participation was limited to the inclusion criterion found in Appendix B.2. Five of six staff (83%) participated in one focus group conducted on August 11, 2010. My proposed method of data collection for program staff was to conduct semi-structured interviews; however, in our initial meeting in December 2010, staff informed me of their preference for a group type of format because it allows others
to interact and expand on comments. This was consistent with Krueger and Casey (2000) as focus groups have the potential to enhance data quality through participant interaction.

Demographic data of participants are included in Table 2.

Phase two participants ranged in age from 47 to 58 years with a mean age of 54 years. Sixty percent of participants (3/5) were female and 40% (2/5) were male, and 80% (4/5) reported their primary ethnicity as Native Hawaiian with 20% (1/5) reporting as Japanese.

Table 2

Program Staff Participant Demographic Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Years</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td>47-58</td>
<td>54</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>Female</td>
<td>3</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>2</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Primary Ethnicity</strong></td>
<td>Native Hawaiian</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Japanese</td>
<td>1</td>
<td>20%</td>
</tr>
</tbody>
</table>

Phase three participants included haumāna of Hui Hoʻola o Na Nahulu o Hawaiʻi and adhered to the haumāna inclusion criteria (Appendix B.3). To reach saturation (Strauss & Corbin, 2007), we held four focus groups with a total of 15 haumāna. On average, the program has approximately 10-15 Native Hawaiian haumāna who participate, and the haumāna who participated in the focus groups represented 100% of the Native Hawaiian haumāna in the program at the time of data collection. It should be noted that not all haumāna who participate in the program are Native Hawaiian; but, for
our study, we only recruited Native Hawaiian haumāna. Focus groups were conducted from August 11, 2010 to September 24, 2010.

As indicated in Table 3, phase three participants ranged in age from 19 to 51 years with a mean age of 36.5 years. Females comprised 27% (4/15) of participants and males comprised 73% (11/15). All participants were Native Hawaiians. About half (7/15) reported the highest grade level achieved was 9 to 11 and about half (7/15) reported high school or GED achievement level. One participant (7%) indicated “some college”.

Regarding marital status, 27% (4/15) reported “separated”, 60% (9/15) indicated “never married”, and 13% (2/15) reported “married”. In the area of employment, the majority or 73% (11/15) were unemployed, 13% (2/15) reported being “self employed”, and 13% (2/15) worked for wages. The two participants who reported they were “self employed” described their employment as “pounding ‘opihi” and “mechanic and yard maintenance”.

The two participants who worked for wages were employed as a “driver” and in “social” (services). Regarding length of treatment, 53% (8/15) reported less than one year, 20% (3/15) indicated one to two years, and 13% (2/15) had been in treatment over five years. Thirteen percent (2/15) of participants did not answer this question, possibly because they had completed treatment. When asked to report on the frequency of treatment, 40% (6/15) reported treatment at Hui Ho’ola o Na Nahulu o Hawaiʻi as their “first time”, 47% (7/15) indicated “2 to 3 times”, and 13% (2/15) had received treatment more than five times. Sixty percent of participants (9/15) reported living in their own house or apartment and less than half (6/15) reported living with family. The majority of participants or 67% (10/15) reported currently having both a substance use and a mental health problem.
Table 3

*Haumāna Participant Demographic Characteristics*

<table>
<thead>
<tr>
<th></th>
<th>Years</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>19-51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>36.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grades 9 to 11</td>
<td>7</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>High School Graduate</td>
<td>7</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>or GED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>1</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>15</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Never Married</td>
<td>9</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Employed</td>
<td>11</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td>Self-employed</td>
<td>2</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Working for Wages</td>
<td>2</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td><strong>Length of Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>8</td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td>1 - 2 years</td>
<td>3</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>5 years plus</td>
<td>2</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment before Hui</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First time</td>
<td>6</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Hoʻola o Na Nahulu o Hawaiʻi</td>
<td>7</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>2 - 3 Times</td>
<td>7</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>5 plus</td>
<td>2</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td><strong>Living Situation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own Home or Apartment</td>
<td>9</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Other: With Family</td>
<td>6</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral health problem(s)</strong></td>
<td>10</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td>Only Substance Use</td>
<td>5</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>Both Substance Use and Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note:* The asterisk (*) indicates two participants did not answer this question.
**Materials.** The following materials were used in Phase Two: 1) three consent forms (Appendix A.1, Appendix A.2, and Appendix A.4); 2) two audio digital recorders, 3) one laptop with an encrypted file for this study, 4) two focus group interview questions (Appendix C.2 and Appendix C.3), and 5) one Capacity Assessment (Appendix D.1).

Staff and haumana interview questions were developed from concepts based on the Lōkahi Triad (Rezentes, 1996), Recovery Paradigm (Onken et al., 2007), Organizational Implementation (Simpson & Flynn, 2007), and the five Cultural Best Practices for Community-Based Recovery Programs (‘Imi Ke Ola Mau, 2009). Eight questions were asked of program staff and were identical to those asked in Phase One of administrative staff. The haumāna focus group questions included nine questions and focused on their experiences with NHCPs and the extent to which these practices were helpful or not in their recovery. All interviews were recorded using audio digital recorders and recordings were transcribed verbatim. Identifying information was removed to protect the identity of participants. Participants were assigned unique codes instead of their names. Participant codes are stored in a separate location from the participant names. Data collection in phase two also included program documents and archival records (see Appendix E.2 for a list of program documents), and in phase three haumāna treatment records (see Appendix E.3 for a list of treatment documents).
**Procedure.** The staff and haumāna of Hui Ho‘ola o Na Nahulu o Hawai‘i practice the *He Mu oli* or release chant every morning as a way of asking permission to shed negative thoughts and to prepare for the day’s task. Everyone at Hui Ho‘ola o Na Nahulu o Hawai‘i is expected to participate regardless of their knowledge of, and level of comfort with, the oli. The words of the oli are written on a flip chart, all participants stand in a circle in the carport, and each person chants all verses of the oli which is followed by another person in the circle until all participants had an opportunity to chant. More experienced chanters assist participants who have a difficult time with the oli. After the oli is recited, participants share their name and identify at least one thing for which they are grateful.

<table>
<thead>
<tr>
<th>Chanter</th>
<th>All</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>He Mu ‘oia.</em></td>
<td><em>He Mu.</em></td>
<td>Defend us from them. Defend us.</td>
</tr>
<tr>
<td><em>He Mu na moe ino ino,</em></td>
<td></td>
<td>Save us from night-mare,</td>
</tr>
<tr>
<td><em>Na moe moe a,</em></td>
<td></td>
<td>From bad luck dreams,</td>
</tr>
<tr>
<td><em>Na pu nohu nohu,</em></td>
<td></td>
<td>From omens of ill,</td>
</tr>
<tr>
<td><em>Na haumia</em></td>
<td></td>
<td>(no translation)</td>
</tr>
<tr>
<td><em>He Mu ‘oia.</em></td>
<td><em>He Mu!</em></td>
<td>From such deliver us. Defend us!</td>
</tr>
<tr>
<td>‘eli ‘eli!</td>
<td></td>
<td>Speedily and entirely!</td>
</tr>
<tr>
<td><em>I a‘e!</em></td>
<td></td>
<td>Oh, la!</td>
</tr>
<tr>
<td><em>Noa honua</em></td>
<td></td>
<td>Freedom complete, absolute.</td>
</tr>
</tbody>
</table>

(Malo, 1951)
This is how we began our mornings at Hui Ho‘ola o Na Nahulu o Hawai‘i, an atypical experience for most researchers, but a familiar cultural experience for me in Native Hawaiian settings: asking permission, identifying names, and offering gratitude.

Focus groups followed the morning protocols and were held in the living room of Hui Ho‘ola o Na Nahulu o Hawai‘i. Each focus group opened with a pule or prayer. Procedures for focus groups are explained in the focus group guide (Appendix C.2 & Appendix C.3) and follow a similar format as described by Krueger and Casey (2000). Specifically, prior to the start of the group, the moderator informed participants of the following: a) explained the purpose of the interview, b) reviewed the consent forms, and c) asked if participants needed clarification of any information presented, reviewed, and discussed up to that point about the study. Participants were informed of the following: a) their participation was voluntary, b) they could withdraw from the focus group at any time for any reason, and c) they would not be penalized for withdrawing from the study. Focus groups were audio-taped and transcribed verbatim. For their time and sharing of knowledge, staff received a makana or gift and haumāna received a $10 gift card to Foodland to compensate for travel time.

Focus groups were facilitated by a member of the research team. To guarantee we followed a similar focus group process, we received focus group re-training that followed a structure suggested by Krueger and Casey (2000). To increase consistency and accuracy across focus groups, the moderator and I met before each focus group to: a) review focus group questions, and b) revisit focus group procedures. During the focus groups I sat on the floor in the living room and followed these procedures: a) mapped where each participant sat, b) assigned a unique code to each participant, and c) began
transcribing using the participant assigned code rather than their name for privacy. My role was explained during the introductions of each focus group. For the most part, I did not participate in the focus group unless I was directly asked a clarifying question by the moderator or by participants.

Focus group questions for haumāna (Appendix C.3) were pilot tested and revised with two adults, a male and female, from the Puna area utilizing a “think aloud” approach to maximize its comprehension (Grinnell & Unrau, 2007).

While both program staff and haumāna focus groups followed the same procedures, two procedures were added to the haumāna focus groups. First, because of the potential issue that individuals may lack capacity to provide informed consent, I administered a Capacity Assessment (Appendix D.1). Prior to the focus group, I met with each potential participant and reviewed the Informed Consent (Appendix A.2) in the privacy of a staff’s office. Across the haumāna focus groups, all 15 participants were determined to possess the capacity to provide informed consent. The second procedure was the administration of an Informed Consent (Appendix A.4) to review haumāna records. This consent was administered at the beginning of each focus group. At the end of each focus group, we gathered for lunch that the research team provided.

**Data Analysis Procedures**

**Procedure.** Two analysts used open coding (Strauss & Corbin, 2007) of qualitative data from 9 transcripts and 56 documents and archival records. To ensure inter-rater reliability (IRR), the analysts were trained on coding. We coded two sets of dummy transcripts. In the first set, we independently reviewed and separately identified the natural meaning units or important segments in three pages of the dummy transcript.
We then met to discuss commonalities, differences, and definitions, and we reached consensus through kūkākūkā or face to face discussions to determine the extent to which transcript segments were relevant or extraneous. Nine codes were identified, seven of which were identified by both analysts at a 64% IRR. Because we wanted closer agreement, we decided to review 10 pages of a second set of transcripts and meet at a later date. Subsequently, an 89% IRR was achieved or 17 agreed upon codes out of 19. With a higher level of agreement, we began the data analysis of the study.

I transcribed the interviews and focus groups verbatim, inserted line numbers on each data source including organizational documents and archival records, and reviewed them for accuracy. Our procedure was to review each data source, code the natural meaning units, and then meet. Each meeting had five objectives: 1) identify common or agreed upon codes, 2) discuss the significance as well as the cultural meaning of each code, 3) identify extraneous strays or codes only identified by one analyst, 4) identify emerging subthemes, if applicable, and 5) decide the next date to meet and what transcripts or documents will be reviewed. I pooled codes into a codebook and noted for each code its data source, transcript page, line number, and the initials of the analyst who cited it.

The codebook was organized by subthemes under which the codes were sorted. However, in the middle of the coding process, we decided to remove the subthemes from the codebook because we felt they influenced our ability to remain neutral when coding subsequent data. Therefore, I went back to the codebook and cleaned it up by reorganizing the codes according to data sources (e.g., Haumāna Focus Group #1) rather than subthemes. I deleted all subthemes. Because we coded manuscripts according to
natural meaning units or codes instead of by subtheme, we did not recode previous
manuscripts. We also agreed that at the end of the coding process, we would assemble all
codes and categorize them into subthemes and themes. Therefore, after coding the last
data source, we met to review the 488 codes. Through the processes of data reduction by
comparing and contrasting patterns in the data as well as kūkākūkā or focused
discussions, 23 subthemes emerged. We then met again, and through the same processes,
we came to a consensus that three themes represented the 23 subthemes and one
overarching theme represented the three themes. Each theme is represented in both
Hawaiian and English and is described in the Chapter 4, Findings.

As noted above, analysts discussed the cultural meaning of the data. The
procedure was twofold. First, we used ourselves as an internal source of knowledge to
interpret or make sense of the cultural significance of data based on our experiences and
training in both Hawaiian and “Western” epistemic perspectives, grounding the data to
concepts or practices that were personal and familiar. Then, through kūkākūkā we
checked to see if our interpretation of the cultural meaning made sense to each other.

Second, if applicable, we used external sources of Native Hawaiian knowledge
such ‘ōlelo no‘eau (Pukui, 1983) to cross reference patterns in the data. For example, we
reviewed transcripts from a haumāna focus group in which participants discussed how
keeping their hands busy working in the ‘āina, making dye from milo wood, and
stamping their kihei or ceremonial garment for graduation contributed to their recovery.
We likened their descriptions to a source of Native Hawaiian knowledge found in ‘ōlelo
no‘eau that states, “E ho‘ohuli ka lima i lalo. Turn the hands down or when the palm of
the hands face down they are occupied and productive” (Pukui, 1983). In this passage,
we discussed the concepts of productivity, collective work, and Native Hawaiian learning methodology. Cross-walking coded data to both internal and external sources of Native Hawaiian knowledge enhanced the meaning and richness of data interpretation and offered a way to blend or understand the data and/or subthemes from a Native Hawaiian epistemic perspective and a “Western” epistemic perspective.

While discussions on culture and meaning enhanced the depth of our interpretation of what we were seeing in the data, it also extended the analysis period from the projected four months to six months. Native Hawaiians believe that if it is worth doing, it is worth taking the time to do it well, which is reflected in this ‘ōlelo no’eau, “‘A‘ole e ‘ai ‘ia he maunu ‘ino. It will not be taken by the fish; it is poor bait. People will pay no attention to poor production. When it is good, it will attract attention” (Pukui, 1983).

**Vetting – Returning to participants.** “‘A‘ohe hana nui ke alu ‘ia. No task is too big when done together by all.” (Pukui, 1983). To heighten trustworthiness of our initial findings, I returned to the interview participants on May 10, 2011 at Hui Ho‘ola o Na Nahulu o Hawai‘i to test our interpretations and to elicit other perspectives of the data. The meeting to vet the findings with participants followed a process described by Onken et al. (2002).

**Participants.** Twelve participants or 50% (12/24) of the study participants attended the vetting meeting that included two administration staff (50%), four program staff (80%), and six haumāna (40%). One haumāna arrived late from Kona (approximately 100 miles from Hui Ho‘ola o Na Nahulu o Hawai‘i) and missed the
meeting. The haumāna in attendance represented three of the four haumāna focus groups.

**Materials**. The following materials were used in the vetting process: 1) two audio digital recorders, and 2) paper copies of the presentation of the study’s initial findings.

**Procedures**. The meeting began with an oli or chant of gratitude, pule or prayer, and then lunch provided by the program. Next, I reviewed the purpose of the study and shared my personal kuleana or dual responsibilities/positions as a researcher and as a Native Hawaiian within this study. Then, I described the meeting goals: 1) to review the research process with the group or "What we did", 2) to present and discuss our interpretations of the data or “What we found”, and 3) to ask for assistance in telling the larger story or “What we are learning”. During the discussion of findings, I checked with participants if our interpretations reflected their experiences with NHCPs at Kū Aloha Ola Mau and Hui Ho‘ola o Na Nahulu o Hawai‘i. As I went through each finding, I probed with some variant of the question, "Does our interpretation reflect your experience?” after which, I asked, “How can I make this more accurate?”

After the presentation of our interpretation of the data, I asked participants, “Can you help me understand how these themes and subthemes influence the implementation of NHCPs at Kū Aloha Ola Mau and at Hui Ho‘ola o Na Nahulu o Hawai‘i?” This allowed me to listen to participants as they pieced together a story line in understanding why and how Kū Aloha Ola Mau identified, developed, and implemented NHCPs to address substance use or co-occurring disorders among Native Hawaiians. At the end of the discussion, participants shared their thoughts about the findings. The meeting to vet
the findings lasted an hour and a half and the gathering totaled three and a half hours. To compensate for their travel, each haumāna received a $10 gift card to Foodland stores. A summary of participant responses is presented in the Findings Chapter that follows.

**Trustworthiness of analysis.** Lincoln and Guba (1985) offer four criteria to enhance the trustworthiness of qualitative inquiry. The aim of trustworthiness in qualitative analysis is to support the argument that the analysis’ findings are “worth paying attention to” (Lincoln & Guba, 1985, p. 290). The four criteria include credibility, transferability, dependability, and confirmability.

“Credibility” refers to the degree to which the research findings are a credible representation of the original data from which they were drawn. Three strategies were used to maximize “credibility”. First, I pooled data (Lincoln & Guba, 1985) from multiple sources to gather richer and more credible data. Second, two researchers analyzed the data to decrease the potential for researcher bias (Patton, 2002). Third, returning to participants to vet our interpretations of the data or “member checking” (Lincoln & Guba, 1985) provided an opportunity for participants to comment about the degree of accuracy or credibility to which the findings reflected their experiences.

“Transferability” is the extent to which the findings from this study can apply beyond this inquiry (Lincoln & Guba, 1985). In order to address transferability, I provide a “paper trail” of my analysis so other researchers can transfer the findings of the study, and/or repeat the study’s procedures. Furthermore, Yin (2003) suggests that reliability or demonstrating the repeatability of the study’s operations is addressed in this case study by using a case study protocol; in this study, the dissertation is the case study protocol as it contains all the needed elements: 1) overview of the case study, 2) field procedures, 3)
case study or research questions, and 4) outline of the final report (e.g., the dissertation). Additionally, an extensive case study database (Yin, 2003) was maintained and included data from field notes, direct causal observations, long table of findings (e.g., codebook), and discussions of analysts’ meetings. According to Yin (2003), the case study database is a mechanism of documenting and organizing data collected in the case study. Thus, in the study, a chain of evidence is maintained from which other researchers can follow any evidence from initial research questions to study conclusions.

“Dependability” refers to how well the processes of data collection, data analysis, and theory generation are integrated (Lincoln & Guba, 1985) and “confirmability” refers to the degree to which the results could be confirmed or corroborated by others. According to Lincoln and Guba (1985), both dependability and confirmability can be determined through a well-managed audit. I used my Committee Chair as the main auditor of the methodology of my study, and I received guidance from other committee members regarding data collection and analysis procedures. The Chair and I met periodically to discuss how data were collected, how best to analyze the qualitative data, and how to approach the vetting process. He examined the process by which the various stages of the study, including analytic techniques, were conducted and determined whether this process was applicable to the research undertaken and whether it was applied consistently (Lincoln & Guba, 1985).

Several strategies were used to enhance confirmability. I maintained an audit trail of the study including the coded transcripts used to develop the subthemes, themes, and codebook. A case study database also strengthened confirmability. A chain of evidence will allow an auditor, and others, to trace the findings back to the original source.
Returning to participants to check my interpretations helped to confirm the findings.

Another strategy I used and which is detailed in Chapter 2 compared the study’s findings with the five Native Hawaiian CBPCBRPs (‘Imi Ke Ola Mau, 2009). The five Native Hawaiian CBPCBRPs were developed by an expert panel who reviewed three State of Hawai‘i reports that described what stakeholders identified as needed for a recovery program to be helpful to Native Hawaiians with co-occurring disorders. Comparing the findings to the five CBPCBRPs allowed me to use the expert panel to corroborate the findings.

Rigorous, constant, and comparative data analytic methods using multiple data sources create a rich understanding of this organization case study. These findings are described in the next chapter.
Chapter 4. Findings

This chapter is formatted in three sections. The first section presents the inductive findings of this qualitative case study. The second section applies the findings to answer the research questions, and the third section applies the findings to the literature.

Qualitative Findings

Two analysts identified 488 codes which were reduced to 23 subthemes through a process of continually going back to the data, identifying commonalities, and engaging in kūkākūkā or focused face-to-face discussions to analyze the data. This process was repeated as we collapsed the 23 subthemes into three themes, and finally into one overarching theme. We also noted exemplary quotes that illustrate the meaning of the subthemes and themes.

In collapsing the 23 subthemes to three themes, we identified that codes within four subthemes did not fit neatly into one of the three themes. For example, in one subtheme, some of the codes fit best under one theme while other codes fit best under another theme. Instead of trying to force the data to fit a particular theme, we decided to open up these four subthemes, allowing the raw data to move to the categories or themes with which they held together in a meaningful way with the other data. In the codebook or long table, these four subthemes are listed under more than one theme. The four subthemes include: 1) recovery, 2) values, 3) ‘ōlelo or Hawaiian language, and 4) practices. Again, we returned to the data and through saturation in the data and kūkākūkā, we pooled themes into one overarching category or theme that best represented the data.
Each theme is described in Hawaiian and English. I believe the essence of the theme is best illuminated when both English and Hawaiian languages are used; additionally, in order to ground the themes in Hawaiian knowledge, I introduce the description of each theme with an ‘ōlelo no‘eau or traditional poetic saying as a portal into Hawaiian epistemology and ontology.

**Subthemes.** This section describes the 23 subthemes with a description and an illustrative quote. In order to trace illustrative quotes back to their original data source, they are cited by source and line number at the end of each quote. Data sources include Administration staff (A), Program staff (P), and Haumāna (H) with the numbers 1 to 4 following the administration and haumāna sources to indicate from which interview or focus group the quote was cited. Table 4 summarizes the 23 subthemes and Table 5 shows the subthemes that were collapsed into themes.

**Legality.** “I mohala no ka lehua i ke ke‘ekehi ‘ia e ka ua. The Lehua blossom unfolds when the rains tread on it or people respond better to gentle words than to scoldings” (Pukui, 1983). We interpreted legality as a safe environment in which haumāna felt comfortable to discuss their drug use with staff and not be penalized. Staff perceived their role not as a parole officer colluding with the legal system, but rather as a person who will walk the long journey with haumāna. “[…] easy to be security guard and more difficult to be welcoming, to be human being, but we do it” (A1, 664-665).

**Persevere.** “He a‘ali‘i ku makani mai au; ‘a‘ohe makani nānā e kula‘i. I am a wind-resisting a‘ali‘i (plant); no gale can push me over” (Pukui, 1983). Participants described persevere as a philosophy to continue in the face of challenges during the adoption of NHCPs as the organization faces budget cuts or when staff turnover.
Persevere speaks to the resilience of the organization to remain optimistic over time. “We fall apart and come back. Some programs give up” (P, 920-922).

**Resistance.** We interpreted resistance as the struggle to understand the use of NHCPs as a modality of healing by staff, haumāna, and evaluators. For staff, resistance was the extent to which they did not embrace cultural values and practices. For haumāna, resistance to participate in cultural practices related to how they perceived it connecting to their recovery. For researchers who were hired to evaluate Hui Ho'ola o Na Nahulu o Hawai‘i, resistance was interpreted as the challenges of understanding treatment through a Hawaiian epistemic lens.

“[…] they couldn’t grasp it. So Uncle […] took them to his house to stay in Kalapana so they can see it, so they can feel it, so they can be part of him and his ‘ohana […] they got some of it, but they could not get the core of what Uncle was sharing” (P, 503-507).

**Genealogy.** Genealogy was described as a process of discovering, representing, and connecting to a person’s identity and purpose in life. Participants explained that by working on their genealogy, they discovered familial strengths and learned that their personal actions represented those who raised them. Genealogy also included a spiritual dimension in that it was described as an unfolding of a person’s destiny over which s/he may have no control. Similarly, the question, “pehea kou piko?” refers to the spiritual un-severed umbilical cord that binds a person to their ancestors. “When you say, ‘pehea kou piko?’ you asking about their ancestors. So, when you connect with dem, you connecting with everybody […]” (P, 766-768).
Transportation. Transportation by the organization to and from a haumāna’s home was consistently cited across haumāna transcripts as a factor that contributed to their recovery. We interpreted transportation as an organization resource facilitator. In this segment, a haumāna talked about his eagerness while waiting for the morning van,

I love it, so I be ready one hour early, brah. I be waiting on my table like dis, “oh geez, dey stay late.” I stay ready fo use da phone and say, “you guys goin come get me or what?” (H1, 301-304).

Funding. Funding included both insurance and grant generated funds. Staff primarily perceived funding as a barrier that restricted and devalued cultural practices when compared to Western evidence-based practices. NHCPs haven’t “[…] been as welcomed as a modality or as an alternative to any kind of Western stuff” (A3, 303-305). Issues cited by participants included insurance companies requiring more credentialed providers and the inadequacy of payment for cultural providers. In one instance, funding liability forced the organization to stop the use of laʻau lapaʻau or medicinal herbs. While funding was described primarily as a barrier, grant funds were cited as a helpful resource for haumāna to pay for their initial drug assessment and to help the organization with start up funds for program planning.

Naming. “I ka ʻōlelo nō ke ola, i ka ʻōlelo nō ka make. In language there is life and in language there is death” (Pukui, 1983). Words, as well as names, had the power to heal, kill, and predict the future. Participants described that names connect a person to the past, present, and future; to another person; and to a place. Names that honor past ancestors give mana or life force to that ancestor and to the carrier of that name. Names can manifest the destiny of a person, program, and/or organization. “[…] the name is
important because it tells you what you are going to be and what you are going to do and it unfolds who you are” (A1, 89-91).

**Culture shared/modeling.** Participants talked about the importance of giving and sharing with each other. We interpreted culture shared as the exchange of knowledge, values and practices among individuals as well as a process of learning through modeling. Haumāna described the values of love and aloha exhibited by staff inspired them to want to possess those values. In return, as haumāna gained new tools in recovery they shared cultural knowledge with their ‘ohana. “Dat’s why I like this program. Bring me back to my culture. So no forget em. Can pass em on. As I recover, I can pass em on to family” (H1, 439-441).

**Professional kuleana (responsibility).** Professional kuleana refers to the core attributes of staff in order to provide NHCPs. The staff has a responsibility to be both pono or good and moral (Pukui & Elbert, 1986) and spiritual. At the provider level, participants talked about these attributes in terms of the sacredness of life and the need for providers to be able to discern when and how to heal. This professional attribute also extended to administration. “And every breath you take and every word you say to them is important. And can be healing or take away […]” (A1, 317-318). Conversely, if staff were not pono then this was evident to the haumāna and they stopped coming to the program.

**Cultural kuleana (responsibility).** Cultural kuleana was interpreted as staff’s responsibility to conserve cultural knowledge, practices, and resources for the purpose of continuity. To learn, practice, and teach certain cultural knowledge required a person to obtain permission from the source like a kumu a’o (cultural teacher). In the case of the
NHCPs used at the organization, kūpuna gave their permission for the purpose of preservation. “[…] our kūpuna gave their blessings and said, ‘it’s okay’. Because if you don’t share what you know and what you have today, it will only die […] It is our kuleana to share our knowledge and share our aloha” (A4, 470-474). Once permission was given and the practitioner possessed the knowledge, then they had the kuleana to continue it for future generations. From the perspective of the organization, its program Hui Ho‘ola o Na Nahulu o Hawai‘i has the kuleana to share the knowledge through retreats and consultations within the organization.

**Spirituality.** Spirituality was interpreted as an immaterial reality often experienced as a connection to a larger universe or life force that provided meaning and inspiration to participants. Spirituality may be manifested in physical signs and objects. Participants described that a person’s ability to receive spiritual signs depended on her/his ability to be completely open to the universe and accept signs as a divination of their destiny. Folding the space between the physical and spiritual realms was described by participants in the concept of activating. Activating the spiritual essence of a symbol like a plant was a way of connecting or attaining oneness with a material object. “When you feed it with water, you activate it. So when you drink da water…you now connected one on one with that plant” (P, 1133-1145). Participants also talked about spirituality as the core of the work done with haumāna. Connecting haumāna to a larger life force or spirituality was the nexus of healing. Throughout their narratives, participants described culture and spirituality as finely woven together, and without spirituality, culture would not work because the results would only be physical.
**Recovery.** Recovery was a multidimensional concept described by haumāna as a life philosophy, a process to achieve holistic life goals, outcomes of abstinence, and relationships. Haumāna spoke about recovery as a life philosophy of gratitude and service. Most haumāna described recovery in terms of fulfillment of life goals such as improving physical health, receiving mental health support, and finding employment or housing. Specific to abstinence, recovery included desired outcomes of treatment such as decreased use of drugs and/or alcohol, changed thinking patterns, and altered behaviors. Haumāna also talked about recovery as a relationship with the community, healthier types of relationships with others, and harmonious familial relationships. In the following segment, a haumāna illustrates his gratefulness in recovery.

I was told dey get grant. I brought my money everything, and dey say just sign da paper. That kine stuff I get so grateful […] just like, every Monday we go to da ‘āina (land) I like blast weed whacking. It’s an irreplaceable ting […] I like say mahalo, so wen we go to da ‘āina I do da work. Attitude is gratitude in action (H1, 256-258).

**Hawaiian culture.** Culture was a broad term that included the shared experiences and meanings among participants. As such, we interpreted Hawaiian culture to include common beliefs and behaviors, life-activities, and a shared method of learning. Predominant beliefs included the importance of relationships in the physical and the spiritual worlds, the emphasis on a communal orientation, the need to practice culture daily, and the esteemed position of kūpuna. Participants also talked about their belief that the Hawaiian culture is a healing one with the potential to address modern day issues such as substance use. Related to life activities, participants shared that by engaging in
NHCPs they were able to transfer acquired beliefs and behaviors into daily life activities. For example, by participating in hula, they learned structure and kuleana which was then incorporated into how they approached daily activities. As a tie that binds, food was described as a cultural practice and a life activity that reinforced relationships.

“Ma ka hana ka ‘ike. In work there is knowledge” (Pukui, 1983). Participants described the primary method of learning was listen, observe, participate, and replicate. As an applied learning in a group setting, haumāna were expected to join in specific cultural activities whether or not they fully understood what they were doing.

[...] you do first and then learn later. Like if everybody go work, you just do and follow and do it. Western style they want to teach you dat dis goes here, instructions, follow step one, step two, and step three (P, 1028-1034).

**Self-identity.** Participants defined their self-identity in relation to three dimensions: a) loving self and others, b) self-discovery, and c) divine purpose. While participants acknowledged the importance of loving self, most spoke about the need to focus on doing for others such as family and other ‘addicts’. Participants stated that Hawaiian values learned in the program taught them humility, love, and kindness to others. Participants noted that self-discovery was a lifelong process in which they were learning about culture, genealogy, inner peace, potential, recovery, and gratefulness.

“You learn more, because you take away da alcohol and drugs, the problems still there, but you can find out more about yourself and be more grateful, yeah?” (H1, 105-107).

As part of the process of self-identity, participants described searching for a divine purpose in life and understanding that Hui Hoʻola o Na Nahulu o Hawaiʻi was put in their life for some divine reason.
Equality. “Hoʻokahi ʻiliwai o ka like. The likeness is all on one level or one is just like the other” (Pukui, 1983). Equality was interpreted as a strong organizational belief that guides interaction and relationships among the administration, staff, and haumāna. "In terms of worth, we are all flat" (A1, 48). The organization approaches relationships with haumāna utilizing a strengths perspective (Saleeby, 2008) and a person-centered theory (Rogers, 2003). Organizational staff values the worth of each individual, uses a non-judgmental approach, and focuses on the assets of each haumāna rather than their challenges/deficits. In multiple responses, haumāna across the four focus groups described this egalitarian relationship and how they benefited from it. “No more da line. You know da, you da ‘client’, I da ‘counselor’” (H4, 360-361). While multiple haumāna responses referred to the benefit of such an approach, a downside of such a relationship was identified by a haumāna who use to relapse in order to stay in the program. Yet, she admitted that when she relapsed, the organization never judged her.

Western culture. Participants talked about Western Culture in three areas: 1) the similarities and the differences between the cultures of Western and Hawaiian, 2) integration of services and practices grounded in two worldviews and the extent to which they blend together, and 3) the need for a cultural-based evaluation.

Similarities and differences. Participants infrequently cited similarities between cultures. When they did, participants talked about similarities as related to structure and outcome. A participant stated that teaching structure exists in both Western-type and Hawaiian-type of programs; however, “[…] applying it in a cultural context where you go through the whole hoʻoponopono thing is helpful in understanding rules [… ] the end result is the same, change” (A3, 351-353). Participants also talked about the similarity
between Western and Hawaiian methods in promoting recovery. However, sometimes staff need to explain to haumāna the connection between method and outcome.

Participants described the differences between cultures in contrasting statements. We interpreted differences in terms of values, approaches, and outcomes. Participants talked about cultural conflicts between staff and haumāna when staff did not practice organizational values. In addition, haumāna noted the difference in values when comparing other treatment programs with Hui Ho‘ola o Na Nahulu o Hawai‘i. “When come ovah here, they more welcome kine. Some places, you no like go because dey no more aloha. But you need da help” (H4, 271-273). The organization takes a holistic approach to help haumāna. Instead of focusing only on relapse prevention to reduce criminality, the organization strengthens the capacity of the haumāna in life. When reflecting on other treatment programs, a haumāna stated, “Teach me how to be more smart and not to get caught. Nottin about yourself, what you like become, what you like from your life?” (H4, 271-273). Outcomes or indicators of success are measured in a variety of ways. A few unintentional outcomes were mentioned by participants as indicators of haumāna engagement that differed from other treatment programs such as haumāna eagerness to come to treatment, their willingness to arrive early, and the incessant conversations they have with staff throughout the day.

Integration. Integration or blending Western and Hawaiian cultural approaches has been an organizational lesson learned in: 1) funding, 2) staffing, 3) services/practices, and 4) evaluation. As the organization obtained State funding, they hired a clinical coordinator to strengthen clinical outcomes and review organizational policies and procedures. Another lessoned learned was staffing and the longstanding dilemma of
whether to hire culturally strong practitioners and teach them clinical knowledge, or hire clinically strong providers and teach them cultural knowledge. Through years of struggle, the organization’s lesson learned is to hire culturally strong individuals and then teach them the clinical knowledge, if needed.

Integrating Western services and Hawaiian practices has also been a challenge. Through trial and error, the organization cross-walked certain practices such as curricula based on Native Hawaiian concepts with Western-types of interventions such as Cognitive-Behavioral Therapy. Additionally, the practice of hoʻoponopono was cited by staff as the primary enhancing service integrated with therapy and counseling; however, the term “hoʻoponopono” was not commonly cited by haumāna. Last, participants also cited that while there are many instances in which the two cultures blend, there are moments when they do not. When this occurs, the organization’s philosophy is to adhere to the Hawaiian culture in decision making.

_Evaluation._ Even though the organization conducted a program evaluation on Hui Hoʻola o Na Nahulu o Hawaiʻi, program staff described the need for an evaluation grounded in the Hawaiian culture to understand the extent to which relationships, services, and practices are helpful. A staff noted that a benchmark that needs to be evaluated is when alumni return and ask for help with their homework and other life tasks. Another staff talked about the need to evaluate the cultural curriculum at Hui Hoʻola o Na Nahulu o Hawaiʻi so that it can move to the level of an evidence-based practice. Still, the challenge of approaching the previous program evaluation from only a Western epistemic worldview is illustrated by the following comment. “[…] they hired Western-wise so dey went make everything Western” (P, 493-496).
**Organization.** We interpreted organization as a multi-dimension concept that included: 1) planning, 2) implementation, 3) *wahi pana* or a sense of place, 4) training/mentorship, and 5) treatment environment.

**Planning.** Planning included the process of engaging stakeholders to address substance use on Hawai‘i Island. Community participation was a key factor in planning and a Policy Steering Committee (PSC) of stakeholders was developed to guide the planning process. The PSC kūpuna named the program, enforced community rules, and led the planning process. The PSC determined the program’s location, philosophy, and type of NHCPs.

**Implementation.** Implementation included the initial start up of the program and practices, and the ongoing use of these practices over time. The program was implemented as a cultural healing center located in the high drug use area of Pahoa. As a healing center, there were no formal admissions and discharges, and the four NHCPs implemented were: 1) ho‘oponopono or resolving relational conflicts, 2) la‘au lapa‘au or medicinal medicine, 3) *lomilomi* or massage, and 4) *mo‘olelo* or storytelling. Support from the organization’s administration was a contributing factor to the continual use of NHCPs. The Board of Directors made a decision to support the executive director in any organizational activity that was ‘pono’. The role of the executive director, as she defines it, is to not interfere but act as liaison between the Federal and State governments and the Program.

**Wahi pana or a sense of place.** We interpreted the reoccurring references to a community within a geographic area as *wahi pana* or a sense of place (McGregor, 2007). *Wahi pana* locates knowledge to a specific area. In their description, participants
recognized that community people bring place-based knowledge, contributing to the planning, leadership, and program implementation. From wahi pana come the kūpuna who bring cultural knowledge specifically practiced in certain areas. As a wahi pana, each community has a shared responsibility for sobriety by connecting that which is being promoted in the program (e.g., healing and sobriety) to community activities (e.g., a clean and sober activities). "[...] we need to have Hawaiian activities that are connected to Hawaiian groups, civic groups, paddler groups…” (A3. 400-401).

Training/Mentorship. We understood training/mentorship as reconnecting the organization to the Hawaiian values and beliefs through continual applied learning opportunities for staff by annual retreats, practicing values once a month, and working shoulder to shoulder with haumāna and with kūpuna. Practice effectiveness seemed related to the depth an organization and its leadership are connected to the Hawaiian culture.

[…] you can’t do culture a little bit. It’s not effective. You have to go deep into the culture. When you go deep, then you see positive healing. So, the agency leaders need to get involved and need to be able to see the outcomes, whether it is visiting […] the Hui (Hui Ho‘ola o Na Nahulu o Hawai‘i), or going down to Waipi‘o Valley. You have to be there. It can’t be explained to you (A1, 747-753).

Treatment Environment. Participants talked about having options in the treatment environment that are not available in other programs. These options were described as working the ‘āina, practicing oli, making ‘ohe kapala or applying designs on ceremonial garments, and working with kūpuna. Kū Aloha Ola Mau teaches haumāna to remain
connected to the origins of the practice, its protocol, utility, and purpose. By comparison, a participant commented that NHCPs are practiced in Hawai‘i without truly understanding its substance. “We kept the activity but we lost sight of the focus” (A212).

**Kūpuna (Elders).** Kūpuna or Native Hawaiian elders functioned as key personnel involved in major organizational processes. The roles of kūpuna ranged from planner and community enforcer to practitioner and organizational leader. For example, as a practitioner and organizational leader, kūpuna lead ho‘oponopono sessions when staff separated from the organization. When planning a community program, one participant stated the importance of finding a kupuna, “Go find your kupuna and then go out and talk to your kupuna in the community you plan to have your hale (facility) at [. . .], they will know what the program needs and they will guide you” (A4, 480-484). Yet, participants acknowledged kūpuna who have deep cultural and spiritual knowledge are a finite and increasingly scarce resource.

**‘Āina (Land).** “Aloha mai no, aloha aku. When love is given, love should be returned” (Pukui, 1983). This ‘ōlelo no‘eau describes the mutual exchange inherent in traditional Hawaiian relationships. ‘Āina was described by participants from this relational perspective of giving and receiving. Thus, we interpreted ‘āina as ‘that which feeds and that which we feed’. Participants talked about giving back to, helping with, caring for, planting, and communicating with the ‘āina. “You plant em, take care of em, just like one baby, grow good. Go dere every time, talk to em, its real stuff” (H1, 413-414). Participants also described how they received or benefited from ‘āina-based activities. For example, benefits of working the ‘āina were described by haumāna as a
calming effect, as a privilege to care for the plants, and as a place where they practiced new principles and morals.

**Values.** We interpreted values to include principles that teach or reinforce a healthy and holistic way of living. Asking permission was a key value practiced at the organization through daily oli or chant, when entering the ‘āina, and when working with kūpuna. For example, staff and haumāna engaged in the morning He Mu oli that served several purposes: a) to ask permission to begin a new day, b) to focus on the task at hand, and c) to shed or “He Mu” negativity. Learning and reinforcing values were sometimes described by participants as attitudinal and behavioral changes.

Like sometimes you see one mango tree on side of da road […] my first thought was, “wow, that ting growing over da side of da fence. Brah, if its ovah […] load em up, pickle mango (laughter).” But, now I have different feelings to want to ask like anything else, ‘oh my braddah, I can borrow dis?’ Dat’s da principle. Den, “mahalo” (H1 470-475).

Likewise, the organization expected staff to practice certain values such as aloha and respect. For most staff, it was not a problem because they came with these values. For others, it led to their separation from the organization.

**‘Ohana (Family).** ‘Ohana or family was a key finding cited across all focus groups and interviews. The organization uses a kinship type of approach that perceived everyone involved in the program as ‘ohana. Participants talked about ‘ohana in relationships, as space, and as a treatment philosophy.

**Relationships.** ‘Ohana-type of relationships was fostered in the organization among staff, among haumāna, and between staff and haumāna. Participants expressed
how they strived to operate as a healthy ‘ohana through love and respect. To reinforce ‘ohana-type of relationships within the organization, policies depict the role of staff as a parent to the haumāna. Staff had the responsibility to nurture and mentor haumāna as one would with their child, and haumāna have the reciprocal responsibility to listen and learn. “[…] coming to da ‘ohana people make me feel wanted, loved, and you get trust and can open up a little, more than I usually do” (H1. 201-205).

Space. We interpreted space to include both material space such as a building and immaterial space such as time. The physical building of the program is a free-standing home in Puna, Hawai‘i from which services are provided. For the organization, the choice of operating a treatment program from a home was purposeful as it provides a comfortable and familiar setting. Space also included temporal space. Relationships were viewed from a lifetime perspective rather than limited to a treatment episode. For example, once haumāna develop a relationship with kūpuna, it cannot be broken regardless of program status. Also, the organization believes that haumāna will always be part of the ‘ohana, even after death. Space, both the physical and the temporal, was nicely captured in the following illustration. “So everybody will ‘come home’. Dat’s why da hale, very homey. And everybody tends to come home on Christmas, holidays, on their birthday. Thanksgiving is a big deal. Summers too” (A4. 490-494). From this lifetime perspective, ‘coming home’ makes sense.

Treatment philosophy. As a treatment philosophy, a family-centered approach is emphasized by the organization to encourage participation by family members of haumāna in prevention, certain treatment services, and during haumāna graduation. The
organization’s philosophy is to treat the whole family to assist them to reunite and heal together.

ʻŌlelo (Hawaiian language). Participants described the practice of ʻōlelo or the Hawaiian language in terms of its perceived benefit. For example, learning the language helped participants focus on their treatment, connect to family, and begin a journey of self-discovery. While describing their experiences with ʻōlelo, most participants did so in a sentimental and/or emotion way. “[…] reminds me who I was and who I used to be. Remembering what I used to know. Ever since drugs came into my life, I kinda like forget [.. […] give me more encouragement to finding myself” (H4, 573-578).

Practices. We interpreted practices to include certain dimensional aspects of NHCPs. Dimensional aspects included how it was practiced, what it taught, and what it emphasized. For example, participants explained that pule or prayer was the most important component in hoʻoponopono and laʻau lapaʻau or medicinal herbs; hula taught structure; and lomilomi emphasized the here and now, since healing can only occur in the present. The practice of hoʻoponopono and the perceived etiology of the issue was described by a participant as,

The hoʻoponopono or the peeling away, there’s a whole bunch of other stuff. Layers and layers that’s piling up on them. Not because of the drugs, but because they are lost. One kupuna said [...] ‘uhane hele? The spit flew, the spirit left (A4, 167-170).
<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legality</td>
<td>Dimension of organization climate that contributes to a safe and welcoming environment for haumāna.</td>
</tr>
<tr>
<td>Persevere</td>
<td>Organization philosophy to support cultural programs in the face of adversity and change.</td>
</tr>
<tr>
<td>Resistance</td>
<td>Organizational challenges to cultural practices from staff, haumāna, and research evaluators.</td>
</tr>
<tr>
<td>Genealogy</td>
<td>A process of discovering, representing, and connecting to a person’s identity as expressed in the question, “Pehea kou piko?”, or, who are your ancestors?&quot;</td>
</tr>
<tr>
<td>Transportation</td>
<td>An organization resource that helps haumāna in their recovery.</td>
</tr>
<tr>
<td>Funding</td>
<td>An organization resource that often limits cultural practices.</td>
</tr>
<tr>
<td>Naming</td>
<td>Names connect a person to a place, another person, and/or destiny.</td>
</tr>
<tr>
<td>Culture Shared/ Modeling</td>
<td>Reciprocal sharing of aloha (love and affection) and cultural knowledge. As haumāna gain tools in recovery, they share these with their ’ohana.</td>
</tr>
<tr>
<td>Professional Kuleana</td>
<td>Staff responsibility to possess attributes of pono or good and moral, and spirituality in order to promote healing.</td>
</tr>
<tr>
<td>(Responsibility)</td>
<td></td>
</tr>
<tr>
<td>Cultural Kuleana</td>
<td>Staff responsibility to conserve Native Hawaiian cultural knowledge and practices for the purpose of perpetuity.</td>
</tr>
<tr>
<td>(Responsibility)</td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td>Believing in and connecting to a universal life-giving force. Spiritual dimensions manifest in physical signs and symbols. The core of the work with haumāna is to connect them to a life-giving force.</td>
</tr>
<tr>
<td>Recovery</td>
<td>A multidimensional concept identified by haumāna to include a life philosophy, a process to achieve holistic life goals, outcomes of abstinence, and relationships.</td>
</tr>
</tbody>
</table>
Hawaiian Culture

Predominant beliefs include the importance of relationships in the physical and spiritual worlds, the emphasis on a communal orientation, and the ability of the culture to heal modern day problems like substance use. The primary method of learning is through a hands-on approach within a group setting focused on a specific activity.

Self-Identity

Self-identity in relation to the dimensions of loving self and others, self-discovery, and divine purpose.

Equality

Relationships are based on equality, non-judgment, and mutual respect.

Western Culture

This subtheme compares and contrasts Western Culture with the Hawaiian Culture. Areas of integration and need are described.

Organization

Organization is a multidimensional concept that included planning, implementation, a sense of place or wahi pana, training/mentorship, and treatment environment.

Kūpuna (Elders)

Kūpuna function as key personnel involved in major organizational processes. Kūpuna also maintain numerous roles within the organization and with the community.

ʻĀina (Land)

ʻĀina or land was described from a relational context of reciprocity and is interpreted as ‘that which feeds and that which we feed.’

Values

Values or principles that teach or reinforce a healthy and holistic way of living. Asking permission was a key value practiced daily at the organization.

ʻOhana (Family)

The organization uses a kinship type of approach that treats everyone in the program as ʻohana. ʻOhana is described in relationships, as space, and as a treatment philosophy.

ʻŌlelo (Hawaiian Language)

A practice that helped participants focus on their treatment, connect to family, and begin a journey of self-discovery.

Practices

Dimensional aspects of NHCPs that included how it was practiced, what it taught, and what it emphasized.
Table 5

Themes and Collapsed Subthemes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
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</thead>
<tbody>
<tr>
<td>Pilialoha</td>
<td>Legality</td>
</tr>
<tr>
<td>Loving Relationships</td>
<td>Culture Shared/ Modeling</td>
</tr>
<tr>
<td></td>
<td>Professional Kuleana (Responsibility)</td>
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<td></td>
<td>Cultural Kuleana (Responsibility)</td>
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<td></td>
<td>Hawaiian Culture</td>
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<td>Equality</td>
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<td></td>
<td>‘Ohana (Family)</td>
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<td>Kūpuna (Elders)</td>
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<td>Spirituality</td>
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<td>Practices</td>
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<td>Values</td>
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<tr>
<td>Koho‘ia</td>
<td>Genealogy</td>
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<tr>
<td>Choice, No Choice</td>
<td>Naming</td>
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<td></td>
<td>Self-Identity</td>
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<td>Recovery</td>
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<td>Values</td>
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<td>‘Ōlelo</td>
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<tr>
<td></td>
<td>Practices</td>
</tr>
<tr>
<td>‘Ākoakoa</td>
<td>Western Culture</td>
</tr>
<tr>
<td>Integration</td>
<td>Organization</td>
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<td></td>
<td>Persevere</td>
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<td></td>
<td>Resistance</td>
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<td></td>
<td>Funding</td>
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<td></td>
<td>Values</td>
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</tbody>
</table>

**Themes.** In this section, three themes are presented and summarized in Table 5. Each theme begins with an ‘ōlelo no‘eau then a description of how it integrates the subthemes.
Theme one: Pilialoha or loving relationships. “Ua ola loko  I ke aloha. Love gives life within. Love is imperative to one’s mental and physical welfare” (Pukui, 1983). Relationships were a common theme across all evidentiary sources. As the most prominent theme, relationships describe the connections and associations people maintain with each other (human realm), with places (earthly realm), and with spirituality (spiritual realm). While the Hawaiian word for relationship is pilina, participants described a certain type of relationship, one which was characterized with love. Therefore, pilialoha best represents the narratives of participants. Thirteen subthemes are integrated into the theme of pilialoha and include legality, culture shared/modeling, professional kuleana (responsible), cultural kuleana (responsibility), culture, equality, ‘ohana (family), kūpuna (elders), ‘āina (land), spirituality, recovery, practices, and values.

Treated in a safe, respectful, and welcoming manner were cited by haumāna as reasons for engaging in treatment. As haumāna experienced healthy ‘ohana-type of relationships based on these values, they wanted to emulate them in their lives. Similarly, staff talked about their kuleana to be pono as a way to prepare to touch another life.

Relationships with places were described by participants through ‘āina-based learning and activities in which they took care of the land and in turn, the land was a place where haumāna applied new morals and practiced new values. As a staff stated,

We teach dem about land and its sacredness, we teach dem wahi pana and how important it is to malama da ‘āina […] our own evaluation of how they show some progress […] dey stop throwing cigarettes butts on da ground […] we don’t have to put signs say ‘don’t throw dat’, dey get da internal […] da kaona or
da deeper meaning of how important da land is so they don’t want to throw, cuz get lotta connection to da culture (P, 431-437).

As a free-standing house, the treatment facility was a welcoming environment to which haumāna felt comfortable to “come home”.

Spiritual relationships were reinforced as participants learned the responsibilities of carrying an ancestral name or practicing to ask permission before engaging in cultural activities. Similarly, transcending the confines of the physical self and becoming part of another person or object took on a spiritual meaning as described by participants who activated the life force of a plant to join it spiritually.

**Theme two: Kohoʻia or choice, no choice or identity.** “He meheuheu mai no kūpuna. Habits acquired from ancestors” (Pukui, 1983). Kohoʻia is the Hawaiian word for choice. “My mother use to say, you have a choice, but you really have no choice” (B. Jenkins, personal communication, March 30, 2007). What Aunty Betty Jenkins was describing was destiny, a reoccurring concept expressed by participants in shaping their identity. To understand this concept, we first place it within the Hawaiian world in which the piko or un-severed spiritual umbilical cord ties Hawaiians to their ancestors. Within this cord that connects the past with the present and future, flow the sources of knowledge, skills, and habits from ancestors (Blaisdell, 2009). While this may seem improbable in other cultures, it is possible within the Hawaiian culture. Seven subthemes were collapsed to represent the theme of kohoʻia and include genealogy, naming, self-identity, recovery, values, ʻōlelo, and practices.

Identity is defined as a process of connecting, discovering, and representing self in the context of others that in itself, or as a result, provided participants with a purpose in
life. Self is an inclusive term to mean an individual, group, or organization. For the individual, she/he has the capacity to access ancestral resources in shaping identity because it is part of her/his DNA. Discovering who ancestors were, what they were named, and from where they came were positive experiences for haumāna in discovering a healthy identity without drugs and alcohol. By walking in the past (e.g., genealogy), cultural activities connect a person to the present (e.g., identity) and to the future (e.g., destiny). While groups and organizations may not necessarily have a genealogy per se, the gift of a name can be transformative. Kū Aloha Ola Mau, formerly Drug Addiction Services of Hawai‘i, received its name which means to stand tall in order to perpetuate healing and restore healthy lives. Kupuna Aunty Abbey Napeahi warned them to be careful in choosing a name because it is the name that you will become. If you put a negative in front of the name like Addiction, you will be seeking addiction, you will have no other choice.

**Theme three: ‘Ākoakoa or integration.** “‘Unu mai a ho‘unu‘anu‘a ke kilu o Kalama‘ula, ho‘ole‘ale‘a i ke kaha o Kaunalewa. Bring all the kilu for amazement at Kalama‘ula to make merry on the field of Kaunalewa. To come together for a gay time and bring whatever you have to add to the fun” (Pukui, 1983). I selected this ‘ōlelo no‘eau because it describes the different contributions made for a specific purpose.

‘Ākoakoa or integration is descriptive of the organizational processes of Kū Aloha Ola Mau. While the standard use of term ‘ākoakoa is to assemble or gather, we interpreted it on an organizational level to indicate the gathering of many components for the purpose of integration. Seven subthemes were integrated into ‘ākoakoa and included Western culture, organization, persevere, resistance, transportation, funding, and values.
Throughout the organization’s development and growth, participants talked about the differences and similarities when two worldviews join. For example, participants talked about the importance of asking for permission within the Native Hawaiian culture and how this was not an emphasized practice in the Western culture. While the purpose is integration, there are points in which they do not blend which can result in tension, as is illustrated in the following narrative,

Every time she (haumāna) hug you, she like squeeeeeeze you! She like pick me up off da ground, like. Anyway, her counselor, she had one Masters Degree, she had problems, she no like hug. One time, da haumāna came, it was her graduation, and she went fo hug her and she said, “no, no, no, don’t grab me like dat.” Oh, brah, da haumāna took it negatively, had one major confrontation. She was majorly hurt. That was one thing with that particular counselor and she eventually chose to leave. Some counselor, dey no like hug nobody (P, 589-598).

Participants spoke about community-based knowledge and resources such as the concept of wahi pana that shaped and guided the organizational processes of planning, implementation, training, and evaluation. Organizational resources were described as facilitators or barriers to participants. As a resource facilitator, transportation was consistently cited by participants as a factor that contributed to their recovery. Funding, both insurance and grant generated, was primarily cited as a barrier, but it also provided benefit to haumāna and the organization. The organization’s philosophy, primarily generated by its leadership and shared by the staff of Hui Ho‘ola o Na Nahulu o Hawai‘i, was spiritually inspired and offered hope and provided perseverance to the organization.
when challenged with funding and staffing issues. As with all organizations, resistance to the use of a new innovation such as NHCPs is a natural milestone in its development.

Table 6

Themes

| Theme                | Descriptor                                                                                                                                 |
|----------------------|---------------------------------------------------------------- Adam removed duplicate info. |
| Pilialoha             | As the most prominent theme, relationships describe the connections people maintain with each other (human realm), with places (earthly realm), and with spirituality (spiritual realm). |
| Koho‘ia               | Identity is a process of discovering self in the context of others through cultural practices of genealogy and names. |
| ‘Ākoakoa             | ‘Ākoakoa or integration is descriptive of the organizational processes of Kū Aloha Ola Mau. The differences, similarities, and areas of integration are highlighted within an organization that uses both Hawaiian and Western cultures. Organization resources, barriers, and a driving philosophy are described. |

After analyzing the three themes, we further reduced the themes into one overarching theme. Again, we did not force the data; instead, the overarching theme emerged from the themes through the process of going back and forth between the codes, subthemes, and themes.

**Overarching theme: Pili‘ana or connection.** Pili‘ana or Connection is the overarching theme and is expressed as “Hānau ka ‘āina, hānau ke ali‘i, hānau ke kānaka or the land, the chiefs, and the commoners belong together” (Pukui, 1983). Connection incorporates the three themes of pilialoha, koho‘ia, and ‘ākoakoa.
At the nexus of the Hawaiian culture are relationships that connect haumāna to staff, staff to kūpuna, and haumāna to community. Yet, participants talked about the giving and receiving that transcended the human realm, and were experienced by working with the ʻāina and by joining the spiritual life force or mana of objects. A continual movement of asking permission, engaging, and mutual benefit seemed to bind people, land, and the spiritual realms together. Kohoʻia or identity was a process of finding self-worth, responsibility, and a divine meaning that united people to a larger purpose in life. Participants frequently talked about the significance of names and genealogy as ways of linking to a person’s identity as a positive, reinforcing factor in their lives. The notion that destiny was almost predetermined was cited by participants from which we interpreted kohoʻia or as a participant stated, “choice, no choice” (P, 1147-1148). Desired goals in recovery included abstinence and good mental health, but haumāna largely identified more holistic life goals aimed at re-establishing a person’s identity with the family and community.

ʻĀkoakoa or integration was the coming together of many parts that made up the whole organization. Respecting differences and similarities from two distinct worldviews offers a helpful perspective aimed at drawing out the best of both Western and Hawaiian cultures. Of particular value is staff trained in both cultures who act as cultural translators within and outside the organization. Staff that possess the cultural knowledge and substance use credentials are a great resource to the organization in meeting funding requirements and in raising the organizational level of cultural knowledge by training and mentorship of other staff. A clear philosophy by an organization’s leader provides an
overarching context from which to understand changes, both positive and negative, throughout an organization’s life.

**Vetting – Returning to Participants.** I returned to the participants on May 10, 2011 at Hui Ho‘ola o Na Nahulu o Hawai‘i to solicit feedback on the initial findings. Participants unanimously agreed the subthemes, themes, and overarching theme represented their lived experiences at Kū Aloha Ola Mau and at Hui Ho‘ola o Na Nahulu o Hawai‘i.

When I explained ‘what we did’, participants had no questions about the research process of data collection and analysis. When I explained ‘what we found’ in the interpretation of the data, an administrative staff asked, “what is included in resistance?” I reviewed the codes interpreted as resistance and asked if the participant and others had thoughts about it. The administrative staff stated, “no, no, that describes it!”

In the first theme of pilialoha or loving relationships, a haumāna participant agreed and stated, “[…] dis place always welcome me with one open arms; …need to talk to somebody, you can call. I feel dat right what you saying.” When I discussed the second theme koho‘ia or choice, no choice all participants agreed with what the data represented. In fact, a haumāna offered his confirming remarks, “choice, no choice, dat one deep meaning we use ovah here teach us who we are and where we going.” In theme three, ‘ākoakoa or integration, a haumāna offered the following comment about staffing, “Yup, dat’s da line right deh. Dat, dat […] client and […]” He agreed with Kū Aloha Ola Mau’s current organizational practice and policy that emphasized hiring staff who possess cultural knowledge over clinical knowledge and in doing so, cultural conflicts between staff and haumāna can be minimized. At the end of the meeting, staff offered
comments that confirmed the findings. “Now we finally have something that represents us” and "when I first saw 'connectivity', I thought, huh? Then it dawned on me, yes, that is it, connections to each other and spirituality. Everything is spiritual." To clarify her comment, we initially interpreted the overarching theme as ‘connectivity’; but, after the input from participants at the vetting meeting, I revised it to ‘connections’ as this word had more relevance to participants.

Returning the data to the participants was one method to increase confirmability by having multiple set of eyes reviewing the findings, by sharing the extent to which the findings reflected their experiences, and by offering it in a setting that allowed participants to see and question my intentions and sincerity through kūkākūkā or face to face discussions.

**Research Questions**

This section addresses the five research questions. While questions vary in nature, findings are applicable to more than one question. Furthermore, the questions focus on the implementation of the program in which NHCPs are embedded rather than the implementation of separate practices.

**Question one.** Why and how did an organization identify, develop, and implement NHCPs in the treatment of substance use and co-occurring mental health disorders?

Since the question consists of two sub-questions of why and how, I will answer them separately. Why the organization of Kū Aloha Ola Mau decided to identify, develop, and implement NHCPs seemed to be influenced by external and internal factors. External factors included political pressure and community involvement. In 1995,
Hawai‘i’s Congressional Senator Inouye provided funding to strategically plan how best to address substance use in the high-use area of Hawai‘i Island. The funding guidelines were non-prescriptive and allowed the organization and the Hawai‘i Department of Health to approach planning, development, and implementation with Hawai‘i Island communities in a culturally thoughtful way. Because of the level of trust and buy in, community members, particularly kūpuna, were invested in the process and influenced the identification of NHCPs. Kūpuna named the program “Hui Ho‘ola o Na Nahulu o Hawai‘i” to mean “the group that gives life and healing to the people of Hawai‘i”. They insisted that if the name is what the program will become, as discussed in the concept of koho‘ia, then Hawaiian cultural practices must be offered. As suggested in the name, kūpuna believed that healing, not treatment, would best address the issue of substance use.

The most influential internal factor was organizational leadership. The executive director advocated for the funding to be channeled to Hawai‘i and seemed to negotiate with the Hawai‘i Department of Health to engage communities into a strategic planning process to determine how best to use the funding on Hawai‘i Island. Believing that the Hawaiian culture and its spirituality heal, she supported the kūpuna recommendation to use NHCPs and spirituality as the core of all services offered to clients. Additionally, it also seems that because of her years of collaboration with Hawaiian communities, she believed in the concept of wahi pana or a sense of place to determine the needs of geographic communities. Wahi pana was incorporated into the planning process by acknowledging the place-based capacities of communities, encouraging the participation of kūpuna from different districts, and integrating place-based knowledge and spirituality
into the new program. In summary, the study indicated that political pressure, community involvement, and a strong leadership influenced why the organization identified, developed, and implemented NHCPs to address substance use and co-occurring mental health issues.

The second part of the question focuses on the “how” or the process the organization used to identify, develop, and implement NHCPs. First, as stated, federal funding, supported by Hawai‘i’s Senator for a three-year period, provided the impetus to initiate the process. Second, the organization recognized the worth and capacities of communities to lead the process by incorporating place-based knowledge and resources into the planning. Guiding the process was community kūpuna. Third, to facilitate the stages from identification to implementation of the program, a Policy Steering Committee (PSC) led by kūpuna determined the following: 1) the type of program, 2) program’s name, 3) location, and 4) types of NHCPs to be offered. The program was implemented as a healing center in Pahoa, Hawai‘i in 1997 and offered four NHCPs. In summary, guiding the process to identify, develop, and implement NHCPs was federal funding, incorporation of community capacities, and a planning committee to effectuate the work.

**Question two.** What Native Hawaiian Cultural Practices were implemented and where did they come from?

Kū Aloha Ola Mau implemented the four NHCPs of ho‘oponopono or resolving relational conflicts, la‘au lapa‘au or medicinal medicine, lomilomi or massage, and mo‘olelo or storytelling. In reality, the practices did not come first; instead, the kūpuna came first then the practice followed. Four community-based kūpuna were hired by Kū
Aloha Ola Mau in their new program and each kupuna brought with them a cultural practice that was offered to clients.

**Question three.** What key organizational factors influenced the identification, adoption, and implementation of these NHCPs?

A broad range of factors impact the diffusion of a program innovation (Simpson & Flynn, 2007). Key organizational factors based on the Innovation Implementation Framework posited by Simpson and Flynn (2007) are used to describe the stages of identification, adoption, and implementation of NHCPs. Since the framework does not include an adoption stage, I describe the planning and preparation stages in lieu of an adoption stage.

**Identification stage.** The identification stage was largely influenced by the three key factors of: 1) political influence, 2) structural approaches, and 3) organizational leadership. First, Hawaiʻi’s Senator Inouye provided the impetus to address substance use by spearheading federal planning funds to Hawaiʻi Island. Second, structural approaches were utilized that emphasize relationship building to engage communities in a culturally appropriate manner and included the following four processes: a) face to face meetings in a geographically neutral area to listen, clarify, and build consensus, b) hoʻolauna or the Hawaiian practice of introduction to acknowledge connections and spirituality, c) Assets Mapping (Minkler, 2005) to foster community ownership by incorporating wahi pana or the place-based capacities and resources such as kūpuna and spirituality, and d) a Policy Steering Committee of community members as a planning entity to develop and follow-through with a strategic plan. Third, organizational
leadership, to a large extent, advocated for the funding to be used to engage communities and influenced the structural approaches employed.

Adoption stage. Adopting a program innovation includes the organizational steps of goal specification, action planning, and evaluation of progress. Four key factors were identified during this stage as: 1) adequate time to build relationships, 2) naming, 3) align form with function, and 4) kūpuna as leaders. First, an extended period of time was needed when working collaboratively with communities to develop trust, determine community interests, and solidify working relationships. Second, the process of naming as an element of koho‘ia was a key factor that provided a direction for the planning committee to help define the nature of the innovation. Third, aligning the program’s function or the proposed types of services with its form as a cultural healing program helped the PSC to evaluate its progress. Last, community kūpuna were instrumental in facilitating the stage of adoption by determining the commitment level of partners, giving the program its name, and providing the evaluative question of pohō wale or assessing the extent to which efforts are done in vain. Kūpuna stated, “if we have a Hawaiian name […] why are we not doing cultural […] Pohō to have this and we are doing a different way. A Western way” (A4, 80-82).

Implementation stage. The stage of implementation included four steps: 1) training, 2) adoption, 3) implementation, and 4) practice improvement. The key factors in the first step of training included: 1) utilizing internal staff as trainers of culture, 2) working side-by-side as equals, 3) leadership, and 4) regulatory body. Training was minimal at initial implementation since the organization hired staff with a high-level of competency to implement the program. However, over time, training needs emerged as
the organization sought additional funding and began to integrate Western addiction treatment and NHCPs. To upgrade staff knowledge and skills in both Western treatment approaches and NHCPs, the organization annually hosts a two-day cultural retreat. The key factor of utilizing the staff of Hui Ho'ola o Na Nahulu o Hawai‘i as cultural experts to assist with the retreat acknowledges the internal capacities of the organization, ensures the training is relevant, and provides a low-cost solution. Another key factor to upgrade staff cultural skills is to work shoulder to shoulder with kūpuna and haumāna. This is based on equality in relationships, the expectation that everyone participates in program activities, and the Hawaiian method of learning that emphasizes physical participation and demonstration. Another key factor is organizational leadership to promote a climate that is open to change. Last, findings indicate licensure and accreditation are key factors that limit the on-going use of NHCPs.

The second step of adoption includes the decisions and actions that an organization takes to achieve institutional commitment to an innovation. Key factors include: 1) leadership and 2) community sanctioning. Leadership was a key factor in the decision phase of adoption. The board of directors supported the executive director to pursue funding that aligned with the concept of pono or goodness and morality (Pukui, 1983). Additionally, the executive director strongly believed the Hawaiian culture is a healing culture that can resolve present-day challenges such as substance use. In the action phase, organizations generally assess the quality and utility of the innovation by testing it out in a real world setting. The findings indicate that the key factor of community sanctioning of a healing center was an alternative “testing out” and legitimate validation to its quality and utility.
The third step of implementation involves the appraisal of the program over a longer period of time to address its effectiveness, feasibility, and sustainability. Key factors included: 1) tracking effectiveness through non-empirical methods, 2) leadership philosophy, and 3) hiring a clinical coordinator. Effectiveness was initially tracked by casual observation, intuition, and self-reports from consumers. Leadership belief that funding must fit the organizational philosophy emphasizing the concepts of pono and healing influenced the types of funding pursued. Over time, to address sustainability, the organization integrated Western-type addiction services with NHCPs. State funding was secured that required measurement of clinical outcomes. A clinical coordinator was hired to: 1) strengthen the integration between Western services and NHCPs, 2) bridge communication among policy makers, funders, community providers, and program staff, 3) develop policies and training reflecting the integration, and 4) track effectiveness utilizing standard addiction instruments.

The key factors in the final step of practice/program improvement were: 1) organizational commitment, 2) ‘ohana-type of relationships, and 3) a fee-for-service grant. As a program is routinely implemented, the presumption is that measures of client outcomes are tracked and costs associated with the innovation are evaluated. The key factor of organizational commitment supported the allocation of resources to develop a fuller body of evidence of non-empirical (e.g., intuition) and empirical (clinical outcomes) indicators of haumāna success. Integration of Western-based treatments with Hawaiian practices necessitated the tracking of clinical outcomes of addiction. To date, the program maintains strong treatment outcomes and recognizes a need to evaluate the program culturally.
As an indicator of success, consumer engagement in treatment was fostered by the key finding of ‘ohana-type of relationships. Relationships between staff and haumāna were beneficial to haumāna as they reinforced healthy behaviors through staff modeling and provided stable relationships over time. Haumāna often described “returning home” to the program even after treatment completion. Last, a fee-for-service type of grant in which certain negotiated services are paid at a specific fee was a key factor. While this type of funding allows the organization to determine its own level of staff productivity, it does not guarantee that routine costs associated with the program are covered. Furthermore, in economic periods of austerity, this arrangement leaves the program and organization vulnerability to shifts in funding priorities on state and federal levels.

**Question four.** How has participation in NHCPs helped and/or hindered haumāna in their recovery outcomes?

The findings suggest that pili‘ana or connections helped haumāna in their recovery. Four key factors helped haumāna maintain connections in their recovery: 1) utilizing the concepts of lōkahi and pono, 2) fostering pilialoha or loving relationships, 3) teaching and reinforcing healthy behaviors, and 4) finding koho‘ia or identity.

Isolation was a common experience described by haumāna from years of drug use and poor mental health. Personal, social, and communal needs were often ignored as drugs and alcohol became the most important need to fulfill. As a result, haumāna were often disconnected from systems of support. By teaching the key concepts of lōkahi and pono, haumāna social and collective harmony were strengthened by achieving personal balance of mind, body, and spirit (pono), then aiming for a balance of self within the collective relationship with universal dimensions of spirituality, environment, and
humankind (lōkahi). Participation in NHCPs helped haumāna to heighten their spiritual awareness, deepen their connection to the natural environment, and amend and foster familial and social relationships. Maintaining social and collective harmony was described by haumāna as giving back, passing on, and mentoring other individuals in their life.

As a key finding, pilialoha or loving types of relationships were helpful to haumāna. Pilialoha was modeled by staff as it fostered trust, openness, and a feeling of ‘ōhana or family. In their narratives, haumāna frequently cited loving ‘ōhana type of relationships as a transformative force that helped them stay motivated, return for treatment, and share with staff honestly.

In another key factor, the study indicates that NHCPs were beneficial to haumāna as a mechanism to teach and reinforce healthy values by nurturing the life of the haumāna so that the haumāna could contribute to familial and societal life. Recovery outcomes for most haumāna included a wide range of holistic life goals. In order to achieve recovery outcomes, haumāna needed to “erase and replace dose tings” (H4, 118-119) like unhealthy values with healthy values. For example, the findings indicate that ‘āina-based learning through the Hawaiian method of passing on knowledge of “you do first, den learn later” (P, 1021) helped transform and restore haumāna connections to communal life. Haumāna developed a healthy code of conduct with the ‘āina and then applied this code to govern relationships with people.

Another key finding helpful to haumāna was the concept of koho‘ia or identity as experienced in the NHCPs of naming and genealogy. By understanding meanings inherent in names and by learning about past ancestors, haumāna drew strength and mana
or personal spiritual power from these practices that enhanced their identity and gave meaning and purpose to their life.

The findings also indicate one downside to pilialoha as described by a haumāna who intentionally relapsed to remain in the program. While we did not explore this narrative further, it does raise the question as to the extent loving-type of relationships may impact haumāna unfavorably, especially given some of the issues previously described such as social isolation. This may indicate a possible need to develop a component to foster sobriety supporting natural niches in the larger community.

**Question five.** How are NHCPs related to the five Native Hawaiian Community Best Practices for Culturally-Based Recovery Programs (CBPCBRPs) identified by ‘Imi Ke Ola Mau (2009) in the treatment of co-occurring disorders?

Study findings confer the five Community Best Practices were integrated into Hui Hoʻola o Na Nahulu o Hawaiʻi as services offered to haumāna in substance use treatment. The findings also suggested applicability to individuals with substance use and co-occurring mental health disorders to the extent that 67% of the sample self-reported as having a co-occurring condition. In understanding the relationship between ‘Imi Ke Ola Mau’s framework and NHCPs, the study found areas of similarities, differences, and expanded or new knowledge. The areas of expanded and new knowledge that emerged are the focus in answering this question because they are the most contributory to the framework. The literature review section of this chapter provides a detailed discussion of similarities and differences.

As a summary, ‘Imi Ke Ola Mau’s five CBPCBRPs include: 1) integration of kūpuna, 2) use of land and sea-based sites, 3) use of cultural values and traditional
practices, 4) use of language consultants, and 5) incorporation of family and community into treatment.

The concept of pilialoha or loving relationships was a strand woven across the five Community Best Practices (CBP). The study found that relationships were described as connecting to ancestral kūpuna through genealogical work (CBP One), as enhancing the association between spirituality and ‘āina by working the land (CBP Two), as reinforcing healthy values to promote self within the context of a collective orientation to promote lōkahi (CBP Three), as using language to promote familial bonding (CBP Four), and as integrating the concept of ‘ohana into treatment by promoting ‘ohana type of relationships between haumāna and staff (CBP Five).

Four (4) expanded or new areas of knowledge were identified in the study and contribute to ‘Imi Ke Ola Mau’s framework. These areas contribute to four of the five CBPs. First, as related to CBP One, ‘Imi Ke Ola Mau described kūpuna as “holders” of culture and knowledge. The findings suggest the capacity of kūpuna extend beyond “holder” of knowledge and culture; they possess the capacity to generate Hawaiian knowledge and culture. Second, new knowledge added to CBP Two indicates that by developing a healthy code of conduct with the ‘āina, haumāna transferred this code to govern interactions with humans. Third, in CBP Three, new knowledge emerged relating to the expansive nature of values and that values are taught for the purpose of sustaining an individual within communal life. Fourth, as related to CBP Five, the findings suggest that power, which is inherent in relationships between staff and clients, is redefined from a concept based on dominance to a concept based on nurturance as described by haumāna in ‘ohana-type of relationships with staff.
Finally, absent from ‘Imi Ke Ola Mau’s framework is the identification of spirituality. While the study’s findings suggest that spirituality is an important cultural practice, it may be such that it is inherently deeply integrated into all CBPs and thus its place among all Native Hawaiian practices is common knowledge and therefore indistinguishable.

**Literature Review**

The three frameworks discussed in Chapter 2 are reviewed in this section: 1) Recovery Paradigm (Onken et al., 2007), 2) Community Best Practices for Culture-Based Recovery Programs (‘Imi Ke Ola Mau, 2009), and 3) Organizational Implementation (Simpson & Flynn, 2007).

**Recovery paradigm.** Onken et al. (2007) provide an ecological framework to understand the concept of recovery as an interaction between person-centered elements and community-centered elements. This interaction or exchange is influenced by the capacity of the person to re-author components in her/his life and the capacity of the community to provide opportunities that facilitate integration into society. In light of the study’s findings, I discuss the three components of the recovery paradigm: 1) person-centered, 2) exchange-centered, and 3) community-centered (Figure 4).

As expected, the person-centered component is the most descriptive since data were collected from individuals who were struggling with relapse and beginning to re-build personal capacity to address their addiction or co-occurring disorder.

**Person-centered elements.** A person-centered component includes a sequence of elements that lead to a person’s ability to thrive. I begin this section by reflecting on a
haumāna’s life story and his ability to thrive. Then, I sequentially discuss the paradigm’s elements and the similarities with the study’s findings.

Thriving, as the last element of the person-centered component, is the successful navigation through adversities from which personal qualities are strengthened (Onken et al., 2007). When I think of thriving, I am reminded of a haumāna who participated in the study’s focus group as a program alumnus. As he reflected back to the beginning of his recovery, he described with much pain that his life with drugs and depression was unmanageable and he “would pray dis fucking hell would end” (H1, 86). By the time I met him in the focus group his life was different. His story included a life characterized by abstinence, acceptance of his depression, self-employment, and a qualitatively better relationship with his wife and grandchildren. I wondered about the paths he walked that led him to where he is today. How did he assemble these elements of recovery to thrive?

He, like other haumāna, made conscious decisions in his life given what he thought was best. The degree to which these choices resulted in healthy or unhealthy consequences seemed less important than his ability to self-determine his story. While haumāna storylines may differ, similarities that I identified in this study can be illustrated in his narrative. First, pursuing holistic life goals can be indicators of re-building a prosperous life. This is predicated on the realization of his personal capacities (e.g., hope and self-determination) and the availability of environmental resources (e.g., supportive relationships that facilitate his navigation through systems). Second, as thriving indicates continual growth, the foundation for such growth was facilitated by his incorporation of healthy values which will be discussed in the Recovery element of Wellness. It would seem that continual use of healthy values within an environment of supportive
relationships reinforces its use and promotes thriving within society. A supportive environment can also include community functions that promote positive mental health and sobriety. Last, his philosophy about gratitude and service is integrated into thriving as a goal-directed purpose in life; for example, worship, ʻāina stewardship, and giving back to others are actions that seek lōkahi or relational harmony that gives meaning and enhances life purpose. While meaning and purpose in life are recovery elements of a Person-Centered component, what follows are other elements that are defined and discussed against the study’s findings.

**Hope.** As a resounding tenet of recovery, hope is the first element of a Person-Centered component. The findings indicate that hope was often inspired and fostered by interactions with organizational staff and ʻohana-type of relationships. Likewise, staff sharing and modeling cultural values based on inclusion and acceptance fostered a sense of belonging for haumāna, instilling a hopeful future. The sense of belonging as a catalyst to hope was also fostered by communal-type of cultural activities and by a method of learning that encouraged active participation.

The organizational belief that the Hawaiian culture heals was an agent of hope in that if culture permeates all program spaces as staff and haumāna eat together, interact together, and engage in treatment together, then they share in recovering together. This is predicated on the belief that both spirituality and culture are finely woven together at the center of treatment. Spirituality offers a pathway to cope with crises (Tanyi, 2005), feelings associated with stigma and shame (Folkman & Nathan, 2011), and existing struggles inherent in living with a substance use disorder, as well as the internal and environmental conditions that often contribute to despair (Miller, 1999). Connecting to
an eternal higher authority helps to reframe moments of despair by believing a person’s current hardship will improve (Pargament, McCarthy, Shah, Ano, Tarakeshwar, Wachholtz, 2004). The implication is that a person is never alone in her/his recovery journey; in fact, s/he shares recovery with people who are 'ohana. By practicing cultural activities together, communal healing and a hopeful future are possible.

Sense of agency. Similar to hope, ecological factors such as the influence of a supportive and loving treatment program provide the impetus for positive life changes. The drawing of confidence and strength from cultural practices that promote a healthy self-identity was a powerful experience for haumāna. By answering the question of “‘o wai ‘oe? Or who are you?” haumāna were better equipped to navigate through and mitigate barriers generated by having a substance use disorder or co-occurring disorder.

Self-determination. The study found that many haumāna, through word of mouth, chose to attend Hui Ho‘ola o Na Nahulu o Hawai‘i when given the choice over other Western treatment programs. While the reasons varied, the element of choice— in most cases to meet court ordered requirements – was present and determined by haumāna.

Koho‘ia or choice, no choice was related to self-determination. A predetermined destiny seems to contradict the notion of self-determination; however, the findings indicate that practices such as genealogy and naming connected haumāna to past ancestors, and thereby, drove them in a certain direction to want to learn more.

We found the concept of gratitude and service an important element of haumāna recovery that related to several elements in this framework. Gratitude was a feeling of deep appreciation that seemed to be linked to a behavioral component of giving back or as a haumāna stated, “Attitude is gratitude in action” (H1, 256-258). The action he
referred to is part and parcel of the Hawaiian worldview of reciprocity and mutuality. It is the lōkahi or unity that is sought by achieving balance. Within self-determination, the feeling of gratefulness and the need to serve were factors that directed haumāna to clean the ʻāina, to return as graduates to help staff, and to participate in community events on behalf of the program. This key finding suggests that a dimension of haumāna self-determination was their ability to return to serve others in fulfillment of life goals.

**Meaning and purpose.** The personal stories of haumāna living with an addiction or co-occurring disorder that lead to treatment often include a long history of hurt and pain that involved multiple systems such as Child Welfare Services, ʻohana and friends, and Courts and Corrections. Regaining a sense of direction, a life without drugs, coping with mental illness, and dealing with the consequences of past choices require re-establishing healthy and meaningful connections (U.S. DHHS, 2002). In another key finding, the study indicates that cultural practices such as genealogical work and reinforcing values of mālama ʻāina or caring for the land offered a revised perspective on life from which haumāna drew a new source of purpose and meaning. Genealogy and the discussion of the three piko or spiritual umbilical cords suggest that a person’s life, its meaning and purpose, may be predestined (Pukui, Haertig, & Lee, 1972). The concept implies a person has the responsibility to nurture the good within that destiny as it extends to her/his future generations. Furthermore, contaminating the piko through unhealthy behaviors brings shame to ancestors as well as dishonors future generations.

Infusing positive values into daily life can provide a new sense of direction. This was reinforced by ʻāina-based learning by asking for permission and treating the ʻāina
with respect. Similarly, the concept of gratitude and service provided haumāna with a new way of conceptualizing what was important and how best to utilize their capacities.

**Awareness and potentiality.** Supportive, non-judgmental relationships offer hope and provide a fertile soil upon which talents can flourish. The study found that when haumāna felt loved, they trusted and opened up to staff allowing for a process of engagement, learning, and healing. By observing, participating, and replicating behaviors in cultural practices like oli or chant, haumāna gained a sense of self-efficacy through individual and group achievement. Also, haumāna awareness increased as they experienced staff in recovery model healthy values. As a key finding, the practice of ‘ohe kapala or stamping designs on ceremonial garments for graduation honors the new identity of haumāna in sobriety and the genealogical identity of her/his ‘ohana. Therefore, graduation is a rite of passage that signifies the emerging of a new life through the reawakening of new capacities.

**Re-authoring.** Re-authoring is a transformative process of critically re-examining oppressive dominant discourses to facilitate coping, healing, wellness, and thriving for individuals with a substance use or co-occurring disorder. Study findings indicate that joining relationships as an equal partner, receiving and giving dignity, and seeking commonalities rather than differences are environmental factors that promote healing and facilitate coping. These types of intimate relationships were described in the narratives of haumāna by connecting to ‘āina, staff, and the spiritual realm. Re-authoring requires equilibrium of these external dimensions to achieve lōkahi or unity, balance, and harmony. As previously discussed in the literature, the Lōkahi Triad (Figure 5) conceptualizes the achievement of unity as a relational balance between universal forces
of Ke Akua or God, Ke Ao Nei or nature, and Na Kānaka or humankind (Rezentes, 1996). It implies that macro-level forces that contribute to stigma such as social, political, and economic structures must also be mediated to achieve a sense of balance.

While the Lōkahi Triad includes broader macro-dimensions, Paglinawan (2011) posits a second triad focused on individual attributes to achieve an inner state of goodness and morality known as pono (Pukui & Elbert, 1986). The Pono Triad (Figure 6) represents a relational balance between individual-level dimensions of Ka ‘Uhane or Spirit, Ka Na‘au or Mind, and Ke Kino or Body.

![Pono Triad Diagram]

**Figure 6.** Pono triad.

*Note:* This figure represents balance of three individual dimensions to achieve pono.

Due to the consequences of substance use and poor mental health, individual-level dimensions may be unbalanced. Spiritual connectiveness, healthy behaviors, and positive self-talk can promote balance. Realigning individual dimensions to achieve pono enhances a person’s ability to strive for balance among macro-level dimensions to achieve lōkahi, and to surmount ecological factors that contribute to stigma and
oppression. Re-authoring a new life story emerges as a person balances both individual- and macro-level dimensions to promote healing, a recovery-oriented life, and recovery maintenance.

**Exchange-centered elements.** This section describes the results of re-authoring one’s life through three exchanges of social functioning, power, and choices that recast social roles and heighten social engagement.

**Social functioning and social roles.** Positive peer relationships helped to promote social functioning and recast social roles. Haumāna often mentored other haumāna who needed assistance with cultural activities. Program staff noted this is an indicator of “success” since the act of passing on one’s knowledge to others demonstrates successful navigation outside the realm of self. Additionally, haumāna perceived staff as peers in recovery from addiction which seems to align with the concept of egalitarian relationships. It also reinforces the concept of modeling and requires staff to engage haumāna in the transformative process of dialogue and reflection as a precursor to telling a new life story.

Haumāna described social functioning as reconnecting to roles that were mitigated during periods of addiction and psychological distress. Regaining these important familial and life roles seemed to be at the nexus of their desired goals of recovery. Still, the study found new roles emerging through the re-authoring process. For instance, in order to expand his social support network of peers and thereby dissolve social isolation, a haumāna joined a Native Hawaiian male sailing team. This, as well as his talent in water sports led him to pursue a Water Safety Certificate and apply for a
position as a life guard. These choices were available to him through his ability to re-author his life and engage in meaningful exchanges with resources in his environment.

**Power.** Equalizing power was most evident in the social interactions of haumāna and staff. Viewing each individual as possessing the same worth provided a psychological benefit to haumāna. Haumāna perceived loving, egalitarian-type of relationships were important to their recovery. They were more likely to trust and discuss challenges as an equal partner within ‘ohana type of relationships. The implication is that our social work profession’s emphasis on maintaining boundaries and distance in treatment relationships may be counter-beneficial to certain populations that perceive close, loving types of relationships with providers as helpful in recovery.

The study also found that names have power and give identity. Deconstructing the name of “client” and re-constructing it to “haumāna” dissolves the power separating “professional” from “person served”. Haumāna were empowered as the name gives cultural kuleana or a position of privileged responsibility. For example, if the name haumāna is defined as a person who takes in knowledge from a kupuna (Pukui, Haertig, & Lee, 1972), then the name bestows upon the haumāna responsibility to actively seek out learning in order to receive knowledge. In a Hawaiian cultural program, this means active participation from which knowledge will be taken in or “do and you will learn”.

Last, although organizing political action and community activities contribute to reclaiming power, the study did not find these cited in haumāna narratives. I offer two reasons that may explain this absence. First, most haumāna were in the earlier stages of recovery and it is likely that spearheading macro-level activities require haumāna to have successfully navigated through certain person-level elements of recovery. Second,
because the ‘ohana is the most salient concept that defines Native Hawaiians from other peoples (Rodenhurst, 1989), most narratives focused on how to strengthen and nurture ‘ohana relationships by re-establishing functions and roles with their ‘ohana.

Choice among meaningful options. The study found that case management services provide an essential support to navigate systems and to meet food, shelter, and legal needs. Meaningful options depend on the availability of tangible and intangible supports within the environment (Onken et al., 2007). Tangible supports identified in the study included: 1) transportation, 2) treatment programs, and 3) the ability to choose a counselor from among staff. Due to the lack of adequate transportation, the program provided this essential service to link haumāna to treatment. Among treatment settings, many haumāna chose to participate in Hui Ho‘ola o Na Nahulu o Hawai‘i. In addition, haumāna had the freedom to partner with any staff with whom they felt most comfortable to provide psychological (intangible) support in times of distress and case management (tangible) services to work on holistic life goals related to education, employment, and civic duties. Last, the ability to choose among meaningful choices is predicated on the recovery elements of agency and self-determination. For example, haumāna who choose to attend Hui Ho‘ola o Na Nahulu o Hawai‘i also choose to fully participate in all cultural activities regardless of their comfort with, and knowledge of, cultural practices. This example illustrates the concept of koho‘ia or Choice, No Choice/Identity.

Community-centered elements. As indicated in the element of thriving, environmental opportunities must be in place for individuals to successfully navigate a life in recovery. The findings indicate loving relationships nurture growth and promote self-actualization toward recovery through social connectedness. Haumāna described
their experience of relationships fostered at the organization as a mutual exchange leading to a recasting of social relationships. For example, as haumāna felt loved and were treated with respect, they wanted to model these values and behaviors with others which often improved their social functioning within their ‘ohana and in the community.

Social circumstances and opportunities. Fulfillment of basic needs is a precursor to higher levels of self-actualization and growth (Maslow, 1954). The study found data that suggested negative indicators of social and economic well-being existed among haumāna such as unemployment, lack of adequate food, and limited public transportation. To address these barriers, the organization provided assessments at no cost to the haumāna, lunch every Friday, and transportation to treatment. Social supports such as friends, ‘ohana, and treatment opportunities are important environmental conditions that facilitate positive change. By integrating cultural practices with Western treatment services, the organization offered haumāna options in treatment not necessarily available in other programs. While a program with a Native Hawaiian cultural focus is not a recovery pathway suitable for everyone, it is a viable option for individuals who may not fit well in treatment models that are more Western-centered. Last, gratitude and service were influential in recasting opportunities as haumāna became role models. Peer to peer support is a powerful way to address internal feelings of stigma (Onken et al., 2002) by reshaping the internal perception of what is possible when living with an addiction or co-occurring disorder.

Integration. Community integration requires the successful acquisition of social skills and the ability to live among others (U.S. DHHS, 1999). As previously described, “ma ka hana, e ka ‘ike or in work there is knowledge” (Pukui, 1983) is a strategy used by
the organization to orient haumāna toward mutual interdependence. Through active participation in NHCPs, haumāna acquire skills to re-integrate into island community life. Yet, the study found limited data to indicate integration of haumāna into social events on Hawai‘i island. This finding may bring to the surface an area of program development that may need strengthening, that of, helping to establish sober supporting places and activities such as work, leisure, and socialization in the larger community. This may also indicate a need to build natural niches in communities that maintain and nurture the gains made through treatment programs so that haumāna can thrive in society beyond these programs.

**Summary.** An ecological framework to understand recovery as a process of exchange between person-centered capacities and community-centered resources is posited by Onken et al (2007). Study key findings supported many elements within the framework but were experienced by Native Hawaiian haumāna with a substance use or co-occurring disorders in different ways. The study found loving relationships, gratitude and service, and identity were significant concepts that cut across all elements of recovery. These concepts promoted hope, agency, and self-determination that contributed to the re-authoring process. Additionally, they influenced the exchange process between personal capacity and community resources and were experienced by haumāna as helpful to mitigate the integration into larger societal roles, functions, and opportunities.

Specific key findings were also noted as contributory to the Recovery Paradigm. First, the concept of reciprocity as a part of self-determination or decision-making control differs from Western ways of defining self-determination which is based on fulfillment of
individual need. Second, the study found that haumāna drew a new sense of meaning and purpose by engaging in the practice of genealogy and giving them the responsibility to engage in healthy behaviors that honored past, present, and future family generations. Third, an indicator of a haumāna successfully expanding her/his social functioning and roles is when s/he can teach another person the knowledge and skills acquired. In addition, staff in recovery were perceived by haumāna as peers. Therefore, staff had the professional responsibility to be a positive role model and the prerogative to be a peer mentor. The implication is that by approaching recovery from multiple roles, staff could engage haumāna in dialogue and reflection as a transformative process to re-authoring their life story. Fourth, the study found that the practice of `ohe kapala or stamping designs into ceremonial garments for graduation increased haumāna awareness and potentiality through the development and reinforcement of a new identity. Graduation was a rite of passage to signify the emergence of a new life. Fifth, the study found that power among organizational staff and haumāna was equal. Egalitarian relationships were cited by haumāna as important to their recovery. The findings suggest a reconsideration of how social workers maintain strict boundaries with certain client populations. Last, the study found only limited data to support haumāna participation in political action and community organizing activities as an indication of self-empowerment, as well as integration of community activities that promote sobriety and positive mental health into society events.

**Community Best Practices for Cultural-Based Recovery Programs**

In 2009, ‘Imi Ke Ola Mau proposed a framework of five community practices as best-practices for cultural-based programs that serve Native Hawaiians with co-occurring
conditions. The framework provides examples of how each best practice can be applied within an organization. I discuss similarities, differences, and expanded or new areas of application and knowledge between the ‘Imi Ke Ola Mau’s framework and the study’s findings.

**Community practice one: Integration of kūpuna**

**Similarities.** Kūpuna are well incorporated into the organization, participating in the processes of program planning, training, and implementation. Considered key organizational personnel, kūpuna are cultural and spiritual practitioners. The program’s kūpuna are sometimes asked by administration to be part of exit interviews with staff to provide the practice of ho'oponopono. Overall, the findings suggest that kūpuna performed multiple roles as staff, community facilitator, teacher, mentor, and cultural and spiritual leader.

**Differences.** The study did not find kūpuna who served on Kūpuna Councils or as advisors to boards. However, in the planning phase to address substance use on Hawai‘i Island, kūpuna served as members of the Policy Steering Committee (PSC) and maintained a significant role to advise the federal government about the development of the community plans.

**Expanded or new areas.** Community planning was an area of expanded knowledge, particularly related to the role of kūpuna as expert informants of community needs and responsibilities. Kūpuna facilitated planning processes and enforced the community principle of active participation. Expanding on the framework’s assertion that kūpuna are “holders of ‘ike” or cultural knowledge, this study also found that kūpuna were perceived as the “source” of Hawaiian traditional values and practices. The
distinction between “holder of ‘ike” and “source” relates to the generative power of the latter. A holder suggests stagnation; it lacks the power of reproduction. A source implies a fluid process of rejuvenation and procreation of culture and knowledge. It is related to the concept of the three Piko in which kūpuna and ancestral spirits are the fontanel lifeline that provides a source of ancestral knowledge and wisdom (Pukui, Haertig, Lee, 1972).

**Community practice two: Use of land and sea-based sites**

*Similarities.* This study confirmed the use of land and sea-based activities as important components to Native Hawaiians in recovery. Kū Aloha Ola Mau’s ‘āina -based program primarily consisted of nurturing and cultivating their Kapoho, Hawai‘i property that consists of approximately one acre of uncultivated space upon which a large open-walled structure was erected. Cultural protocols practiced at the Kapoho property included oli, pule, mo‘okūʻauhau (genealogy), ‘ohe kapala (stamping on ceremonial garment) and pani (closure celebration). ‘Āina-based learning provided a safe and neutral environment for haumāna to apply the values, knowledge, and behaviors that reinforce the concept of self as interdependent on other ecological forces (e.g., Lōkahi Triad).

Because the organization owned a ‘āina base, cultural activities focused on the land rather than the sea. The sea-based activities referenced in the findings included hiʻuwai or ocean water cleansing for pani or graduation ceremony, and reef activities to learn about balance and interrelationships within the ‘ahupua‘a or land division from mountain to ocean.
Differences. The findings did not include ‘āina-based learning at the lo‘i or taro patch and heiau or traditional Hawaiian place of worship. One reason for the lack of these ‘āina-based learning examples is that the Kapoho property does not include a lo‘i or a heiau.

Expanded or new areas. One area of expanded knowledge relates to the transfer of behaviors developed in one area in a person’s life to another area in a person’s life. The findings indicated practicing the protocol of asking permission from a higher authority as well as the spiritual authority imbued in the ‘āina reinforced certain values such as mutuality and reciprocity. These values then were used by haumāna to approach their everyday life tasks. By developing a healthy code of ethics and conduct with the ‘āina, haumāna applied this code to govern human relationships. Transferring the use of this code from the ‘āina realm to the human realm fostered social harmony and healing.

Community practice three: Use of cultural values and traditional practices

Similarities. This study confirmed the integration of Native Hawaiian values and practices as helpful to Native Hawaiians with substance use or co-occurring disorders. The study found that in order to “deliver” cultural values and practices, providers had incorporated these in their own lives. Organizational documents confirmed that prior to employment, a potential hire must be knowledgeable in Hawaiian history as well as cultural values and practices. Employees were also expected to model these behaviors as “mākua” or parents to haumāna.

Similarly, if we revisit the multidimensional aspect of mind, body, and spirit (Figure 6) as asserted by the ‘Imi Ke Ola Mau (2009), then we return to the concept of pono and lōkahi as a relational balance that promotes conditions in an individual's life to
heal. This study conferred the framework's assertion that NHCPs teach and reinforce values that enhance cultural identity, responsibility, and pride within the individual. Subsequently, this study indicated that these healthier skills, beliefs, and behaviors extend out from the individual to permeate other systems within the individual’s ecology.

**Differences.** Several differences emerged in the findings when compared to the framework. First, the practice of *lua* or Hawaiian martial arts was not mentioned by study participants. Since most NHCPs offered by the program depend on the knowledge and skill of the program’s kūpuna and staff, it is likely that lua was not a practiced tradition for them. Second, the value of haʻahaʻa or humility was listed as an example of a best-practice; however, study participants did not specifically identify this value per se. Yet, the protocol of asking permission was interpreted as practicing the value of haʻahaʻa. A fuller discussion of values is described below in expanded or new areas. Last, there was no clear distinction made between “healing practice” and “cultural practice” in this study. The organization approached the use of NHCPs in addiction treatment services from a perspective that the Hawaiian culture heals; therefore, it would seem reasonable to assume that “healing practice” and “cultural practice” are synonymous.

**Expanded or new areas.** Two areas emerged as new. I preface the discussion of these two areas by cautioning the interpretation of singular values as truths. Illuminating a single value misses the vast unmentioned and related values that are interconnected. In traditional Hawaiian society, values exist for a purpose, and the primary purpose was to sustain the ‘ohana (Handy & Pukui, 1972). Numerous values supported the concept of nurturing ‘ohana and many are cited in this study. In 1989, the Office of Hawaiian Affairs (OHA) gathered *manaleo* or kūpuna whose first language was Hawaiian to
identify cultural values and their meaning in defining the Hawaiian Universe. Aunty Betty Jenkins, now in her 80s, attended as her mother’s kāko‘o or assistant. She recalled OHA conducted a series of these gatherings, and at the time of our conversation 22 years later, she lamented the passing of the entire kūpuna cohort who had participated in this statewide effort. She explained,

Dear, the final OHA report listed six values, but it really is six times six times six times six. The number is expediential. One value does not stand alone. This would be unfathomable in a Hawaiian Universe full of connections. One value is only at the surface and hundreds of others lay beneath the surface to enhance, define, and describe it (personal communication, July 27, 2011).

The first new area that emerged acknowledges that the integration of values into an organization must have a purpose, and recognizes the dynamic and expansive association values have with each other. The findings suggest the purpose of integration of values and traditional practices are to teach and reinforce healthy values to nurture an individual life, so the individual can contribute to communal life. Along their journey of self-discovery, haumāna described recovery in terms of holistic life goals of employment, housing, and health. Values played a critical role in moving the individual from the singular frame of self to the larger dynamic picture of self in community by understanding and practicing relational dimensions that achieve pono and then lōkahi. On an individual level, seeking balance of internal dimensions of mind, body, and spirit promotes pono or morality of self that feeds and nurtures a person's capacity and ability to seek balance with larger universal forces to promote lōkahi or harmony in life. This process that leads to morality of self within the relational context of Na Kānaka
(humankind), Ke Akua (God), and Ke Ao Nei (nature) is a healing transformation by restoring a person’s connection to self and communal life.

Second, while the emphasis for this best-practice focuses on the integration of values and practices into treatment for the benefit of haumāna, the study found that staff also benefited by listening to, observing, and practicing with cultural practitioners and kūpuna. This has several implications for the organization. The first implication relates to staff development and aligns with the method of learning cited in this study as staff work shoulder to shoulder with practitioners and kūpuna to upgrade knowledge and skills. Second, reinforcing positive values enhanced staff’s ability to role model as healthy parents to haumāna as expected of them in organizational policy. Third, staff participation in cultural practices that promotes healing is a way to foster employee well-being. Organizations that utilize NHCPs may find it beneficial to incorporate this practice into their employee health and well-being policies.

Community practice four: Use of hawaiian language consultant

Similarities. The findings indicate kūpuna, staff, and haumāna function as "language consultants” in the planning, training, and implementation of NHCPs. The language expertise of kūpuna were utilized to a greater degree in the implementation of NHCPs (e.g., use of language in protocol and teaching place names) than in the administrative review of contracts and policies. The review of administrative documents for language accuracy and integrity was performed by staff. Because kūpuna are viewed as the source of cultural practices and values, they are also perceived as the source of ‘ōlelo or Hawaiian language. Teaching ‘ōlelo was generally conducted by kūpuna to
staff and haumāna. Haumāna often shared this knowledge with other haumāna and ‘ohana members.

**Differences.** The term "language consultant" was never cited in the study but the function of ensuring cultural accuracy and integrity was a shared responsibility among administration, program staff, and haumāna, and not restricted to kūpuna.

**Expanded or new areas.** Three expanded knowledge areas were identified as: 1) mutuality, 2) cultural preservation, and 3) identity. The concept of mutual exchange characteristic of pilialoha or loving relationships provides the context to understand the "use of a language consultant". As haumāna acquired new knowledge, they returned the knowledge to individuals within their environment. In their narratives, haumāna described how they taught ‘ōlelo to their ‘ohana. According to staff, haumāna teaching another person is a sign of “success” as an indication that learning has taken place. Thus, within this context, pilialoha can be viewed as a mechanism to connect haumāna to important individuals in their lives to promote a relational balance (e.g., restoration of familial ties). The next expanded area of knowledge relates is cultural preservation. The findings indicate all organizational staff had the duty to preserve the integrity and accuracy of the Hawaiian culture which includes the use of ‘ōlelo. Last, the study found that learning ‘ōlelo reawakened some internal memory or purpose in the lives of haumāna that was forgotten because of drug use. ‘Ōlelo was one of several practices that guided haumāna toward recovery through koho‘ia or finding identity.

**Community practice five: Incorporation of family and community into treatment**

**Similarities.** The organization encourages the participation of ‘ohana into program activities during graduation and seasonal camping retreats. Aina-based
activities during camping retreats helped to strengthen ‘ohana bonds. Also, activities focused on mo’okū’auhau or genealogy benefited haumāna in recovery by identifying familial strengths and reinforcing principles of mutuality, kuleana, and collectivism.

**Differences.** The framework cites the use of ho’oponopono to resolve ‘ohana issues. While ho’oponopono was cited as a cultural practice used to address issues with staff, haumāna did not reference its use with their ‘ohana. Also, the inclusion of community stakeholders into treatment activities was not mentioned by haumāna.

**Expanded or new areas.** The subtheme of ‘ohana is possibly one of the most important concepts found in this study as it relates to relationships and its influence on the treatment environment. The program creates a climate in which all participants and staff are equal and share a kinship type of relationship. Creating healthy ‘ohana-type of relationships in treatment can be as important as incorporating ‘ohana members into treatment. Haumāna stated a supportive ‘ohana type of relationship was a critical factor in reinforcing new values, re-shaping behaviors, and heightening social connectiveness. For example, staff modeling healthy interactions in the role of a makua or parent facilitated haumāna acquisition and replication of new patterns of interaction at the program and at home with their ‘ohana. Yet, the role of staff as mākua and haumāna as children seems to contradict the concept of equal relationships.

It would seem that the stratum of power that generally exists is hierarchy-type of relationships such as a parent and child can cause tension, especially for a program that fosters relationships based on egalitarianism. Throughout their narratives, participants did not mention this potential tension which seems to suggest that if it existed, they were able to hold contradictions without cognitive dissonance. Yet, if viewed from a Native
Hawaiian worldview in which power in ‘ohana relationships is based on the values of mutuality, respect, and understanding, then it takes on a different purpose. The parental and child relationship has the sole purpose to ensure the development of the child to be a functioning member in a specific ‘ohana, within a specific community (Handy and Pukui, 1972). Therefore, the responsibilities of staff as mākua is to love, teach, and nurture haumāna to be a healthy community adult members. In return, haumāna have the duty to develop into healthy adults. In the ‘ohana system, power is recast from dominance to nurturance. If we apply this re-conceptualization of power to the social work profession, then we need to reconsider the extent to which the profession delineates boundaries and emphasizes professional distance in the worker/client relationship. In this study, the boundary line that divides a worker from a client is called into question if it does more harm than good in the promotion of client recovery and the fulfillment of life goals.

Summary. ‘Imi Ke Ola Mau offers a cultural framework to assist community-based programs that serve Native Hawaiians with substance use or co-occurring mental health conditions. The framework provides examples of how a program can incorporate five NHCPs to best serve Native Hawaiians. Study findings conferred all five cultural practices were integrated into the organization and offered as services to haumāna. Differences emerged across all best-practice areas but with minimal variation.

Expanded or new areas were perhaps the most contributory to enhance the framework. Cutting across all five best-practices was the concept of pilialoha or loving relationships as illustrated by connections to spiritual ancestors (Community Practice One), the realms of ‘āina and spirituality (Community Practice Two), self and community (Community Practice Three), ‘ohana (Community Practice Four), and staff and ‘ohana
(Community Practice Five). Four additional expanded or new knowledge areas emerged and included the following: 1) kūpuna as the regenerative source of Hawaiian knowledge and culture, 2) the transferability of a healthy code of conduct from ‘aina interactions to human interactions, 3) the expansive concept of values taught for the purpose of supporting the individual within communal life, and 4) the re-conceptualization of power from a domination-based concept to a nurturing ‘ohana-based concept. Last, the concept of spirituality or connecting to a higher authority was frequently cited in the descriptions of the five cultural best practices; however, it is not cited as a stand-alone best practice in ‘Imi Ke Ola Mau’s framework. While spirituality is clearly a critical NHCP, it may be diffused in all cultural practices and is another cross cutting strand similar to pilialoha or relationships. As Kupuna Jenkins suggests, spirituality may be one of the vast number of values that support other values and practices hidden beneath the surface.

Organizational Development

Simpson and Flynn (2007) offer a planning and implementation framework to understand the process of adopting and implementing evidence-based practices and programs as innovations (Figure 7). Because the study focused on Hui Ho‘ola o Na Nahulu o Hawai‘i as a cultural program of the organization of Kū Aloha Ola Mau, this section will describe the application of this stage-based framework, that is, the parts that seemed relevant as well as the shortcomings, as to implementation of this cultural program. The framework’s three stages include: 1) strategic planning, 2) preparation, and 3) implementation. The implementation stage contains both individual-level and organizational-level factors that impact an innovation from conceptualization to practice.
Moving innovations into treatment: A stage-based approach to program change. *Journal of Substance Abuse Treatment, 33*, 111-120

**Strategic Planning.** Strategic planning includes the following individual factors: 1) staff needs, 2) staff functioning, and 3) integrative process. The findings indicate that the factors identified in the framework are more applicable to the implementation of a practice-based innovation (e.g., a specific intervention) rather than the implementation of a program innovation. The findings suggest two new areas of knowledge that influence planning: 1) structural approaches and 2) key leadership.

Structural approaches include the use of Community Asset Capacity Mapping (Minkler, 2005) to guide the process of strategic planning with community partners and the development of partner relationships. Facilitating the planning process was community kūpuna as place-based, spiritual, and cultural leaders.
The strategic planning meeting accomplished the following: 1) reinforced participant connections through the process of hoʻolauna or introductions, 2) determined the mission that program services be grounded in the spirit and culture of Hawai‘i, 3) reconfirmed the community need to address substance use, 4) determined that a healing center rather than a treatment center should be implemented, and 5) established a Policy Steering Committee (PSC) as the governing body responsible for planning oversight.

Summary. Organization program innovations involving community collaboration emphasize community needs, resources, and relationships rather than staff needs and functioning which are factors relevant to practice-based innovations. Relationships with community stakeholders involve a process of listening, clarifying, and building consensus. Structural approaches and kūpuna leadership were key factors that emerged and influenced the stage of strategic planning with communities.

Preparation. Preparation involves the steps of goal specification, action planning, and evaluation of progress. The findings suggest that when working with Native Hawaiian communities, one of the most important steps to successful preparation is building sustainable relationships with community partners.

Goal specification. The PSC met for a year with the goal of ensuring stable relationships among partners and to reinforce community principles. PSC kūpuna “taught” the action oriented principle of community responsibility as expressed as “commit and produce, or get out” (A1, 463-464).

Action planning. After relationships were solidified and commitments discerned, the next action was to name the program because the name would guide future steps. The name, Hui Ho‘ola o Na Nahulu o Hawai‘i, was gifted by Aunty Abbey Napeahi a
traditional practitioner in ho‘oponopono, to mean the group that gives life back to the community. As indicated in the concept of koho‘ia, because the name focuses on healing and giving life, the PSC believed Hawaiian healing practices must be integrated with Western-types of addiction services.

Evaluation of progress. The PSC kūpuna introduced the concept of “pohō wale” or done in vain (Pukui & Elbert, 1986) by asking rhetorically, why do we have a Hawaiian name if the program offers Western-only services? Pohō wale aligned the function (e.g., program type) to its form (e.g., healing center rooted in Hawaiian culture and spirituality). Therefore, the PSC decided both Hawaiian and Western practices would be offered.

Organizational readiness and functioning factors. The framework did not identify these factors in the pre-implementation stages; however, the findings suggest the following factors applied: 1) motivation and 2) institutional resources. These factors initiated change by providing external resources. Federal funding initiated the planning process to address the methamphetamine use on Hawai‘i Island. The funds were earmarked by Hawai‘i’s Senator Inouye for services to Native Hawaiians on Hawai‘i Island. The funds were funneled through the Hawai‘i Department of Health resulting in a two-day community planning meeting with various Hawai‘i Island stakeholders.

Summary. Goal specification, action planning, and evaluation of progress were factors identified in the findings. An extended period of time was needed to solidify relationships among community and organizational partners. Naming of the program was an important factor that establishes a direction as an organization prepares to implement an innovation. Realigning function with form is a helpful way to evaluate progress.
Organizational readiness and functioning must be considered as key factors that affect the dynamic change process in the pre-implementation stages. The next stage of implementation process includes three major steps: 1) training, 2) adoption, and 3) implementation.

**Implementation Process – Step 1: Training.** The first step in the implementation process is training and includes: 1) innovation relevance, 2) access to the innovation, and 3) accreditation. Start-up training of staff was minimal since the program was implemented with new staff that possessed a high-level of cultural and spiritual knowledge.

**Relevance.** Relevance relates to the determination by staff as to the relevancy of the training needed to implement an innovation. However, since the innovation was implemented as a new program with new staff, this training consideration did not apply.

**Accessible.** The program began in Pahoa, Hawai‘i, an accessible area targeted for its high substance use.

**Accreditation.** Initially, accreditation was not an issue since a federal grant supported the program planning and start-up. As a lesson learned, implications of accreditation are described later in this section.

**Organizational readiness and functioning.** The organizational factor most relevant to training was climate. The organization’s climate can be characterized as embracing change, building cohesion among its workers, and developing sustainable partner relationships that address individual-level factors. While organization leadership is not an organizational factor noted in the framework, the study found that leadership affects an organization’s readiness and functioning. The organization’s climate was
greatly influenced by the executive director who committed institutional resources to the early stage of implementation.

*Lessons learned.* Four lessons learned are identified as: 1) staff attribute of knowledge, 2) staff attribute of pono, 3) diffusion of integrated knowledge through participatory training and use of internal resources, and 4) accreditation.

Over time, the organization was faced with the need to hire staff knowledgeable in clinical and Hawaiian practices; however, providers with both competencies were few. Through years of trial and error, the organization learned the most important provider skill set or attribute was the ability to connect, support, and feel affection for another person. “[…] you can teach that person everything they need to know to do the job. But you have to find the right person. A right person is a loving, caring person. Someone with Aloha” (A1, 486-489). This attribute seemed to be found more commonly among providers with Hawaiian knowledge than those with clinical knowledge.

Another attribute expected of program staff is their ability to be pono. Pono or the state of being good and moral (Pukui & Elbert, 1986) is the end-point when individual-level dimensions of spirit, mind, and body are in balance (Paglinawan, 2011). The Pono Triad (Figure 6) offers a conceptualization closer to what staff described in the subtheme of professional kuleana as the importance of being pono before receiving cultural knowledge and providing NHCPs to haumāna. By contrast, when staff were not pono, then they were not spiritually, mentally, and physically available to provide cultural practices which became apparent to haumāna. “We noticed when the staff not pono, the haumāna stopped coming in. And then, new haumāna stop coming in. Whenever they got pono, then there was a flood of new people. So there was a real cause
and effect” (A1,549-552). The implication for cultural staff is if pono is a state in which one seeks to attain, then staff have the ethical responsibility to exclude incongruent influences that compromise pono such as malicious thoughts and actions. This suggests that pono is facilitated by the congruency of spirit, mind, and body dimensions and if any dimension is compromised, so are the others (Kaholokula, 2007).

Another lesson learned was how best to diffuse trainings across the organization. To systematically reach all staff, the organization offered a two-day retreat in Volcano, Hawai‘i as a venue to upgrade cultural knowledge and clinical skills. While this method was expensive, the executive director believed that cultural trainings could not be taught in a didactic seminar setting; instead, culture needs to be experienced by active participation which is consistent with the concept of Hawaiian method of learning. Also, instead of perceiving cultural knowledge as an external resource which the organization must procure, the organization utilized its internal assets to provide cultural trainings. The staff of Hui Ho‘ola o Na Nahulu o Hawai‘i provided cultural and spiritual trainings within the organization which guaranteed that trainings are relevant and accessible.

ʻĀkoakoa or integration of Western-type of services and Native Hawaiian cultural practices is a concept that acknowledges that at times organizational components blend well and at other times they do not. Accreditation of trainings is an illustration of ʻākoakoa. Accreditation is often a process in which certain knowledge is officially recognized or authorized by an external body. Yet, accreditation of training raises larger issues related to the valuation of knowledge. When applied to Western-type of services such as the need to maintain a counselor’s substance use certification, the organization sought continuing education units from the Hawai‘i Department of Health’s Alcohol
Drug Abuse Division to accredit their trainings. However, when applied to NHCPs, accreditation as the legitimization of knowledge by an external source was at the nexus of tension expressed by participants as the de-valuation of NHCPs, of traditional practitioners, and in the payment level for cultural practices. “If you get one guy with big degrees, goin get dis kine money. If you one kupuna doing ho‘oponopono, you going get little bit money. So i think that one constraint [....] dey no pay enough Hawaiian consultants. Challenge.” (P, 874-878).

Accreditation and licensure may provide a level of accountability and legitimacy to the extent that insurance companies reimburse for services according to professional title and scope of service. However, when applied to the regulation of NHCPs, questions could be raised as to “by whose standards” and “by what standards” are accountability determined (Benham & Stein, 2008). Presently, the only NHCP that was regulated by the State of Hawai‘i is lomilomi through the licensure of massage therapists. However, in its past, Kū Aloha Ola Mau discontinued the use of la‘au lapa‘au or medicinal herbs because the Hawai‘i Department of Health cited issues of liability. Accreditation and licensure of NHCPs involves a long and complex history which is better explained elsewhere and the interested reader should reference the work cited (Papa Ola Lōkahi, 2008).

Summary. Staff training at the program’s implementation had limited applicability because the factors of relevance and access were addressed in the pre-implementation stages. The organization’s leader was key in promoting an organizational climate open to change. Over time, relevance and access became more important to upgrade staff knowledge and skills, and the organization utilized the program staff to conduct cultural trainings. To achieve maximum reach, the organization
hosted participatory annual retreats as a training forum for staff on the integration of cultural and Western addiction models. Because accreditation and licensure are based on a system that stratifies the value of different types of knowledge, they remained a concern among organizational staff when they relate to NHCPs.

**Implementation Process – Step 2: Adoption.** The adoption stage includes a two step process of decision and action. Decision includes the following individual factors: 1) leadership, 2) quality or utility of the innovation, and 3) adaptability. Action includes the following factors: 1) capacity, 2) satisfaction, and 3) resistance.

*Decision - leadership.* Two organizational levels were instrumental in driving organizational decision making to adopt this program innovation. First, the board of directors endorsed the executive director’s request to seek funding that she believed was pono. As the concept of pono is subjective and personal, the executive director had the latitude to determine the types of funding opportunities to pursue. The concept of pono played a role in the overall direction of the organization in that decision making, particularly regarding funding, was based on the evaluative criterion of pono or the extent to which the decision and its foreseeable consequences were good and moral. Second, because the executive director believed that the Hawaiian culture heals, she had the strongest influence in decisions to adopt a cultural program.

*Decision - quality and utility.* The quality and utility of developing a healing center was primarily determined through a process of community consensus. The degree to which the quality and utility of a healing center influenced the organization decision to adopt it was again based on the concept that culture heals. As related to pilialoha, the narratives of participants indicated their relationship to spirituality as a life-giving force.
and at the core of healing. This appears to reaffirm the merits of this type of innovation as possessing both quality and utility to address addiction or co-occurring conditions.

Conceptually, what this seems to suggest is that spirituality and culture are the foundational core from which the processes of implementation spiral outward. Spirituality and culture are similar to the organizational factors of readiness and functioning in their influence on various points of impact as the implementation process ascends out from its center.

**Decision - adaptability.** Adaptability or the extent to which front-line staff can agree or disagree with the implementation of services and practices was not asked in this study. The program staff were employed after the decision to implement the innovation.

**Action.** The second step of adoption is action or “testing out” the innovation prior to sustained use. The findings do not describe the extent to which the healing center, in its initial trial period, met expectations, produced satisfactory results, and encountered active and passive forms of resistance. However, resistance was experienced by the organization from several levels as the program matured.

**Lessons learned.** The reasons underlying resistance can be categorized into three areas, as the need: 1) for quantitative outcomes data, 2) for education, and 3) for alignment of staff cultural beliefs with the organization’s culture. Insurance companies were slow to embrace a program that championed the use of NHCPs to address addiction and co-occurring disorders. As a broad-base of empirical evidence often drives the extent to which practices are considered a best practice or an evidenced-based practice, without quantitative outcomes, insurance companies were resistant to support and reimburse this type of cultural program.
The Courts and Corrections system was hesitant to make referrals to the program because they did not understand how participation in a cultural program addressed addiction and co-occurring conditions. Educating systems that interact with haumāna as well as educating haumāna can provide a basis to understand the connection between engagement in NHCPs and the promotion of healing, well-being, and recovery.

Last, staff resistance was identified as staff whose values did not align with the values and culture of the organization as expressed in pilialoha or the belief that relationships are founded on the principles of equality, ‘ohana, and modeling. The few staff who could not embrace the organization’s culture separated from organization.

Organizational readiness and functioning. The nature of implementing a program as an innovation allows for a level of flexibility and of side-stepping potential concerns, especially when the program is not co-located with other programs of the organization. Hui Ho’ola o Na Nahulu o Hawai‘i was first established in Pahoa, Hawai‘i which is approximately 225 miles away from the Honolulu administrative office, and about 20 miles from the organization’s Hilo program. Therefore, the distances allowed the program to maintain a level of autonomy to grow without exposure to certain factors new programs face such as fitting in with established social groups within an organization. At the same time, the program had the institutional support of the executive director to flourish as a healing center, to sharpen staff cultural skills, and to navigate how best to address substance use or co-occurring conditions by incorporating NHCPs.

Summary. In the adoption stage, organizational leadership and community-driven leadership provided the support for the innovation to achieve institutional commitment. Community sanctioning of a healing center that offered NHCPs was an alternative but
just as legitimate way to validate the quality, utility, and testing out of the innovation.

Leadership belief that the Hawaiian culture is a healing culture was a resounding influential factor impacting stages during innovation implementation. Resistance was experienced after the program was implemented and as the program interacted with systems as the need for outcomes and education developed. Last, community belief that culture heals (inclusive of spirituality) became readiness and functioning factors that impacted the innovation during adoption.

Implementation Process – Step 3: Implementation. The implementation stage includes the three steps: 1) effectiveness, 2) feasibility, and 3) sustainability.

Effectiveness. Effectiveness is described as an attitude shift within the organization that moves an innovation from tentative use to longer-range use (Simpson and Flynn, 2007); however, the findings indicate that an attitudinal shift was not required since the program was implemented with the belief that culture heals. As a drop-in healing center, effectiveness was based on intuition, observation, and self-report. The extent to which these indicators were recorded was not found in the archival records. However, over time, as the organization obtained State funding, it began to track clinical outcome data while blending NHCPs with Western-types of addiction services.

In 1998, the organization hired a clinical coordinator as a “translator” to strengthen the integration of NHCPs and addiction services. The clinical coordinator acts as a bridge assuring that clinical practice standards were maintained, assisted in the revision of policies and procedures to ensure they reflect the use of current cultural best practices, and represented the organization in community presentations. Whether this shift to track clinical outcome measures had a positive or negative effect on the continual
use of NHCPs was not described by participants; however, in reviewing haumāna treatment folders, it appears that documentation emphasized substance use assessment, treatment, and outcomes with less of a description of how NHCPs were beneficial to haumāna. In as much, the folders may have emphasized clinical aspects of treatment due to contractual requirements and audits by funders.

**Feasibility.** Feasibility or the innovation’s appropriateness to meet the needs of various clients and its demand on staff resources was a minimal concern during the implementation of the program. The organization and community determined that the four initial NHCPs (e.g., hoʻoponopono, laʻau lapaʻau, lomi lomi, and moʻolelo) could benefit a wide range of clients. These practices were made available and clients determined their level of participation. Additionally, because of its initial organic structure as a drop in center, the program was not considered by staff as too demanding of their time and resources.

**Sustainability.** Sustainability or the ability to channel resources to support an innovation’s routine use over time is an important consideration for Kū Aloha Ola Mau given external funding. Initially, the organization received a three-year federal grant to support the planning and implementation of a healing center. As the federal grant ended, State funds were obtained to provide addiction services that emphasized the use of NHCPs. Sustainability of NHCPs is a factor applicable to kūpuna. As cultural practitioners, kūpuna “brought” with them specific NHCPs such as hoʻoponopono and laʻau lapaʻau. However, the findings indicate kūpuna with this deep cultural knowledge are few in number and a dwindling cultural resource.
Lessons learned. Over time, State funds ebbed and flowed. While relying on only one funding source to support program operations may pose a threat, Kū Aloha Ola Mau approaches change from a spiritual perspective that accepts organizational shifts as driven by a higher authority. As the executive director explained, “[…] it is an opportunity for us to get back to our purpose and for staff to say, ‘I’m in or out’ […] because there is a greater reason and purpose in the universe” (A1, 616-622).

Funding from insurance reimbursements can diversify the funding base and supports the program’s viability. However, reimbursement for NHCPs, except for lomilomi, currently does not exist. Moreover, to be reimbursed for their Certified Substance Abuse Counselors, a hierarchal supervision structure must be in place that typically requires a doctoral level licensed behavioral health provider. Providing health care in rural areas presents many challenges including a limited number of licensed professionals and the organization is not immune to this challenge.

Last, while the organization has hired “Western-wise” consultants to conduct program evaluations on Hui Ho‘ola o Na Nahulu o Hawai‘i, organizational staff stated the need for a culturally-based evaluation which begins with the epistemic core of the program based on spirituality and the Native Hawaiian culture.

Organizational readiness and functioning. Motivation to change was influenced by internal (e.g., strong leadership desire) and external (e.g., community consensus) pressures. By employing cultural practitioners and securing a site in Pahoa, Hawai‘i, Kū Aloha Ola Mau had adequate resources to function as a healing center. The readiness factor of organizational culture supported the implementation of the program.
Summary. The initial structure of the program as a healing center emphasized the application of the practice and tracked effectiveness based on observation, intuition, and self-reports. However, the extent to which these were documented was not indicated in the findings. Tracking clinical outcome data began as new funding was acquired and a clinical coordinator was hired to strengthen the integration of Western addiction services and NHCPs. Feasibility was influenced by the initial program structure. Sustainability regarding growth and change continues to be approached by the organization’s leader from a philosophical and optimistic perspective that is directed by a higher authority. Staffing challenges include the limited number of licensed behavior health providers in rural communities and the scarcity of kūpuna with deep cultural knowledge.

Implementation Process – Step 4: Practice Improvement. The framework suggests an innovation becomes a “successful” routine practice after moving through the stages of planning, preparation, and implementation. Factors that influence an effective practice include: 1) outcomes, 2) services, and 3) budget.

Outcomes. The study found there were different ways to tell a story of success, including both qualitative and quantitative data. Narratives provided by administration and haumāna are one way to convey success. Administratively, as the program developed, the executive director was impressed by the changes she observed in the haumāna as an indicator of the program’s success.

And, because, this isn’t anything you can count, whenever I go over there, and the haumāna are introducing themselves, what you see […] is a light radiate from their eyes, it radiates. They have a big old smile, and they are happy people. If
you were to go to other treatment programs, you would not see that (A1, 555-561).

The extent to which the program helped haumāna was captured in their stories and related to the themes of pilialoha and koho‘ia. As haumāna learned new values through interaction and acquired a healthier relationship with the environment, humankind, and spirituality, they connected to a larger life force that gave them a new purpose in life. This pili`ana or connection allowed them to give back, pass on, and mentor and love other people within their ‘ohana and communities. In this example, a haumāna emphasized the importance of connections by describing how his new identity helped him connect to others and to society.

It helped me socialize and hold conversations. Every time I see somebody (in the past), I not able to function [. …] Now I practice to hold conversations, give da people chance, give myself one chance [. …] Now like trying to function in society. If you don't know what to socialize you not going get no where. You need connections […] (H2, 401-406).”

Connecting to a larger life force provided haumāna a way of living a positive life in recovery.

Outcome data tell another story of success (Table 7). The 2008 outcome results suggest haumāna attained higher percentages in holistic life goals including abstinence when compared to statewide averages at six month post-discharge follow-up.
Table 7

*Outcomes for 2008 of past 30 Days at 6 Month Post-Discharge Follow-Up*

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Statewide outcome results</th>
<th>Program outcome results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment status at follow-up</td>
<td>46%</td>
<td>81%</td>
</tr>
<tr>
<td>Stable living arrangement</td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td>Non-arrest rate</td>
<td>77%</td>
<td>90%</td>
</tr>
<tr>
<td>No emergency room visits</td>
<td>81%</td>
<td>100%</td>
</tr>
<tr>
<td>No drug or alcohol use</td>
<td>56%</td>
<td>73%</td>
</tr>
</tbody>
</table>

*Services.* Hui Ho‘ola o Na Nahulu o Hawai‘i offers a blend of Western-type of services such as cognitive-behavioral therapy and NHCPs. The program has integrated both approaches to maximize grant opportunities. Examples of Western-type of services include individual counseling, case management, and group therapy. Examples of NHCPs include oli, pule, and lomilomi. Grant reimbursement appeared to be on a fee-for-service basis in which each provided unit of service was billed to the Hawai‘i Department of Health. This type of reimbursement structure did not guarantee operational costs were covered. Treatment records were maintained in secured offices and divided into standard sections of assessment, treatment plan, and progress notes. Both Western-type of services and NHCPs were documented in the treatment records. While the study found a plethora of NHCPs, not all of them were documented in the treatment records. This was understandable since the NHCPs identified in this study may not be explicitly understood as a practice by study participants such as a supportive and
loving home and ‘ohana-type of relationships. Comparatively, Western-types of components that may have been helpful to haumāna were also not mentioned such as a therapeutic milieu and positive clinical relationships.

**Budget.** While the study did not specifically review service-cost records and the program budget in relation to the other programs of the organization, the findings revealed an organizational commitment to the program through its financial expenditures. For example, the organization maintained three full time staff, three part time staff, and one full time volunteer at the program. It also committed organizational resources to leasing the house in Puna, paying property taxes for the Kapoho property, and general liability for operations.

**Organizational readiness and functioning.** The factor of staff attributes influenced haumāna recovery by creating an atmosphere of mutual support and long-term loving relationships. Program staff appeared confident in their skill level in both Western services and Hawaiian practices. Institutional resources such as offices, equipment, and staffing appeared adequate to continue to implement a cultural program.

**Summary.** The innovation was sustained as a routine program and evidence suggested it had strong clinical performance outcomes. The organization’s program offered a blend of Western services and Hawaiian practices that is supported mostly through a fee-for-service payment structure with the Hawai‘i Department of Health. The findings also suggested an organizational commitment to the perpetuity of the program.

**Summary.** Overall, Simpson and Flynn (2007) provide a stage-based framework to conceptualize how an innovation is diffused into an organization. Individual-level factors and organization-level factors impact an innovation. The study’s findings indicate
the majority of the factors highlighted in the framework were relevant to understanding the implementation of Hui Ho‘ola o Na Nahulu o Hawai‘i as a program innovation. Yet, there were several areas that differed from the framework: 1) individual-level factors were not always relevant to a program innovation and seemed to fit best with a practice innovation; 2) the dynamics of community collaboration were not captured in the framework as a key external factor impacting the stages of strategic planning, preparation, and implementation process; 3) an extended period of time is needed to solidify relationships in the planning stage; 4) the influences of spirituality, faith, and leadership were individual and organizational factors that impacted the innovation from pre-implementation to on-going use; and 5) the need to attain a relational harmony of self (e.g., pono) and of self within the context of other dimensions (lōkahi) influenced the diffusion of the program in all stages of implementation.
Chapter 5. Discussion

In Chapter Five, I present the limitations of the study and implications for Social Welfare.

Limitations

“A‘ohe pau ka ‘ike i ka halau ho‘okahi. Not all knowledge is produced in one halau” (Pukui, 1983). I first acknowledge the limitations of my “‘ike” or Hawaiian knowledge that may have narrowed the scope of my interpretative lens. While I respect the knowledge that has been passed on to me and view it as an overarching strength of my research, I also have been taught that it represents a sliver of that which we as Native Hawaiians know. Therefore, my view of the nu`u or the mountain’s pinnacle is contextualized to where I am standing; others standing in another ‘ahupua‘a or land division will likely view it differently. In addition, situating my position as a Native Hawaiian researcher includes a host of other influencing factors: a) male, b) born and raised for over twenty years outside of Hawai‘i, c) no substance use addiction or co-occurring mental health condition, d) residing on O`ahu, and e) non-mānaleo or non-Native speaker. I recognize these factors may create “blind spots” for me while conducting research. I addressed these potential limiting factors by working with other researchers who provided another way of perceiving and understanding the data in both the collection and analysis phases. By weaving into the study their strands of experiences and knowledge of the Hawaiian and Western cultures, we created a more durable mat by enhancing multiple subjectivities and thereby reducing a singular bias.

Second, Hui Ho`ola o Na Nahulu o Hawai‘i’s kupuna was not available due to illness during the data collection and vetting meeting. In fact, her influential presence
had been absent for several months prior to data collection. Because kūpuna bring place-based knowledge and certain NHCPs to a culturally-based treatment program, it is probable that the haumāna in the focus groups had not been exposed to certain NHCPs. For example, the practice of hoʻoponopono was not mentioned by haumāna; however, it seems to have a long history at the program and was cited by organizational staff as one of the core services offered to haumāna.

Third, the study’s findings are based on only one organization. Because the case study is a single-case, the findings have limited transferability outside the organization and would warrant further studies. Building on this study, future studies could use a multiple-case design of several organizations that have implemented NHCPs. Then, emergent themes could be based on a cross-comparison of organizations, rather than upon one organization.

The fourth limitation relates to the sample. The sample was drawn from an outpatient substance use program. Sixty-seven (67%) or 10 of the 15 participants self-reported a co-occurring substance use and mental health condition. While a high comorbidity was expected, caution should be taken in extending findings to individuals with a co-occurring condition.

The fifth limitation was the large amount of data that needed to be analyzed when using a case study design with multiple data sources. To assist me in dealing with the complexity of data from multiple sources, I utilized the recommendation from Yin (2003) to develop a case study protocol as a guide to carry out the data collection, data analysis, and report writing. As a result, the dissertation served as the case study protocol guiding me throughout this research.
The sixth limitation is the threat of researcher bias, especially given my past working relationship with Kū Aloha Ola Mau. To reduce the potential for researcher bias, I employed four strategies. First, I adhered to the case study protocol. Yin (2003) suggested that strict adherence to the formal procedures of the case study protocol will ensure quality control during the data collection and analysis. Second, I removed myself from facilitating the five focus groups by utilizing the facilitation and cultural skills of another social worker. Third, I ensured I cross-referenced themes and concepts by returning the preliminary findings to participants to maximize the credibility and accuracy of the findings. Fourth, analyzing the data with a doctoral-level researcher who possesses Native Hawaiian cultural knowledge and language skills increased research objectivity to a desirable-level.

**Implications for Social Welfare**

**Practice.** Implications for social welfare practice are highlighted below and are discussed as related to culture-based, community, and organizations.

**Culture-based.** Social workers are the largest providers of behavioral health services in the U.S. (NASW, 2010). We are positioned well to conceptualize novel and culturally resonant interventions that match the needs of our clients, especially those at greatest risk for substance use and co-occurring conditions. Social workers can tailor programs and services to maximize client engagement, retention, and positive outcomes by examining the values upon which interventions are based and how these values align with the values of the clients being served. My study provided some guidance for doing this by describing key factors that can be integrated in cultural programs to promote client recovery outcomes such as loving and ‘ohana-like relationships with staff.
Another practice implication is the extent to which social workers maintain power by adhering to fixed boundaries. Social workers must continue to develop “culturally sensitive boundaries” (NASW, 2008) to foster client growth and self-determination. Furthermore, this requires that social workers continue to assess if boundaries divide rather than connect a social worker to her/his client. In this program, equality in relationships was a key factor that facilitated the achievement of client recovery goals. This factor may help social workers redefine boundaries so they are “culturally sensitive” with Native Hawaiians.

**Communities.** A practice implication with communities drawn from this study suggests that an extended period of time may be needed when planning with indigenous communities to solidify trust, discern participants’ intent, and integrate community norms into the planning process. The inclusion of community norms epitomizes a Strengths perspective (Saleeby, 2008). Social workers may consider how norms such as wahi pana or community place-based knowledge and resources may be important components when planning with Native Hawaiian communities.

**Organizations.** In terms of organizational practices, many organizations now offer wellness programs to employees to promote health and minimize stress. Social workers in management positions have an opportunity to assess the organizational climate for factors promoting wellness. The study identified that staff well-being was enhanced by participation in cultural activities with kūpuna or elders while working side-by-side with haumāna. This provided staff with a deeper cultural understanding of the type of work they perform. It also gave them a sense of gratitude because of the mentorship received from cultural experts. Social workers can routinely evaluate
organizational processes to identify practices that promote well-being. At the same time, social workers can target changes within the organization’s system to improve processes, enhance staff perceptions, and promote staff wellness.

**Education and Training.** One implication for social work education is its relevancy to incorporate local issues and knowledge into course content. Schools of Social Work, particularly those in rural areas and island regions, have a responsibility to ensure course content integrates the social issues and local solutions relevant to those regional communities and peoples. Given the likelihood graduating social workers will seek employment within those regions, providing them with a real-world context helps to increase social worker competence to address the social and cultural realities of the regions. This study identified the highest prevalence of co-occurring substance use and mental illness is among U.S. indigenous populations such as Native Hawaiians. The study also offered one way to conceptualize how best to address the problem of co-occurring disorders among Native Hawaiians through the implementation of a cultural-based program that blends NHCPs with Western-type of addiction services, and community-based resources.

Another implication is the need to emphasize spirituality in social work education. Social workers who work with indigenous populations within the U.S. often participate in cultural ceremonies and to a lesser degree, provide cultural-types of services. As evidenced in this study, spirituality as a pathway to healing is often the cornerstone of cultural interventions. Integrating the topic of spirituality into education prepares social workers to address the needs of cultural groups, such as U.S. indigenous peoples.
For social workers in the field, while training opportunities to develop knowledge are available outside their organization of employment (e.g., national symposiums), knowledge in core skill areas may be available within the organization. My study found that Kū Aloha Ola Mau uses a unique approach to increase practice-based knowledge and skills by utilizing the cultural program staff as trainers across the organization in regularly scheduled retreats. Assessing the extent to which training needs align with internal competencies of staff may offer a cost-effective way of increasing the knowledge and practice base of organizational workers.

**Research.** As demonstrated with this research study, social workers have an opportunity to develop new knowledge in areas in which gaps exist. Mokuau, Garlock-Tuiali‘i, & Lee (2009) assert the field of social work build a knowledge base on Native Hawaiians and other Pacific Islanders that is anchored in cultural-based practices and models that reflect the values of these populations. Evaluation and research to support a Native Hawaiian knowledge base can incorporate indigenous methodologies that rely on intuitive intelligence, wisdom from elders, and traditional ways of knowing and less on Western defined practices and evidence that may reflect cultural biases (Matsuoka, 2007). In this study, I demonstrated Native Hawaiian methods that reflect the cultural orientation of the research setting and its participants, which was embraced by participants as familiar and acceptable methods to conduct research. As such, these methodologies facilitated trust and provided credence to the research process.

Similarly, pooling together efforts to establish indigenous evidence expands the breadth of available and helpful interventions that may be suitable for a wider range of clients in addressing substance use or co-occurring disorders. The field of social welfare
has an opportunity to be part of a larger dialogue of indigenous and other researchers to establish methods of evidence grounded in the epistemic perspectives on U.S. indigenous peoples. Presently, the Cook Inlet Tribal Council (Naquin & Sommer, 2008) has developed an Indigenous Evidence-Based Practices Model to integrate indigenous knowledge and evidence while examining issues of validity. The profession of social work can collaborate with indigenous communities to develop new knowledge in this area.

Furthermore, as social workers continue to collaborate with indigenous populations, other research implications must be considered. Central to all research is the position of the researcher. The research paradigm of the positivist field worker as a distant and objective observer has caused tension with Indigenous populations (Nabobo-Baba, 2006; Smith, 1999). Indigenous peoples such as Pacific Islanders and Native Hawaiians may expect researchers to be active participants (Hereniko, 1995; Kaomea, 2004), to develop intimate relationships (Nabobo-Baba, 2006), and to possess a sense of spiritual understanding of the peoples with whom they work (Hereniko, 1995; Smith, 1999). At the same time, indigenous scholars continue to define the nature of indigenous research. One definition conceptualizes indigenous research as a transformative social project that gives back to the community solution(s) to address real world problems (Nabobo-Baba, 2006; Smith, 1999). With its commitment to cultural competency, professional use of self, and social welfare, social work is positioned well to advance research with indigenous peoples. However, in order to take up this charge, social workers will need to examine their positionality throughout the research process as well as keep abreast of emerging indigenous methodologies to work effectively with
indigenous populations. In as much, this study was initiated from an emerging need among behavioral health organizations in Hawai‘i to understand how best to implement NHCPs to address co-occurring disorders among Native Hawaiian adults. My positionality as a Native Hawaiian male social worker heavily influenced the indigenous methods I used in this study such as actively participating in program activities of oli or chants (do and learn), assisting the organization with statewide presentations (reciprocity), and offering pule or a prayer before conducting each interview (spirituality).

**Policy.** The NASW has adopted *Sovereignty and the Health of Indigenous Peoples* (NASW, 2009) as a policy statement to guide the professional organization in areas such as social advocacy and social change. The policy statement recommends the use of cultural practices to advance the health and well-being of indigenous peoples. By this policy and others, NASW can advocate for the use of indigenous cultural practices with the U.S. Department of Health and Human Services to advocate for policy changes that support and advance the use of indigenous cultural practices to address co-occurring disorders for the benefit of indigenous peoples and others.

The profession of social work can advance policies that seek to establish or expand funding for the use of indigenous cultural practices in the treatment of substance use or co-occurring disorders. Presently, it is uncertain the extent to which the Patient Protection and Affordable Care Act (2010) will affect the availability of block grants that are used in Hawai‘i to fund NHCPs in substance use and mental health treatment. However, a shift away from state block grants to Medicaid reimbursable services may be detrimental to smaller community-based providers that lack the resources to meet federal
mandates to receive third party reimbursements. NASW can advocate for policies that support the continuance of block grants to states to ensure funding sustainability of indigenous cultural practices for substance use and mental health services.

Furthermore, advancing social welfare policies will require collaboration with federal entities such as SAMSHA and the Center for Medicare and Medicaid Services (CMS). SAMHSA plays a critical role in championing any co-occurring disorder policy effort. The Children’s Health Act (2000) authorized SAMHSA to take the lead in the development of research and services related to co-occurring disorders. The law also authorized funding for these core areas. Collaborating early with SAMHSA would be a strategically wise step as they are likely to be queried by Congress in any proposed federal policy on co-occurring disorders.

Federal funding for indigenous cultural practices also involves work with CMS as a federal source of health care funding to states and tribal entities. A multiple-strategy would be needed, and while NASW can advocate for the continuance of block grants to states as one strategy, it can also work with CMS to expand reimbursable codes to providers. NASW can collaborate with CMS to examine reimbursement codes to see if indigenous cultural practices can be cross-walked (College of American Pathologists [CAP], 2002) to a comparable existing code or gap filled (CAP, 2002) to establish alternative methods when no comparable coded service exists. Opening new channels of reimbursement supports the sustainable use of indigenous cultural practices as a substance use or co-occurring disorders intervention.

Last, on a state-level, social workers and local NASW chapters can work within their state to push for the reimbursement of indigenous cultural practices in state grants,
similar to the inclusion of NHCPs in the treatment of substance use by the State of Hawai‘i (2008).

**Conclusion**

A discussion of the process of why and how an organization implemented NHCPs to address substance use or co-occurring mental health conditions among Native Hawaiians was primarily told through three conceptual frameworks from the literature in mental health recovery, organizational theory, and community best practices of culture-based recovery programs. Study findings conferred a high-level of agreement with the frameworks’ components. New areas of knowledge are the most contributory to the frameworks and a summary follows.

In a world of connections that characterizes a Native Hawaiian worldview, this study as applied to the frameworks emphasized the interconnections that reinforce Native Hawaiian relationships. Key findings that cut across the three frameworks centered on the three themes of: 1) relationships based on support, generosity, and equality; 2) identity as life giving and pre-determined, and 3) blending of Western and Hawaiian knowledge. Other important findings related to: 1) wahi pana or place-based knowledge and resources such as the significance of cultural kūpuna, 2) relational harmony such as pono and lōkahi, 3) the expansive nature of values that reinforce an individual’s connection to communal life, 4) the transferability of a healthy code of conduct from ‘āina interactions to human interactions, 5) an extended period of time to plan with communities, 6) influential role of organizational leadership in diffusion of an innovation, and 7) spirituality and faith as important implementation factors. In addition, study limitations and implications to social welfare were described.
Findings, contributions, limitations, and implications of this study are described to decrease gaps in knowledge as to the implementation of Native Hawaiian cultural practices on an organizational level, specifically in addressing substance use or co-occurring mental health conditions among Native Hawaiian adults. While this study is unique, it may provide other organizations with beneficial lessons learned by one organization that, over 14 years ago, forged into an area in which little was known with the vision to facilitate healing among Native Hawaiians.
Chapter 6. Concluding Reflections

“I went in search of truth and found myself”

Voyages have a wonderful way of bringing us back to the familiar, reaffirming what we already know in those guttural spaces of source, comfort, and truth. It is na ‘Umeke o Ka Po’e Ao Hiwa or the Bowls of Light that my mother’s family from Kamalo, Moloka‘i has cared for since the beginning of time (Willis & Lee, 2005). Within these bowls carry our ‘ohana’s truths, mo‘okū‘auhau (genealogy), and mana (spiritual light).

Because of the interest in understanding indigenous methodologies in social welfare research, I restate for clarity, the Native Hawaiian methods I used to conduct my research. In as much, I ensure to weave the strands that may have been at the fringe of my dissertation into its center.

With Kū Aloha Ola Mau, I used methods that were similar to those practiced at its program of Hui Ho‘ola O Na Nahulu o Hawai‘i, and they included: 1) watch for what is seen and not seen (observe), 2) discern what is said and not said (listen), 3) treat people with kindness and respect each person’s worth (equality), 4) participate actively (just do), 5) embrace the organization’s cultural protocol (ask permission), 6) interact informally (laugh), 7) never go empty handed (hospitality), 8) recognize spirituality (pule), 9) return the findings to participants (coming home), and 10) treat people from the perspective that they will always be in your life (relationships as infinite).

I end my long journey acknowledging that knowledge is drawn from many sources, from each other, our physical environment, and our spiritual realm. In so far, I hope this dissertation has shed light on the reality that Native Hawaiians sip from many ‘apu or cups of fresh, sacred water as sustenance. I feel honored to have shared in the
lives of others who passed on cultural knowledge, knowing that some of the knowledge was not to be shared beyond my listening. I have captured in my study the knowledge that could be shared; as for the other knowledge I have done as I have been taught, “leave it as you found it”. Thus, it remains in the na‘au (a place where wisdom resides) of those who possess it.
APPENDIX A.1

CONSENT FORM ADMINISTRATION / STAFF

Agreement to Participate in
Native Hawaiian Cultural Practices Study

Palama Lee
Principal Investigator
Phone: 291-3015

This research project represents the first part of a larger study of Native Hawaiian Cultural Practices conducted at Kū Aloha Ola Mau. It is being conducted as a component of a dissertation for a doctoral degree in Social Welfare. The purpose of the study is to explore why and how Kū Aloha Ola Mau identified, developed, and implemented Native Hawaiian Cultural Practices in the treatment of substance use or co-occurring mental health disorders. You are being asked to participate because you possess knowledge about Native Hawaiian Cultural Practices at Kū Aloha Ola Mau.

Participation in this project will consist of an individual interview or focus group activity conducted by a member of this study’s research team. Interview and focus group questions will consist of questions that help us gain an in-depth understanding of the evolution of Native Hawaiian Cultural Practices at Kū Aloha Ola Mau, the organizational factors that influence the evolution, and the organizational processes involved in the planning and implementing of these practices. Individual interviews and focus groups will be audio recorded for the purpose of transcription. This part of the study expects to involve 9-11 participants (4 Administration and 5-7 Program Staff participants).

For your time and sharing of knowledge, you will receive a makana. A makana is a Hawaiian cultural gift that includes one bag of poi, some dry fish, and a small bag of pa‘akai or sea salt.

If you agree to participate in this study, you will be interviewed individually or participate in a focus group for approximately 60 to 90 minutes. With your permission, the interview or focus group will be audio-taped for accurate data collection purposes. We want to make sure the findings accurately reflect what you share with us; therefore, we will hold a meeting to provide you with an opportunity to give feedback on the findings before our final report. Subsequently, a written report in the form of a dissertation will be submitted to University of Hawai‘i describing the results derived from this study.

Research data will be confidential to the extent allowed by law. Agencies with research oversight, such as the University of Hawai‘i Committee on Human Studies, have the authority to review research data. All individual information obtained through this study will be kept confidential within the study’s research team, and not shared with anyone.
else. We will de-identify all data and assign unique identification numbers to individual responses and interview and focus group discussions as soon as data are collected so that data are kept in de-identified form by the research team during its use. De-identification of data will involve the removing of any names, position titles, personal information unique to individuals, and any other information that could be linked to a specific individual. All information in subsequent reports and publications will be aggregated, de-identified summaries of data from the staff involved in this study.

All research records such as interview and focus group audio-tapes will be stored in a locked file cabinet in the Principal Investigator’s home office. Audio-tapes will be destroyed immediately after they are transcribed. All other research data will be destroyed one year after the end of the study. This project is expected to be completed by June 2011. Contact information for the Principal Investigator is also provided should any participant have questions or concerns about the study, their participation in the interview or focus group, or the way in which the interview or focus group was conducted.

The Principal Investigator believes there is little or no risk in participating in this research project. It is possible that answering some of the questions during the interview or focus group may cause you to feel uncomfortable. Please let us know at any time if you do not understand a question, you need clarification, you do not want to respond to that question, or you would like to stop for a while.

Participating in this research may have no direct benefit to you. It is believed, however, the results from this project may assist other organizations that are attempting to implement Native Hawaiian Cultural Practices in the treatment of substance use or co-occurring mental health services. This data may allow other organizations to plan and implement Native Hawaiian Cultural Practices to meet the needs of their consumers.

Participation in this research project is completely voluntary. You are free to withdraw from participation at any time, for any reasons, during the duration of the interview or focus group. You also have the right to revoke recording permission at any time. You will not be penalized for discontinuing participation in the interview or focus group.

Should you have any questions about this research study, your participation in the interview or focus group, or the way in which your interview or focus group was conducted, please call Palama Lee at (808) 291-3015, or email at palamal@hawaii.edu.

If you have any questions regarding your rights as a research participant, please contact the University of Hawai‘i Committee on Human Studies at (808) 956-5007, or uhirb@hawaii.edu.

Mahalo for your participation in this research project; it is greatly appreciated.
I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

(Please check all that apply)

[ ] I give permission for this interview or focus group to be recorded on an audio recorder.

[ ] I give permission for the direct quotes from this interview to be included in publications resulting from this study:

Your name: _____________________________________

Your signature: ________________________________ Date: _____________
Aloha. You are being asked to take part in a research study called the “Native Hawaiian Cultural Practices Study”, or the NHCP Study. This is a consent form about this study. The research staff will talk with you about this information. Please read this consent form. Ask any questions you may have with the research staff. Take your time in deciding if you want to be part of this study. If you do not understand any words or parts of this consent form, please ask the research staff to explain them to you. If you agree to take part in this study, you will be asked to sign this consent form. The total time you may be involved in this study is about 3 hours.

You have been asked to participate in this study because you are an adult who receives or received services from Hui Ho’ola o Na Nahulu o Hawai‘i or “the HUI”. Your participation is voluntary. If you decide to take part in this study, you can stop at any time. If you stop, it will not change or affect the care you receive from the HUI. Be assured that the information we share with the HUI will not identify you.

Purpose of the Study

This research study is part of a dissertation for a PhD in Social Welfare at the University of Hawai‘i by Palama Lee who is the Principal Investigator (PI). The reason for doing this study is to help us understand Native Hawaiian Cultural Practices (NHCPs) used at the HUI. We are interested in knowing why and how these practices were identified, developed, and implemented as a substance abuse service. We will ask you about your recovery goals and your participation in these practices.

Procedures

You will be asked to participate in one focus group and one feedback meeting. The focus group will include about four other individuals who receive(d) services from the HUI. A total of three focus groups will be held with a total of about 15 individuals. You will also be asked to participate in one meeting so we can get your feedback about our study findings. You can choose to attend or not attend this feedback meeting. We have described the focus group and the feedback meeting below.

Focus group: The focus group includes group discussions and sharing of personal experiences. The group will be led by two individuals who are trained facilitators in focus groups. One facilitator will ask the questions and the other will take notes. At the
beginning, you will be asked to complete personal information about yourself and tell us how we can contact you. There are nine questions we will discuss. These questions focus on your recovery goals and your experiences with NHCPs at the HUI. The focus group will last about 1.5 hours and it will be held at the HUI. Light refreshments will be served during the focus group. For your time, you will receive a $10.00 gift card to use at Foodland. With your permission, the focus group will be audio-taped so we can later type up the discussion, word for word.

Feedback meeting: We would like to contact you later to invite you to this feedback meeting. We expect this meeting to be held in Fall 2010. The purpose of this meeting is to present the findings of the study to you. We want to get your feedback to help us further understand and interpret the findings of the study. You do not have to come to this feedback meeting if you do not want to. You can tell us later if you want to participate in the meeting. The PI will contact you at the contact information you provide to us. The feedback meeting will be held at the HUI. Light refreshments will be served at the meeting. For your time, you will receive a $10.00 gift card to use at Foodland.

Potential Risks and Discomforts

The PI believes that there is little risk to the participants. Research staff will follow procedures to protect your personal information. However, there is a risk to confidentiality due to the use of group activities in this study. The group facilitator will emphasize to the group the importance of keeping personal information confidential.

There is also a risk of psychological pain such as you feeling upset. Answers to the questions may include sharing your experiences about the problems you have faced with substance use. The PI is a licensed clinical social worker and can provide assistance if you are feeling upset. If increased risk is detected, then the PI will ask permission from you to inform the staff of the HUI to check-in with you such as speaking with the Clinical Coordinator of the HUI about your feelings.

Potential Benefits
There is no guarantee of a benefit to people in this program. However, we believe that the results from this project may assist other organizations that want to use NHCPs to help consumers in substance use treatment.

Compensation for Participation
We want to thank you for your time in participating in this research project. You will receive a $10 gift card to use at Foodland for participating in the focus group. You will also receive a $10 gift card to use at Foodland for participating in the feedback meeting.

Confidentiality
Your personal identification information will be kept secret as allowed by state and federal law. A secret code known only to the PI will be used instead of your name. Identifying information such as your name and contact information will be kept in a separate, locked cabinet from the secret coded data. Audio-tapes, until they are typed up,
will also be kept in a locked cabinet. After we type them up, we will destroy the audio-tapes. These locked cabinets will be located in the office of the PI. However, the University of Hawai‘i (U.H.) Committee on Human Studies has the right to review research data. This project is expected to be completed by June 2011. All research data, including personal identifiable data, will be destroyed 12-months after that date.

Participation and Withdrawal
You can volunteer to be in this research project or not. If you volunteer, you can withdraw at any time for any reason. Withdrawing from the study will have no impact on your services at the HUI, you will still get the regular treatment from the HUI. You also have the right to ask us to stop recording at any time. If you stop participating in this research project before it is finished, it will not change or affect the care you get from the HUI.

If you have any questions regarding this research project, please contact Palama Lee at (808) 291-3015.

If you have any questions regarding your rights as a research participant, please contact the U.H. Committee on Human Studies at (808) 956-5007, or uhirb@hawaii.edu.

Statement of Consent
I have read the above information about this research project, or it was read to me. I have had the chance to discuss this project with _____________________________, research staff member.

- I agree to take part in this study of my own free will.
- I am 18 years of age or older.
- I understand that I can stop participating at any time. If I stop, it will not affect my services from the HUI.
- I understand that if I feel upset by this project, I will have the opportunity to talk to the PI and the Clinical Coordinator of the HUI. I can also contact my social support persons such as my friends, sponsor, or family member. I can also call 911 or the Crisis Hotline at 832-3100.
- The researcher answered my questions in language I understood.
- My consent to participate in this project does not take away any of my legal rights in the event of negligence or carelessness of anyone working on this project.
- A copy of this consent form was given to me.

______________________________  
Name (printed)

______________________________  
Signature of Participant         Date
CONSENT

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

(Please check all that apply)

[ ] I give permission for this focus group to be recorded on an audio recorder.

[ ] I give permission for the direct quotes from this interview to be included in publications resulting from this study. I understand that my name will not be used when quoting me directly.

Your name: ________________________________ (Please Print)

Your signature: ________________________________ Date: __________

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

______________________________
Name (printed)

______________________________
Date

______________________________
Signature

______________________________
Role in Study
APPENDIX A.3

CONSENT FORM REFERRAL

Agreement to be Referred to Native Hawaiian Cultural Practices Study for Haumāna
Palama Lee
Principal Investigator
(808) 291-3015

This research project is being conducted as a component of a dissertation for a doctoral
degree. The purpose of the project is to explore how one organization identified,
developed, and implemented Native Hawaiian cultural practices in the treatment of
substance use and mental health disorders so that we can learn about ways to use Native
Hawaiian cultural practices in treatment.

Referral to this project will consist of your name and phone number given to the
researcher of the project. If you agree to be referred, then the researcher will contact you
and explain the purpose of the study and how you can participate in the study. You were
asked to participate because you are: a) an adult (18 years of age and older), b) Native
Hawaiian, c) current haumāna of Hui Ho’ola o Na Nahulu o Hawai’i, and d) able to
safely and openly participate in a focus group forum.

Being referred to this research may have no direct benefit to you. It is believed, however,
the results from this research may help by making recommendations for developing other
culturally based services to better address haumāna needs. The researcher believes there
is minimal to no risk to be referred to this research project.

All research data will be kept confidential. All research records will be stored in a locked
file in the researcher’s office for the duration of the research project. Information about
you is confidential. Therefore, we will code information you give me. We will keep the
link between your name and the code in a separate, secured location until one month after
we obtain the information to allow time for transcription of audiotapes. Then we will
destroy the link. Audio tapes will be destroyed immediately following transcription. If we
publish the results of this study, we will not use your name. All other research records
will be destroyed upon completion of the project. Agencies with research oversight, such
as the UH Committee on Human Studies, have the authority to review research data.

Participating in this research project is completely voluntary. You are free to withdraw
from participation at any time during the duration of the project with no penalty, or loss
of benefit to which you would otherwise be entitled. You may re-enter if you choose to.

Participating in this research may be of no direct benefit to you. It is believed, however,
the results from this project may help by making recommendations for developing other
culturally based services to better address haumāna needs.
If you have any questions regarding this research project, please contact the researcher, Palama Lee, at 291-3015.

If you have any questions regarding your rights as a research participant, please contact the UH Committee on Human Studies at (808)956-5007, or uhirb@hawaii.edu

Participant:
I have read and understand the above information, all my questions have been answered, and I agree to participate in this research project.

_______________________________  ______________________
Name (printed)                          Date
CONSENT FORM – RECORDS HAUMĀNA

KU ALOHA OLA MAU
1130 N. Nimitz Hwy., Suite C302 Honolulu, Hawai‘i 96817
Tel: (808) 538-0704  Fax: (808) 538-0474

East Hawaii Clinic  Hui Ho‘ola
900 Leilani Street  P.O. Box 2300
Hilo, Hawaii 96720  Pahoa, HI 96778
Tel: (808) 961-6822  Tel: (808) 982-9555
Fax: (808) 934-9360  Fax: (808) 982-9554

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

I authorize and request Hui Ho‘ola o Na Nahulu o Hawai‘i of Kū Aloha Ola Mau to disclose/obtain (please initial all appropriate choices):

MD phone no. ____________  Pharmacy phone no. ____________

Verbal ___, Written ___X___, or Electronic/Facsimile ___X___ information from the treatment records as follows:

Patient Name: ____________________________  Date of Birth: _________________

Release to: ________________________________

Obtain from: Hui Ho‘ola O Na Nahulu O Hawai‘i, a program of Kū Aloha Ola Mau

For the purpose of: Research to identify what Native Hawaiian Cultural Practices are used in treatment, how they are used, and the extent to which they are effective.

The types of medical information below cannot be released without my specific consent and knowledge. Therefore, I have initialed before each type of information that I authorize you to release (initial type of information to be released):

___________ Alcohol and/or Drug Abuse Treatment Records.
___________ Psychiatric Treatment Records.
___________ AIDS, or HIV Testing Records.

I hereby release _____________________________

and its staff from all liability and all claims of any nature pertaining to the disclosure of information of any professional opinions, findings, or recommendations contained in these records.
This consent may be revoked at any time, upon notice of the person who has signed below, except when action has already been taken. Without revocation, this consent will expire one year from date of signature.

Date: ________________________________
Signature: ________________________________
Witness: ________________________________
Relationship to patient: ________________________________

Redisclosure is prohibited

This information has been disclosed to your form records protected by Federal (42 CFR part 2), Federal Health Insurance Portability and Accountability Act (HIPAA 45 CFR, parts 160 & 164), and State (HRS 325-101) confidentiality rules. The Federal rules and State law prohibit further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2, HIPPA, and HRS 325-101. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
Revised: April 2007
APPENDIX B.1

RECRUITMENT PROTOCOL OF ADMINISTRATION

The following protocol describes how administrative staff will be recruited to the study by the Executive Director of Kū Aloha Ola Mau.

Protocol:

1. The Executive Director of Kū Aloha Ola Mau will determine if the individual meets the inclusion criteria.
   a. Inclusion Criteria:
      i. Possesses knowledge about the history of the organization including its funding, policies and procedures, and services, and
      ii. Previously or currently involved in the governance of the organization such as an administrative position, a member of the board of directors, organizational consultant, or member of a kūpuna or elder council. The inclusion criteria for the program sample include the following: 1) presently employed at Hui Ho'ola o Na Nahulu o Hawaiʻi substance use program.
2. If yes, then the Executive Director will inform the researcher (either by email or telephone) the names and phone numbers of the individuals.
3. The researcher will immediately give a numerical code to each individual and keep the list of codes and the identifying information separate. After initial contact by the researcher is made to the individual, the researcher will dispose of the identifying information of that individual.
4. The initial contact will include: a) greeting and source of referral, b) purpose of study, c) expected involvement in the study such as participation in one interview, d) approximate length of interview, e) rights to confidentiality, f) procedure to de-identify data and when data will be de-identified, g) purpose of audio recording interview, and f) answering of any questions.
5. The individual will be asked if they want to participate in the study.
   a. If no, the researcher will thank the individual for their time.
   b. If yes, the researcher will provide the individual with dates and times to meet the researcher at the program to conduct the interview. The researcher will inform the individual that he will call one day before the scheduled interview date to confirm the date, time, and location of the interview.
6. The day before the scheduled interview date, the interviewer will call the individual to confirm the date, time, and location of the interview.
7. During the initial face-to-face meeting, the consent to participate will be read verbatim and questions related to the consent and/or the study will be explained. Once the individual gives consent to participate in the interview, then the interview will be conducted.
APPENDIX B.2

RECRUITMENT PROTOCOL OF PROGRAM STAFF

The following protocol describes how Hui Ho'ola o Na Nahulu o Hawai‘i staff will be recruited to the study.

Protocol:

1. Inclusion criterion:
   a. Currently working at Hui Ho'ola o Na Nahulu o Hawai‘i (paid or volunteer staff).

2. The researcher will email the Clinical Coordinator of Hui Ho'ola o Na Nahulu of Hawai‘i and request that the Clinical Coordinator post 3 recruitment announcements in each of the staff offices. The recruitment information will include the following:
   a. Purpose of the study
   b. Expected involvement in the study
   c. Approximate length of focus group
   d. Rights to confidentiality
   e. Procedure to de-identify data and when data will be de-identified
   f. Purpose of audio recording interview
   g. Date, time, and location of focus group.

3. Individual will be asked if s/he wants to participate in the study to call the researcher at 291-3015.

4. The researcher will inform the individual that he will call one day before the scheduled focus group date to confirm the date, time, and location of the focus group.

5. The day before the scheduled focus group date, the interviewer will call the individual to confirm the date, time, and location of the interview.

6. On the day of the focus group, the consent to participate will be read verbatim and questions related to the consent and/or the study will be explained. Once individuals give consent to participate in the focus group, then the focus group will be conducted.
APPENDIX B.3

RECRUITMENT PROTOCOL OF HAUMĀNA

The following protocol describes how consumers will be referred to the study by Hui Ho‘ola o Na Nahulu o Hawai‘i staff. The protocol is written in a format to guide the staff through the referral. Prior to referral, the PI will train the program’s Clinical Coordinator and Program Manager on the following: a) the study’s purpose, b) the inclusion criteria, c) on language to use in informing the client about their participation being voluntary and their right to not participate or withdraw at any time with no effect on their services from the agency, and d) how to administer the Permission to Contact form and to clearly explain to the client what the permission form is for.

Procedure:

1. Does the consumer meet the following criteria to be referred to the research project?
   a. Inclusion Criteria:
      i. Adult (18 years of age and older)
      ii. Native Hawaiian
      iii. Current program consumer of Hui Ho‘ola o Na Nahulu o Hawai‘i OR a graduate of the program within 12 months.

2. If yes, then the Clinical Coordinator and Program Coordinator will meet with the client and:
   a. provide the client with general information about the purpose of the study,
   b. ensure the client is aware that s/he does not have to participate if s/he does not want to, and
   c. ensure the client is aware that her/his services received from the agency, or services they are eligible to receive from the agency, will not be affected in any way by not participating.

3. If the client indicates an interest in finding out more about the study or participating in the study, then the client will be:
   a. asked to sign the Permission to Contact Form allowing the PI (or member of his research team) to contact the client at a later date to conduct the initial interview, including administering the Consent to Participate Form and assessing the client’s competency to provide informed consent to participate in the study

4. Place the Permission to Contact Form in the provided self-addressed stamped envelope, seal it, and mail it to the PI.
APPENDIX C.1

INTERVIEW GUIDE (ADMINISTRATION): INTRODUCTION AND QUESTIONS

Introduction – Key Informant Interviews

Aloha, my name is Palama Lee from the University of Hawai‘i and I want to thank you for agreeing to participate in the interview/focus group. I am gathering information on Native Hawaiian cultural practices at Kū Aloha Ola Mau. I would like to know the process of why and how your organization identified, developed, and implemented Native Hawaiian cultural practices.

In the interview, I will ask you about your knowledge and experience with this process.

The information you provide will be kept confidential. No identifying information will be used unless you give your permission. The interview will take about 90 minutes, and I would like to record your answers.

If you are willing to participate and be recorded by an audiotape, please sign the attached consent form.

Key Informant Interview Questions

Q1.
1. Can you describe your relationship to Kū Aloha Ola Mau?

Q2.
1. What Native Hawaiian cultural practices have been offered to haumāna at Kū Aloha Ola Mau?

Probing Question.
1. Where did these practices come from?
2. If any practice is no longer offered, can you describe why it is no longer offered?

Q3.
1. Why did Kū Aloha Ola Mau adopt Native Hawaiian cultural practices?

Q4.
1. How did Kū Aloha Ola Mau adopt Native Hawaiian cultural practice(s) as a treatment model?

Probing Question(s).
1. Were practices adopted at the same time or at different times?
2. What did the process to adopt look like?
   a. What factors influenced the decision to adopt the practice(s)?
i. Were the quality and utility of the practice(s) a factor?
ii. Was adaptability of the practice(s) to meet certain characteristics of your organization a factor (e.g., existing values, existing treatment modalities)?
b. What actions followed the decision to adopt?
   i. Was there a “trial period” to test out practice(s)?
   ii. Did the practice(s) live up to expectations (e.g., satisfied with the preliminary results)?
c. Was there resistance to adopt?

3. What factors influenced the adoption of Native Hawaiian cultural practices?
4. What would you do differently if you were to adopt cultural practices again?

Q5.
1. How did Kū Aloha Ola Mau implement Native Hawaiian cultural practices?

Probing Questions.
1. Were practices implemented as adjunct services (added to other existing services) or were they stand-alone services (offered only as cultural practices)?
2. Were practices implemented together or at different times? Why?
3. What went well during the implementation?
4. Were there barriers to implementation, and if so, what were they?
5. What factors influenced the implementation of Native Hawaiian cultural practices?
6. What would you do differently if you were to implement cultural practices again?

Q6.
1. Describe how the organization changed over time as it adopted and/or implemented Native Hawaiian cultural practices?

Probing questions.
1. If practices were adopted and/or implemented over time, describe how after each adoption and/or implementation the organization changed
2. If practices were adopted and/or implemented at the same time, describe how after the adoption and/or implementation the organization changed.
3. What factors influenced the change process?

Q7.
1. Is there anything else you would like to share on this subject? Or, perhaps you have questions for me.
APPENDIX C.2

FOCUS GROUP GUIDE (PROGRAM): INTRODUCTION AND QUESTIONS

Introduction – Focus Group (Program Staff)

Aloha, my name is Palama Lee from the University of Hawai‘i and I want to thank you for agreeing to participate in the interview/focus group. I am gathering information on the Native Hawaiian cultural practices at Kū Aloha Ola Mau. I would like to know the process of why and how your organization identified, developed, and implemented Native Hawaiian cultural practices. Our focus group facilitator is ______________. He will be asking you about your knowledge and experience in the implementation of Native Hawaiian cultural practices. During the focus group, I will be taking notes.

The information you provide will be kept confidential. No identifying information will be used unless you give your permission. The focus group will take about 90 minutes.

If you are willing to participate and be recorded by an audiotape, please sign the attached consent form.

Focus Group Questions (Program Staff)

Q1.
1. Please describe what you do at Hui Ho‘ola o Na Nahulu o Hawai‘i.

Q2.
1. What Native Hawaiian cultural practices are offered at Hui Ho‘ola o Na Nahulu o Hawai‘i to haumāna in recovery?

Probing question(s)
1. Are the practices offered on site or are they offered off-site?
2. Does certain staff deliver certain types of practices?
3. Does staff receive and/or need a certain type of training to deliver the practices?
4. Are certain types of resources required to deliver the practices?

Q3.
1. What factors influence implementation?

Probing question(s)
1. How does leadership influence implementation?
2. How does funding influence implementation?
3. How does staff attributes (e.g., value professional growth, confidence in own skills, interactions and values, ability to adapt) influence implementation?
4. How do costs influence implementation?
5. How does the organizational climate influence implementation (e.g., its mission, the way it communicates, staff trust, level of stress, and its openness to change).

Q4.
1. Does the program delineate between Native Hawaiian cultural practices and Western practices?
2. If so, what is the difference and is this difference conveyed to haumāna?

Q5.
1. Is there anything else you would like to share on this subject? Or, perhaps you have questions for me.
APPENDIX C.3

FOCUS GROUP GUIDE (HAUMĀNA): INTRODUCTION AND QUESTIONS

Introduction – Focus Group (Haumāna)

Aloha, my name is Palama Lee from the University of Hawai‘i and I want to thank you for agreeing to participate in the interview/focus group. I am gathering information on the Native Hawaiian cultural practices at Kū Aloha Ola Mau. I would like to know the process of why and how your organization identified, developed, and implemented Native Hawaiian cultural practices. Our focus group facilitator is ______________. He will be asking you about your experience in recovery and what helped and/or hindered your recovery. During the focus group, I will be taking notes. The information you provide will be kept confidential. No identifying information will be used unless you give your permission.

The focus group will take about 60-90 minutes.

Remember:
• No right and wrong answers.
• We want to hear from each of you; we will call on quiet folks and ask talkative folks to “hold that thought.”
• Everything you say is confidential; data will be aggregated and reported in my dissertation.

Because we need to describe who we spoke to, we will ask you to complete a “data sheet”.

If you are willing to participate and be recorded by an audiotape, please sign the attached consent form.

Focus Group Questions

Q1. (OPENING)
1. What do you like to do?

Q2. (RECOVERY)
1. What does “recovery” mean to you?

Q.3. (RECOVERY OUTCOMES)
1. What do you want to get out of recovery?

Q.4. (ORG READINESS & FUNCTIONING)
1. Please describe what is helping you in this program?

Probing Questions
1. How has program resources (e.g., location of site, accessibility of site, meeting room) helped you in your recovery? (Resources)
2. How has staff helped you to your recovery? (Staff attributes and Training)
3. How has the cost of services helped you in your recovery?

Q.5. (ORG READINESS & FUNCTIONING)
1. Please describe what is not helping you in this program?

Probing Questions
1. How has program resources (e.g., location of site, accessibility of site, meeting room) not helped you in your recovery? (Resources)
2. How has staff not helped you to your recovery? (Staff attributes and Training)
3. How has the cost of services not helped you in your recovery?

Q.6. (IDENTIFICATION & IMPLEMENTATION OF NHCPs)
1. In this program, what has been your experience with Native Hawaiian Cultural Practices?

Probing Questions
1. What has been your experience with kūpuna? How has this experience helped you in your recovery?
2. What has been your experience with land and sea-based activities? How has this experience helped you in your recovery?
3. What has been your experience with Native Hawaiian values and traditional practices? How has this experience helped you in your recovery?
4. What has been your experience with the Native Hawaiian language? How has this experience helped you in your recovery?
5. What has been your experience with the program including your ‘ohana into your recovery? How has this experience helped you in your recovery?
6. What has been your experience with the program including the community (e.g., your neighborhood, your church members, your canoe club) into your recovery? How has this experience helped you in your recovery?

Q.7. (IDENTIFICATION & IMPLEMENTATION OF NHCPs – GENERALIZABILITY)
1. Now that you have just described your experiences with Native Hawaiian Cultural Practices, I would like to ask you if you think these practices have been helpful to every haumāna or only to you? Please describe.

Q.8. (LESSONS LEARNED)
1. If you were the program director for a day, what would you change about this program so that it better connects your culture to your recovery?

Q.9. (CLOSING)
1. Is there anything else you would like to share on this subject? Or, perhaps you have questions for me.
APPENDIX D.1

CAPACITY ASSESSMENT

INSTRUCTIONS FOR ASSESSORS: Please review the Capacity Assessment before initiating the focus group interview. Ask the prospective participant to answer the following questions as True or False. Refrain from interviewing participants unable to answer all questions correctly. Thank you. If you have any questions or require assistance, please call Palama Lee, Principal Investigator of the NHCP Research Project, at 291-3015.

I. I will be asked questions about services I receive(d) here at this substance use treatment program.

☐ TRUE

☐ FALSE

II. Questions asked in the focus group interview may make me feel uncomfortable.

☐ TRUE

☐ FALSE

III. I can stop my participation in the focus group interview at any time.

☐ TRUE

☐ FALSE

IV. I am not allowed to ask any questions.

☐ TRUE

☐ FALSE

V. The purpose of this project is to understand why and how Native Hawaiian Cultural Practices are identified, developed, and implemented at Kū Aloha Ola Mau.

☐ TRUE
FALSE

**NHCP USE ONLY**

Agency Name: ___________________  Name of Assessor: ___________________

Number of items correct: ______ OF FIVE

Signature: ___________________________________________________________

Date: __ __ / __ __ / 20__

This form is adapted from the Hawai‘i State Department of Health, Adult Mental Health Division, Evidence-Based Practices Training and Evaluation Grant, Informed Consent for Fidelity Assessment of Interviews. Permission to use and adapt this form was obtained.
## APPENDIX E.1

ARCHIVAL RECORDS AND DOCUMENTS. DATA COLLECTION – ADMINISTRATION.

<table>
<thead>
<tr>
<th>Archival Records and Documents</th>
<th>Document mentions Native Hawaiian Cultural Practices (NHCPs).</th>
<th>Document mentions why and/or how NHCPs were identified.</th>
<th>Document mentions why and/or how NHCPs were developed.</th>
<th>Document mentions why and/or how NHCPs were implemented.</th>
<th>Document identifies key factors influencing evolution of NHCPs.</th>
<th>Document identifies the benefits and/or who will benefit from the use of NHCPs.</th>
<th>Document mentions how the organization changed over time as it implemented NHCPs.</th>
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APPENDIX E.2
ARCHIVAL RECORDS AND DOCUMENTS. DATA COLLECTION – PROGRAM

<table>
<thead>
<tr>
<th>Archival Records and Documents</th>
<th>Document mentions Native Hawaiian Cultural Practices (NHCPs).</th>
<th>Document identifies specific NHCP.</th>
<th>Document mentions how NHCPs are implemented.</th>
<th>Document identifies key factors influencing implementation of NHCPs.</th>
<th>Document identifies the benefits and/or who will benefit from the use of NHCPs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Fact Sheet (History, Outcomes, and Description)</td>
<td></td>
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<tr>
<td>Native Hawaiian Curriculum Outline notes</td>
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</table>
# APPENDIX E.3

## ARCHIVAL RECORDS AND DOCUMENTS. DATA COLLECTION – HAUMĀNA

<table>
<thead>
<tr>
<th>Archival Records and Documents</th>
<th>Document mentions Native Hawaiian Cultural Practices (NHCPs).</th>
<th>Document identifies specific NHCP.</th>
<th>Document mentions haumāna recovery outcome</th>
<th>Document mentions how participation in NHCP is/was helpful to the haumāna</th>
<th>Document mentions how participation in NHCP is hindering or hindered the haumāna</th>
<th>Document mentions participation in NHCP helped and/or hindered haumāna in their recovery outcome</th>
<th>Document identifies the benefits and/or who will benefit from the use of NHCPs.</th>
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</thead>
<tbody>
<tr>
<td>Treatment Plan</td>
<td></td>
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<td>Progress Notes</td>
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<td>Discharge Summary</td>
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</table>
RESPONSES TO CHS’S REQUEST FOR FURTHER CLARIFICATION

June 6, 2010

Memorandum

To: Committee on Human Studies
   University of Hawai‘i
From: Palama Lee, MSW, LCSW
       Myron B. Thompson School of Social Work - Dissertation
RE: CHS 18057 “An Examination of the Evolution and Implementation of Native Hawaiian Cultural Practices in the Treatment of Adult Substance Use or Co-Occurring Mental Health Disorders: An Organization Case Study Focusing on Consumers”.

Dear Committee Members,

The following are responses to your request for further clarification, elaboration, and revisions to our proposal and consent form regarding CHS 18057 “An Examination of the Evolution and Implementation of Native Hawaiian Cultural Practices in the Treatment of Adult Substance Use or Co-Occurring Mental Health Disorders: An Organization Case Study Focusing on Consumers”.

1) The Committee had concerns regarding the telephone consent process. The primary issue is that it be clear that participants are competent to consent. Further, that it is understood by the participant that they do not need to participate. Committee members questioned whether there are any procedures planned, or that could be put in place at the point of initial face to face contact, to assure that the PI, or other research staff present are aware of the competence issue, and will be alert to watch for problems.

Response:

The application has been revised to clarify the procedures of referral and consent to address the above mentioned concerns by the Committee. Also, I have provided a summary in bullet format to clarify the procedure.

Recruitment

- The Clinical Coordinator and Program Manager of the treatment program will identify clients who meet the following inclusion criteria: a) adult, b) Native Hawaiian, and c) currently receiving services or graduated within 12 months from the program. The rationale for the Clinical Coordinator and Program Coordinator identifying and initially screening clients is that they maintain a trusting and
familiar relationship with each client; they know the client’s ethnic background, and have knowledge of the level of participation in the program.

- Upon meeting each client, the Clinical Coordinator and Program Coordinator will: a) provide the client with general information about the purpose of the study, b) ensure the client is aware that s/he does not have to participate if s/he does not want to, and c) ensure the client is aware that his/her services received from the agency or services they are eligible to receive from the agency will not be affected in any way for not participating. If the client indicates an interest in finding out more about the study or participating in the study, then the client will be: a) asked to sign the Permission to Contact Form allowing the PI (or member of his research team) to contact the client at a later date to conduct the initial interview, including administering the Consent to Participate Form and assessing the client’s competency to provide informed consent to participate in the study.

Consent to Participate

- The PI will meet with the client and review together the Consent to Participate Form. Then the PI will conduct the Capacity Assessment form (Attachment B.1.) to ensure the client is competent to provide an informed consent. Only after the client answers all items correctly will the PI proceed with obtaining informed consent. Again, it will be emphasized to the client that participation is completely voluntary, and if they chose not to participate, or if they decide to withdraw from the study after they have consented to participate, that they will not have any of the services they currently receive or are eligible to receive affected by their decision.

2) In addition, members questioned whether staff from the treatment facility might also be involved in screening or referring eligible participants, to help address concerns about competency. Is there a concern that such a procedure might result in selection bias?

Please see answer to #1, recruitment procedures. Also, the recruitment procedure will definitely result in selection bias. The PI acknowledges this limitation in dealing with a vulnerable population in that we are only able to talk to people who are able to talk to us. Because of this concern, we have added question seven to the Focus Group Questions or Appendix A.1 of the application which states, “Now that you have just described your experiences with Native Hawaiian Cultural Practices, I would like to ask you if you think these practices have been helpful to every haumāna or only to you?” We added this question to obtain the perception of clients and the extent to which the benefits of these practices can be applied to other clients beyond this select group.

3) On page 2 of the CHS application, the description of the recruiting procedures states that the PI will be conducting the Capacity Assessment. In the next paragraph, however, it appears that the Clinical Coordinator and the Program Coordinator will recruit the participants. Please clarify.
• **Recruitment.** As indicated in the response to #1, the Clinical Coordinator and Program Coordinator will assist in the screening of potential study participants. They will determine if clients meet the eligibility criteria through their knowledge of the client’s ethnic background, participation in the program, and baseline competency. All eligible clients who wish to participate will be referred to the PI by signing the Permission to Contact Form.

• **Consent to Participate.** The PI (or a member of the research team) will contact the client to arrange for an initial interview. In this interview, the PI will review with the client the Consent to Participate form, and administer the Capacity Assessment form. All clients assessed to clearly understand the information contained in the Consent form who want to participate will be asked to sign the form. A copy of the Consent to Participate form will be provided to the client.

4) The protocol described for the Capacity Assessment indicates that subjects will be considered eligible if they answer 3 of the 5 questions correctly. The Committee, however, felt that answering question III incorrectly, and possibly question IV, should by themselves be considered proof the subject is not able to offer informed consent.

In response to the Committee’s concern about the criteria for passing this assessment instrument, we will now require that the client provide the correct response to all 5 questions before any client can consent to participate in the study. Since each item represents a critical component in ensuring that the client understands the conditions for his/her involvement in the study, and since each paragraph of the consent form is thoroughly discussed with the client prior to the start, missing a single item raises doubt in the mind of the researcher as to the competency of the client.

5) Is it possible any of the potential subjects might be considered mentally disabled? If so, this should be noted on section 2 of the application.

See revised application, section 2.

6) It is unclear as to how the medical records will assist in this research. Please clarify how the medical records will be used. Also, will the medical records be linked with the subject’s treatment plan?

The specific documents that will be reviewed in the medical record include the following:
1. Treatment plan,
2. Progress notes, and
3. Discharge summaries, if applicable.

The medical records will assist the research as a separate source of data to examine the implementation process of Native Hawaiian Cultural Practices (NHCPIs) at the organization. First, the documents identified above in the medical records identify
what NHCPs are implemented in treatment (e.g., chants or oli), how they are implemented (e.g., at the beginning of every education group meeting), and the extent to which they are/were effective (e.g., helpful and/or not helpful to the client’s recovery). Discharge summaries were included because if the sample at the treatment program is similar to other individuals who seek substance use treatment, then it is likely that they may have been discharged from the program (e.g., completed treatment or early termination for non-compliance) and are returning for additional treatment services. Therefore, the discharge summaries may indicate if NHCPs were identified as a reason for discharge.

Second, because the implementation literature indicates that an important component of the implementation process is the outcomes of service use, the medical records will be used to describe the connection of NHCPs to client self-identified recovery goals. Client stated goals and perceived benefits of treatment influence treatment retention and treatment success.

Last, the Committee asked if the medical records will be linked with the subject’s treatment plan. As mentioned previously, the Treatment plan is part of the subject’s medical record.

7) In section 3a of the application form, psychological pain should be checked as a potential risk. This should be stated on the consent form as well. Steps that will be taken to address this potential risk should be noted in section 3b of the application as well. For example, instructions to focus group participants about keeping the confidentiality of the discussion and reference to question 4 with regards to handling subjects experiencing distress.

In section 3.a. of the application, psychological pain has been checked off, and it has been added to the consent form.

In section 3.b., steps to address the potential risk of psychological pain have been added such as the presence of trained staff at the focus group as well as being able to ask the Clinical Coordinator of the program to check-in with the participant experiencing such risk. Also, in section 3.b., in order to address loss of privacy, a statement has been added instructing focus group participants to protect the privacy of others by keeping confidential all focus group discussions.

In section 4, steps have been added to address how participants experiencing distress will be handled.

8) Gas cards may not be an appropriate means of compensation for all participants. Some subjects may not drive.

Foodland gift cards for $10.00 have been substituted for the Gas cards. The Program Coordinator thought that Foodland gift cards were appropriate and clients will have a choice of using the gift cards at either the Pahoa or Hilo locations.
9) A template of the “Authorization for Use or Disclosure of Protected Health Information (PHI)” should be filled out and submitted as part of this application, so that it is clear what specific information will be collected.

The agency’s Authorization to Release/Obtain Confidential Information form (Attachment B.4) has been added as part of the application. The form has been filled out to the extent possible. On the form, the client can authorize the release of information related to: 1) Alcohol and/or Drug Abuse Treatment Records, 2) Psychiatric Treatment Records, and 3) AIDS or HIV Testing Records. This study will only collect information that relates to the client’s Alcohol and/or Drug Abuse Treatment Records to assist in identifying what NHCPs were used in treatment, how they were used, and the extent to which they were effective. Again, the research project plans to only review the client’s Treatment plan, Progress notes, and Discharge summaries. While the form does not allow for the listing of these documents, the PI (or a member of his research team) will explicitly inform the client that the study will review only these three documents before s/he considers to provide consent to review her/his records. We are working with the agency to see if these documents can be added to the form.

10) On the “Permission to Contact Form”, the line “Records received by…” should be removed. The protocol makes no reference to any records being collected at this point. Also, please verify whether the actual mailing address is required, and if it is not, remove this as well.

The “Records received by…” line has been removed as well as the line requesting the client’s mailing address.

11) The consent form reading level should be simplified. The consent should also note the total time involved in participating in this project will be around 3 hours.

The attached consent has been simplified. Also, the estimated total time of 3 hours to participate in this study has been added to the consent.

12) In the signature section of the consent form, the checkboxes for recording the focus group session and for direct quotes should be larger, or more prominent. Also, please verify that the quoting directly will be without using the subject’s names.

Checkboxes have been enlarged, and a sentence indicating that direct quoting will not use the subject’s name was added.

13) The consent form should include an assurance that any data or reports provided by, or about the subject, which are to be shared with the treating organization, will not be linked or identifiable.

This assurance was added to the consent form.
Should you require further clarification, elaboration, or revisions, or have any questions on the responses provided, please call me at 291-3015, or email me at palamal@hawaii.edu

Mahalo for your comments and feedback on my original proposal. I look forward to hearing back from the Committee on these responses.

Aloha,

Palama Lee, MSW, LCSW
Myron B. Thompson School of Social Work - Dissertation
University of Hawai`i at Manoa
# APPENDIX G

## GLOSSARY OF HAWAIIAN TERMS

<table>
<thead>
<tr>
<th>Hawaiian Term</th>
<th>Working Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Āina</td>
<td>Land</td>
</tr>
<tr>
<td>‘Ākoakoa</td>
<td>Integration</td>
</tr>
<tr>
<td>‘Imi Ke Ola Mau</td>
<td>To seek life and healing through ke Akua, and is the name of a partnership of community providers that promote the utilization of Hawaiian practices to address co-occurring disorders among Native Hawaiians</td>
</tr>
<tr>
<td>‘Ohana</td>
<td>Family</td>
</tr>
<tr>
<td>‘Ohe kāpala</td>
<td>The practice of stamping or printing with bamboo</td>
</tr>
<tr>
<td>‘Ōlelo</td>
<td>The Hawaiian language</td>
</tr>
<tr>
<td>‘Ōlelo no‘eau</td>
<td>Wise or poetic sayings</td>
</tr>
<tr>
<td>Hilo</td>
<td>District located on the eastern part of Hawai‘i Island</td>
</tr>
<tr>
<td>Ho‘oponopono</td>
<td>The practice of resolving relational conflicts</td>
</tr>
<tr>
<td>Hui Ho‘ola o Na Nahulu o Hawai‘i</td>
<td>The group that gives life and healing to the island, and is the name of the program involved in the case study</td>
</tr>
<tr>
<td>Ka Po‘e Ao Hiwa</td>
<td>Carriers of the Sacred Light as a reference to my mother’s Kamalo family in Tales of the Night Rainbow (2005).</td>
</tr>
<tr>
<td>Kako‘o</td>
<td>Assistant</td>
</tr>
<tr>
<td>Ke Akua</td>
<td>God</td>
</tr>
<tr>
<td>Koho‘ia</td>
<td>Choice or No Choice</td>
</tr>
<tr>
<td>Kū Aloha Ola Mau</td>
<td>To stand tall, with love, to perpetuate healing and life, and is the name of the organization involved in the case study.</td>
</tr>
<tr>
<td>Kūkākūkā</td>
<td>Focused discussion</td>
</tr>
<tr>
<td>Kuleana</td>
<td>Responsibility, privilege, right</td>
</tr>
<tr>
<td>Kūpuna</td>
<td>Elders and ancestors</td>
</tr>
<tr>
<td>La‘au lapa‘au</td>
<td>Practice of traditional medicinal herbs</td>
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<td>Hawaiian Term</td>
<td>Working Definition</td>
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<td>--------------------</td>
<td>---------------------------------------------------------</td>
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<tr>
<td>Lōkahi</td>
<td>Unity, oneness, balance</td>
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<tr>
<td>Mākua</td>
<td>Parents</td>
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<tr>
<td>Mālama</td>
<td>Preserve, protect, maintain</td>
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<td>Moʻokūʻauhau</td>
<td>Genealogy</td>
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<tr>
<td>Oli</td>
<td>Chant</td>
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<tr>
<td>Piliʻana</td>
<td>Connections</td>
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<tr>
<td>Pilialoha</td>
<td>Loving relationships</td>
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<tr>
<td>Pono</td>
<td>Morality, Justice</td>
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<tr>
<td>Pule</td>
<td>Prayer</td>
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<tr>
<td>Puna</td>
<td>District on the Southwest part of Hawaiʻi Island</td>
</tr>
<tr>
<td>Wahi Pana</td>
<td>Sense of place or a notable and distinct area</td>
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</table>
REFERENCE


D. Kavanagh (Eds.), *Translation of addictions science into practice*. (pp. 277-320). Amsterdam NL: Elsevier B.V.


Paglinawan, R.L. (February, 2011). *Pono Triad*. Paper presented at the meeting of the Native Hawaiian Health Scholarship Program on He Mea Ho‘oponopono, Kane‘ohe, HI.


