

Behavioral Healthcare Through the Consumer Lens

Maternal Behavioral Health & Substance Use
Service Provision in Hawaii

May 9, 2022



Table of Contents

Executive Summary	3
Objectives	3
Summary of Findings	4
Background & Introduction: Maternal Behavioral Health & Substance Use in Hawaii	5
Treatment Landscape	5
Prevalence of Select Health Indicators	5
Hawaiian Cultural Considerations	7
Areas of Innovation Opportunity in Hawaii	8
Navigating Care	8
Challenges Accessing Providers	9
Holistic Family Support Needs	10
Cultural Responsiveness: Understanding Cultural Norms and Practices	12
Effective Consumer Engagement	14
Beyond Innovation	15
Communication and Collaboration Across the Ecosystem	15
Housing as Healthcare	16
Domestic Abuse & Receipt of Treatment	17
Appendices	18
Methodology	18
Defining Key Stakeholders	18
Domains of Exploration	19
Recruitment and Engagement Process	19
Project Partners	22
Bibliography	23

Executive Summary

Objectives



The Medicaid Innovation Collaborative (MIC) aims to advance health equity in Medicaid by enabling Medicaid programs to adopt innovations that can address deep-rooted health disparities. To that end, the MIC program brings together the voices of clinical providers, community-based organizations, health plans, state Medicaid agencies, and beneficiaries to develop and deploy digital health and care delivery innovations that reflect the diverse range of real-time priorities and needs of the full Medicaid ecosystem. In the inaugural cohort, made possible through the generous support of The MolinaCares Accord, CommonSpirit Health, and Hopelab, Hawaii’s state Medicaid program (Med-QUEST) elected to focus their efforts on pregnant and postpartum behavioral health and substance use among Native Hawaiian women.



Key to the success of this work is effectively and sustainably integrating the voice of the entire Medicaid ecosystem in Hawaii into both defining the problem as well as developing and implementing solutions that will work best for those they are intended to serve – beneficiaries. To that end, the Center to Advance Consumer Partnership (CACP) conducted 25 interviews with beneficiaries, clinical providers, community-based organizations, health plans, and Hawaii Med-QUEST to learn about stakeholder end-to-end experiences both accessing and delivering behavioral health care and services. Interviews were designed to assess challenges, barriers, and successes stakeholders experience and what elements are needed to close access, quality, and equity gaps. This report provides contextual background for this work and summarizes key findings from stakeholder interviews.

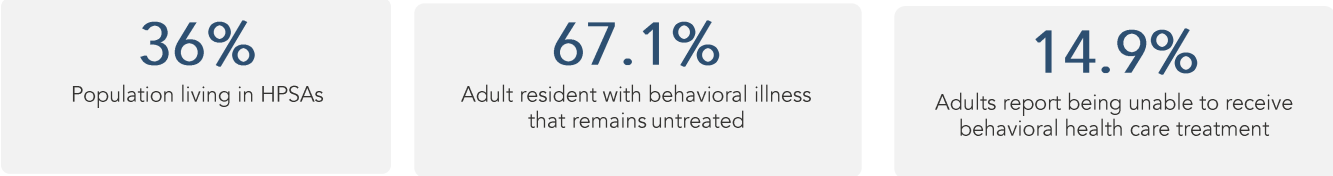
Summary of Findings

Treatment and screening for both behavioral health and substance use, particularly in rural settings and among Native Hawaiian populations, is inconsistent and limited. Although Honolulu offers a range of behavioral health services for pregnant and newly parenting mothers, there are significant gaps in access to outpatient treatment and residential or inpatient treatment for women in rural areas, which encompass 90% of the state. The maternal behavioral health and substance use treatment experience in Hawaii can be characterized in the following ways:

- Many women do not receive regular prenatal care or screening.
- Financial barriers, most notably housing and food insecurity, are significant areas of concern.
- Existing services for behavioral health and substance use treatment in Hawaii are reflective of Western family structures and social norms, which are perceived by patients as out of touch and another form of forced assimilation into Western “culture” and practice.
- Traditional healing practices are highly valued by Native Hawaiian, Asian, Pacific Islander, and Micronesian cultures in Hawaii.
- Infrastructure and geography present logistical challenges, most notably regarding the level of effort and time necessary to travel between islands to receive healthcare—particularly prenatal care, detox, and inpatient (residential) treatment.
- Mistrust and fear of stakeholders in the ecosystem are significant, both from concerns about immediate penalties and from generational/ancestral experiences.
- Domestic abuse and violence in the home prevent women from seeking behavioral health and substance use care and services.

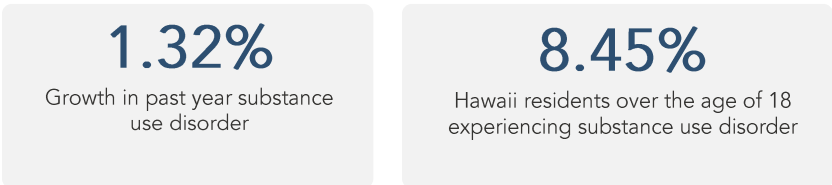
Background & Introduction: Maternal Behavioral Health & Substance Use in Hawaii

Treatment Landscape



Hawaii experiences high rates of poverty and unemployment. A total of 36% of the total population lives in a HRSA-defined Health Professional Shortage Area (HPSA) (HRSA, 2022). HPSAs exist on all five islands; as a result, many Hawaii residents experience significant gaps in access to and continuity of treatment, as they must travel to other islands to receive specialized treatment. SAMHSA estimates that 67.1% of Hawaii residents with any behavioral illness remain untreated (SAMHSA, 2019). However, only 14.9% of Hawaiian adults report that they are not able to receive needed behavioral health treatment (Reinert, October 2021), indicating a significant gap in perceived need for treatment.

Prevalence of Select Health Indicators



Hawaii experienced the highest overall growth in substance use disorder (SUD) in the nation between 2018 and 2019, with estimated prevalence increasing 1.32% (SAMHSA, 2020). Currently, an estimated 8.45% of Hawaii residents over the age of 18 experience substance use disorder, higher than the national average of 7.74% (Reinert, October 2021). Our interviews indicate that methamphetamines and alcohol are the most common substance addictions among pregnant women. According to community-based providers, marijuana use is very common and accepted, and is not considered a drug to report.

Community hospitals and health centers across Hawaii report high anecdotal rates of substance use and postpartum depression among native and non-native women. Furthermore, rates of unintended pregnancy, inadequate prenatal care, reliance on state-funded Medicaid/Med-QUEST insurance for labor and delivery, and reliance on WIC service utilization are high among all women. Significant disparities exist between native and non-native Hawaiian woman across multiple maternal health indicators (see table below).

Hawaii Native vs. Non-Native Maternal & Infant Outcomes

Maternal Health Indicators	Native (%)	State (%)
Aged 15-19 at Time of Delivery	6.8	3.8
Obese During Pregnancy	27.6	19.3
Reported Diabetes Before Pregnancy	6.9	5.4
Experience 2+ Stressors During Pregnancy	47.9	39.9
Smoked During Last 2 Months of Pregnancy	10.3	4.9
Binge Drinking 3 Months Before Pregnancy	24.6	19.2
Illicit Drug Use During Pregnancy	5.3	3.4
Intended Pregnancies	43.0	56.3
Postpartum Depression	14.2	12.0
Infant Mortality		
Neonatal Mortality Rate	4.0	3.6
Post-Neonatal Mortality Rate	3.1	2.1
Abortion Rate (NUMBER Per 1,000 Births)	79	147
Infant Social Determinants		
Unmarried at Time of Delivery	62.2	38.8
Mothers w/ < High School Education	26.2	17.5
Medicaid/QUEST at Time of Delivery	57.1	36.8
WIC Participation	55.0	38.4
(Milton Cortez, 2016)		

As one provider states: "We know native Hawaiian and Pacific Islander women are overrepresented for maternal mortality. That's not shocking when we also know that native Hawaiian and Pacific Islander women are overrepresented for gestational diabetes, with preconception obesity. With living and being tied to partners that are extremely violent and abusive towards them. They're living often in multi-generational families with unstable jobs that have low wage and low benefits."

Hawaiian Cultural Considerations

Native Hawaiians have experienced colonization and a “criminalization of their culture” and only recently have begun to reclaim parts of their culture that were nearly lost. Stemming from Hawaii’s colonial history, mistrust of “outsiders” prevents many Hawaiian women from seeking behavioral health care and substance use services. Women and their extended support systems prefer to address health within the community and culture.

“In Hawaiian communities there is significant stigma regarding mental health issues, which is often an impediment to treatment. It is not typically accepted to seek counsel from someone outside the Hawaiian culture to discuss individual or family issues. – Hamakua Needs Assessment (Milton Cortez, 2016)”.

Deeply understanding and honoring local cultural values is critical to the success of any health sector organization operating in Hawaii. Successful health services organizations build relationships with women and their families steadily over time. Results of a recent community outreach survey conducted by the Kokua Kalihi Valley Health Center showed that *“A ‘Talk-Story’ approach is the best way to build strong and trusted relationships with families and understand their deepest needs. Furthermore, addressing immediate needs creates a pathway to additional healing services [for women and families].”*

Areas of Innovation Opportunity in Hawaii

In Hawaii, there are five clear themes regarding barriers and challenges related to seeking, accessing, and maintaining care for maternal behavioral health and substance use treatment. Solutions should address one or more of these obstacles that prevent women from seeking and receiving behavioral health care and substance use treatment.

1

Navigating Care in a Fragmented Ecosystem
There's no unified way to find out what is available to me

2

Access to Providers
Finding providers who take my insurance and can take me when I'm ready for help is difficult and complicated

3

Holistic Family Support
I'm the primary caregiver for my family— getting treatment impacts my ability to provide for them

4

Cultural Responsiveness
We don't trust people who don't understand our culture, beliefs, and values

5

Effective Engagement
If you don't engage with us in ways we feel respected and heard, finding solutions will be hard

Navigating Care

1

Navigating Care in a Fragmented Ecosystem
There's no unified way to find out what is available to me

When and where a woman begins her behavioral health journey matters. Moms face significant challenges initiating care and maintaining ongoing treatment. As a result, when women enter recovery care, they often present in crisis and require significant, ongoing treatment.

Providers and community-based organizations (CBOs) report that women face multiple entry points into the behavioral health system. For instance, a woman may screen positive for drug use during a prenatal appointment; families already involved with Child Protective Services (CPS) may be identified during a home visit; a woman or her baby may screen positive for drugs during delivery; or women may be identified in the emergency room (ER) during an overdose, or by law enforcement. What is clear is that women do not have a central location to which they can turn for information and support about services that are available to them. They can obtain a referral for treatment through the CARES hotline, where they will be provided with the names of recovery resources that accept Medicaid, but they are left on their own to navigate "the system," which frequently means figuring out how to fly to a

neighboring island for treatment while leaving their family behind – a cultural taboo among Hawaiian families.

Synthesis in the Voice of Consumers:

- I want to get clean but it's hard to find a place that will take women who are pregnant and use [drugs/alcohol].
- I go to a women's clinic on the island. We don't talk about drug use.
- I decided I wanted to try detox, but that means staying in Honolulu, and I have other kids.
- I'd have to leave or miss work if I go away for treatment.
- My first interaction in the ecosystem either builds trust, making me feel helped and supported, or reinforces biases I may already have against the system.
- If my experience isn't supportive and free of judgement, I won't be back for follow-up visits.

Direct Quotes from Research

"They're pregnant and they feel so much shame and so much stigma. It's paralyzing and they don't even know what to do. They just come and are like, "I don't know what to do."
— Clinical Provider

"It's also the person's level of readiness... Those that are dealing with addiction, it's multiple attempts to recovery." — CBO

"If you [do not have a good interaction with] a patient at the front desk and you put them off, it sets the tone for the rest of the experience."
— Clinical Provider

"We're working now to get more peer support people involved, trained and helping people to navigate through the system. Because the system for [addicted] pregnant women is so different [than] for people just with addiction."
— Clinical Provider

Challenges Accessing Providers

2

Access to Providers

Finding providers who take my insurance and can take me when I'm ready for help is difficult and complicated

Honolulu is urban and comparatively well resourced. The remainder of the state's access to appropriate clinical and provider resources for maternal behavioral health and substance use treatment is limited.

As mentioned, pregnant or newly parenting women can call the Hawaii CARES line to request help when in crisis or seeking care. They will be provided with the names of recovery resources that accept Medicaid. However, an acute shortage of providers has led to low availability of appointments or beds with recovery providers. This includes substance use treatment for pregnant and newly postpartum women.

The lack of psychiatric providers has led to a dearth of substance use screening among pregnant women, as clinical providers have no treatment avenues for women in need of services; and is further

compounded by geographic variability in available services. Providers in under-resourced areas of the state report feeling scared to screen pregnant women for behavioral health and substance use needs because they don't have a place to refer them for help or treatment.

Furthermore, when psychiatric providers are available, they are generally not Native Hawaiian. The few Native Hawaiian providers on the islands report having longer patient waiting lists than their counterparts from the U.S. mainland, as women want to talk to clinicians who share a similar lived experience. Hawaiian providers call for increased funding to attract, train, and keep Hawaiian providers in the workforce, and highlight the emotional burden it takes to provide care to women. Many leave the workforce, given the trauma experienced from listening to challenges that fellow community members, particularly those in small, closely-knit communities, face day-in and day-out. Finally, public funding for substance use treatment services is not credentialed for Med-QUEST and thus, is not reimbursable. Providers are forced to choose what services they can offer to patients knowing that they will have to absorb all costs. As a result, some clinics do not treat Medicaid beneficiaries, decreasing women's access to services.

Synthesis in the Voice of Consumers:

- Appointment frequency and location matters. We have families and children we don't want to leave.
- We can't afford to leave our jobs to go for treatment or we'll lose our place to live.
- We have a hard time finding places with appointments – most don't take pregnant women.
- Getting to a doctor or a therapist is too complicated.
- When I'm looking for help, I need it now– I can't wait months for a space to open up.
- We don't have broadband access, cell signals, or easy transportation, so making and keeping appointments is hard.

Direct Quotes from Research

"I've heard [clinicians] say they don't screen [pregnant women] because they wouldn't know what to do. They're terrified when it is the case [when a woman is using], because they don't know how to refer, who to refer to." — Clinical Provider

"Anywhere outside of Honolulu, really is a struggle to [find substance use services for pregnant women], because it's all central to downtown." — Clinical Provider

"We often have people that need to be transferred to Honolulu because of the resources there, and in face Medicaid pays for those medically-necessary services, which substance use would be. However, women need to fly, which is not the best solution, and what if there are 5 other kids? What do you do?" — CBO

"Drug treatment services for pregnant women are very spare. We have services for adults generally. Also, a lot of our OBs don't know where to refer for what type of treatment. [Alcohol needs one type of treatment; meth needs something different.]" — Clinical Provider

"Families can go for years without treatment which creates problems such as more crisis-related care and chronicity of issues." — Hamakua Needs Assessment

"Substance use treatment programs often are not credentialable for Medicaid programs. As far as med-QUEST, we don't have a way to reimburse for this significant coordination of care that occurs for these individuals. We just eat the cost." — CBO

Holistic Family Support Needs

3

Holistic Family Support

I'm the primary caregiver for my family– getting treatment impacts my ability to provide for them

Solutions must account for the holistic support needs of a family. Mothers are usually the primary caregivers in their families, and in Hawaiian culture, are relied upon to be stable and to put their family above all else.

Rarely does a woman experience behavioral illness without it affecting the entire family. Similarly, a mother cannot easily leave her family to get addiction treatment and recovery help without a great burden or fear of Child Protective Services (CPS). There are logistical barriers for arranging care of her family and potential additional financial hardships placed on other extended family members. Community-based organizations report that the top two challenges of pregnant and parenting women are securing housing and food.

In addition, Native Hawaiian culture values family and community above all else. What happens in the family stays in the family, and it is imperative to avoid shame of any kind. As collectivist cultures, traditional Samoan and Chuukese societies had in place “processes to maintain a stable environment,” with extended families or clans providing “protective scrutiny” and avenues for resolving disputes before they grew out of control. Unfortunately, colonization, immigration, acculturation, and economic inequities have eliminated these cultural protective factors. (Magnussen L, Jan 2011)

Vendor partners should consider all family and caregiver types and structures, including family of origin, kinship, and foster care. Solutions should consider that some families are managed by one or two parents, and some homes include other siblings, and/or multiple generations.

Synthesis in the Voice of Consumers:

- The issues we’re dealing with are often family problems driven by trauma, and physical and emotional abuse.
- I’m scared that if I don’t get clean, they’ll take my baby and my other kids, but I don’t have anywhere to get treatment while keeping my family with me.
- We don’t want CPS getting involved and separating our family or taking our children away.
- We don’t all have families that are able or know how to support us.

Direct Quotes from Research

“Trauma-informed care is central. But it's, it's a new kind of thing. A lot of people are uncomfortable with it or they're not knowledgeable of it.” — Clinical Provider

“Child Welfare Services is a major ordeal and fear. It keeps people away from care. It really does. [I have had patients leave the hospital right after giving birth] because they thought their baby was going to get taken away.” — Clinical Provider

“I don't think there is true trust [in the system], and true trust in providers and treatment centers. That is not where [people] come from. And it's almost foreign, scary, unnecessary, it's arm's length.” — CBO

“As a provider, I need you, you know, to have access with transportation to your visits. This is very important. It's a big barrier. If possible, I need you to be in a safe housing situation.... If these things are not together, [substance use treatment] doesn't work as well.” — Clinical Provider

Cultural Responsiveness: Understanding Cultural Norms and Practices

4

Cultural Responsiveness

We don't trust people who don't understand our culture, beliefs, and values

Cultural needs among Hawaiian women reflect the importance of trust, time, family, and ancestral or native practices.

Cultural sensitivities and nuances within the native Hawaiian population undercut care-seeking behavior and impact treatment preferences. Native Hawaiian family life is heavily influenced by traditional East Asian and Pacific Islander cultural practices. Successful providers and community organizations incorporate traditional healing practices, respect for the environment, and community consent and feedback into their work.

All community-based organizations (CBOs) report that no care or treatment is sought or accepted until trust is earned. Trust is not earned without the opportunity to “talk story,” an important oral tradition in Hawaii where people share their daily happenings, history, and what is important to them. However, engaging in “talk story” does not happen without a significant investment of time and trust building.

Many interviewed women’s health organizations offer social services and other supports ,like diapers and food, in addition to caring for the health and well-being of the mother. There is a deep and systemic acknowledgement that when you take care of the mother, you take care of the family. However, resources and billable services are limited for providers.

Substance use and behavioral health is very stigmatized in Hawaii. According to those working directly with Native Hawaiian women, substance use and addiction are Western issues, brought to Hawaii by colonization. This contributes to the strong bias they feel toward western people, practices, systems, and care. It was also reported that in Micronesian languages, there is no word for “depression,” “sadness,” or “anxiety,” so in screening, providers often have to code switch or replace questions with discussion.

All providers and CBOs in Hawaii report that integrating Native Hawaiian healing practices into care and treatment is necessary. Traditional healing practices that often accompany treatment include spiritual practices grounded in family and relationship to earth. These include:

Ai Pono: “Ai” to nourish, “Pono” with balance, harmony, ease, and in perfect wholeness. CBOs that support women’s health and family services incorporate Ai Pono into what they do, often meeting outside to work or to be in a garden, “prescribing” native foods, and encouraging grounding or centering.

Ho’oponopono: “Ho’o” to make “Pono” with balance and harmony.

Ho’oponopono is the ritual of moving things into balance, reconciling, and forgiveness. When one is experiencing what we call depression, anxiety or addiction, those are “hihia,” entanglements of emotions or troubles that need to be acknowledged, repaired, and untangled. Ho’oponopono brings the family together to find out what’s wrong. It includes discussion, chanting, prayer, and forgiveness. It is traditionally done within the family, led by an elder. CBOs report that honoring the importance of ho’oponopono as a part of the culture in the healthcare practice setting, during “talk story” or as a “doctor’s order,” is well-received and helps build trusting relationships.

However, even when trust is built, it does not mean that behavioral health and substance use symptoms, effects, or needs will be shared with providers. For example, one CBO reported having a great relationship with a client and having helped her through four pregnancies. Despite their long-standing relationship, it was a community worker who reported learning about an incredibly violent relationship, in which the client’s partner was actively using substances, during a routine food and diaper delivery.

Synthesis in the Voice of Consumers:

- We want to see providers who look and talk like us, but it is really hard to find them.
- In our culture, women take care of children. I can’t leave them to go away because I’m using drugs or alcohol.
- We want our doctors and therapists to understand our cultural values.
- We can solve our problems within our family.
- These “systems” and benefits are intrusive and don’t consider or honor our traditional practices.

Direct Quotes from Research

“In our culture, women have the sense of Hina. Hina, is fertility. For men (Kāne) it’s Kū, the strong warrior sense. But oftentimes, women have both [Hina and Kū], and that’s what makes them a necessity in our community, because they have the ability to nurture... but also to set clear boundaries and to be that Kū and to, to hold the family together to make decisions.” — CBO

“In Hawaiian culture, there was no word for trauma.” — CBO

“In some communities, there continues to be strongly held beliefs that psychological issues are the result of spiritual, paranormal, ritualistic beliefs and it is important that providers are aware of and sensitive to these beliefs.” — Hamakua Needs Assessment

“We have our [behavioral health] screening [tools], and there’s a lot of difficulty with screeners. You ask a Chuukese person if they’re depressed, they’re like, “What’s that?”. They don’t even really have a good word that translates for it. — CBO

Effective Consumer Engagement

5

Effective Engagement

If you don't engage with us in ways we feel respected and heard, finding solutions will be hard

Families avoid care for a variety of reasons – all synthesized above – including fear, culture and beliefs, financial burdens, language barriers, access issues, employment, transportation requirements, shame and stress. To initiate change and provide care to women and their families, it is essential to build community trust.

To successfully engage with Native Hawaiian community members, it is essential to honor and respect cultural traditions and build trust in the community prior to beginning any project work. To do that, it is essential to understand Hawaii's history. Having been colonized in the recent past, many Hawaiians still live the trauma of having their way of life uprooted. Within 2-3 generations, the Hawaiian Islands have undergone transformation. Land that once housed a complex and ancient culture has been transformed into a vacation destination for non-Hawaiians. Ancient infrastructure and ways of life were nearly obliterated. Only recently has there been an organized effort to reclaim ways of life that were lost. Often, research is conducted about traditional ways of life on the islands, but local communities have received little benefit from the outcomes. As a result, many Native Hawaiians rightfully mistrust groups from the mainland and are hesitant to “talk-story” in a true and meaningful way.

Success in Hawaii hinges on the ability to build trusting relationships with local individuals and/or organizations that work with Native Hawaiians. As one community health worker told us,

“It's not enough to be culturally informed. It's not enough to be trauma informed. People need to be culturally and trauma responsive and be humble in their approach and recognize they are not the ones who know best how to care for these communities. We are the ones that know best how to care for our community. They need to figure out how to work with us.”

Honoring this need requires an in-person presence on the islands for an extended period of time. Attending community events, bringing food and small gifts to honor and thank hosts, and engaging in “talk-story” with locals about their families and daily lives are all activities that need to happen in advance of holding discussions about sensitive subjects such as substance use and behavioral illness. This work takes a considerable amount of time. Organizations seeking to work on the islands must account for this during the early phases of any engagement.

Beyond Innovation

Throughout the course of this work, several other key systemic themes arose that warrant attention and consideration. They include:

Gaps in the behavioral health ecosystem influence care for Hawaiian women and families.

The intersection between health and housing.

The role domestic violence plays in care-seeking among Native Hawaiian women.

While these elements may be outside the scope of MIC's innovation goals, they are worth highlighting here as factors to consider when implementing community-facing programming.

Communication and Collaboration Across the Ecosystem

Community stakeholders are critical to early identification, diagnosis, treatment, and ongoing support. However, many stakeholders operate in silos, thus creating gaps in communication and, ultimately, poor continuity of care for women and families as they move throughout the ecosystem. One provider states:

"Substance use disrupts your executive functioning as a person. So, when we ask people to navigate very complex bureaucratic systems that have a lot of steps when their executive functioning is being compromised it creates another barrier... [For example] if you don't have a license or a social security card you can't sign up for Medicaid. People have a very hard time navigating that process."

Having strong partnership relationships, data sharing, and familiar, continuous support improve the experiences that Medicaid beneficiaries have with the behavioral health ecosystem. Facilitating wraparound care and enabling collaboration across all areas of the ecosystem would benefit all stakeholders – most importantly, Medicaid beneficiaries.

Housing as Healthcare

While the concept of housing as a determinant of health is not new, it is highlighted here in terms of the relevance to this work, as it is an added barrier that women face when seeking or receiving behavioral health/substance use services or even prenatal care. Not having housing produces significant stress. It is an immediate need. If a woman does not know where she will sleep that night – and whether she will be safe – the need to access medical care becomes largely irrelevant. As one community provider states:

“Housing impacts whether you have access to care. It effects whether you actively prioritize yourself and your health, and it is also going to impact your mental, emotional, and behavioral health.”

Homelessness can evoke such stress that prevents women from accessing even the most basic care out of fear of what will happen to their families if they disclose their living situation.

“We provided post-partum care to a woman on the side of the road who had given birth in an encampment. She was homeless and was afraid to deliver in a hospital because she was afraid her baby would be taken away.”

The risk of housing instability and homelessness in Hawaii are high due to an extremely high cost of living in the state. Most consumable goods must be shipped from the mainland, as infrastructure on the island does not exist to provide residents with necessities. For example, a gallon of whole milk can cost up to \$8.99 on the Island of Oahu. This also applies to the materials needed to build homes. The cost of shipping – combined with the demand for vacation properties – has put the opportunity to own a home out of reach for many, and Hawaiian families rely on each other for support. As one community provider told us:

“Housing is very expensive in Hawaii. People cannot survive here on a minimum wage job. The only reason why we can is that it goes back to holistic family support. The only way most of us survive is because we can rely on our families.”

Domestic Abuse & Receipt of Treatment

It is well known that the presence of domestic abuse significantly impedes a woman's ability to seek behavioral health and/or substance use care and treatment. When mothers experience addiction, it often comes after years of abuse or trauma in the home. In Hawaii, this is further complicated by the fact that post-colonial oppressive systems have prevented the Native Hawaiian population from personal and financial success.

"I worked in the behavioral health clinic, and most of my patients were women, many of them pregnant women. Teen mothers, who were victims of abuse and trauma. Substance abuse is simply a symptom of the long-standing aggressions and violence against women that have been perpetuated interpersonally, but also within the systems that continue to hold us back and continue to look at us as a marginalized population rather than to respect us as the indigenous peoples of these islands."

Throughout our discussions with community stakeholders, we heard that when domestic abuse within a family is recognized by the community, typically elders and other family members step in to assist. Neither social services nor law enforcement are called. Typically, detox in a medical facility does not occur, as each of these situations would require involving "outsiders" in family/community business. The situation is solved within the family. The mother and any children are typically removed from the home for a few days and stay with cousins or "aunties" in the community, while men and community elders step in to speak with the woman's partner. It is imperative that potential organizations understand the root causes and traditional solutions to what has been described as a significant problem on the islands.

"What I often see is women dealing with mental health or depression related to their husband's or partner's substance abuse issues. If something serious is happening with the guy...family members will get together. The elders will come in and go to the person's house and be like, 'You're not, you know, like you can't do that anymore. Like, we're all watching you.' Or they will move the woman and her children out of the house for a few days to stay with 'auntie.' In my mind it is very much like a harm reduction approach."

While solving homelessness, housing instability, and domestic abuse is beyond the scope of this work, it is essential that their impact on women and families be considered by any organization looking to develop innovations and programming.

Appendices

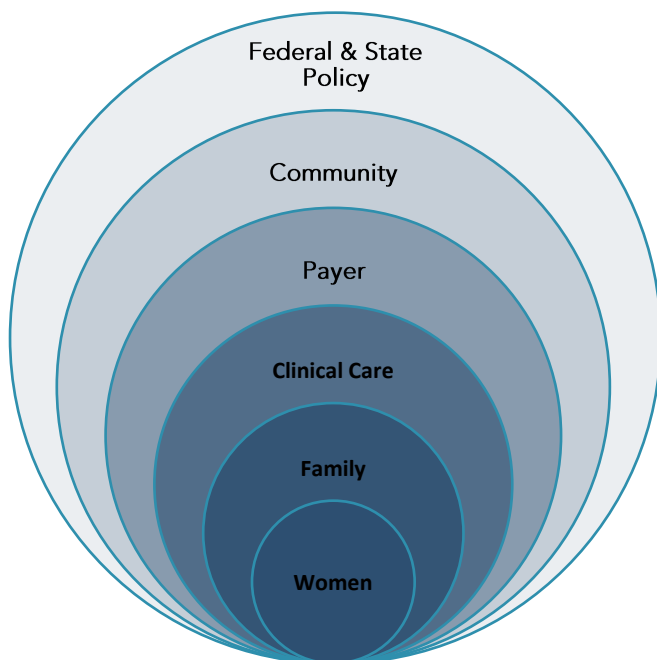
Methodology

Despite our focus on primary beneficiaries, the data provided in this report was generated primarily by community and clinical organizations that have a long and successful history of quality interactions with beneficiaries. Due to both the extremely sensitive and triggering nature of these conversations, and our status as "outsiders", engaging directly with beneficiaries was challenging. However, representatives from our in-state partner organizations were experts in their fields, having collectively worked with native Hawaiian women and families for decades. As such, we did not need direct beneficiary engagement to receive high-quality insights.

To understand the full range of barriers and challenges specific to access, quality, and experience that women face in receiving behavioral health and substance use services, CACP conducted interviews with key stakeholders in the Medicaid behavioral health ecosystem in Hawaii.

Defining Key Stakeholders

Hawaii's behavioral health ecosystem illustrates the interplay between factors affecting women's ability to access and receive ongoing behavioral health and substance use services in Hawaii. Key stakeholders for interviews were drawn from each identified layer of the ecosystem and are defined in this work as: clinical providers, community-based organizations, managed care organizations, state Medicaid agencies, and pregnant and new mothers.



Hawaii's Behavioral Health Ecosystem

Federal & State Policy: Reimbursement Rates & Structure, Social Services, Tax Credits, Justice System, DHHS, Families Initiative

Community: Providers, Local Law Enforcement, Provider Availability, Advocacy Organizations, Faith-Based Organizations, Family & Juvenile Court, Transportation, Urban vs. Rural

Payer: Community & Coordination with Other Ecosystem Stakeholders, Contractual Requirements

Clinical Care: Cultural Competence, Trauma-Informed Care, Translation, Appointment Availability, Care Coordination, Wraparound Services, Family Residential Treatment, Communication & Coordination with Other Ecosystem Stakeholders

Family: SDoH, Social & Emotional Support, Employment, Family Structure, Childhood Adversity of Caregiver, Trauma History

Woman: Age, Race/ethnicity, Gender, Sexual Orientation, Coping Skills, Diagnosis, SDoH, Social & Emotional Support, Employment, Family Structure, Childhood Adversity, Trauma History

Domains of Exploration

Interviews with key stakeholders were designed to better understand women's end-to-end experiences across the following domains:

Learning about and understanding behavioral health and substance use benefits.

Accessing behavioral health/substance use care and services.

Defining high quality.

Needs for and experiences with ongoing support, including long term services and supports (LTSS) transportation, and social determinants of health (SDoH) support.

Identifying best practices and unmet opportunities for enhanced service delivery and innovation.

Recruitment and Engagement Process

To understand the full range of barriers and challenges specific to access, quality, and experience that pregnant and postpartum women face in receiving behavioral health and substance use services, CACP conducted interviews with 25 key stakeholders in the Medicaid behavioral health ecosystem in Hawaii as shown below. To be considered eligible for an interview, women were required to:

Be pregnant currently or have given birth in Hawaii in the past 1-year period, and receive(d) insurance through Hawaii Medicaid/Quest while pregnant/post-partum,

Have lived experience with either behavioral health and/or substance use during pregnancy/post-partum,

Currently reside in a community setting,

Hawaii Ecosystem Interviews by Stakeholder Type

Stakeholder Type	# Interviews
Beneficiary	1
Clinical Provider	9
Community-based Organization	10
Managed Care Organization/Insurer	2
Hawaii Med-QUEST	3
TOTAL INTERVIEWS	25

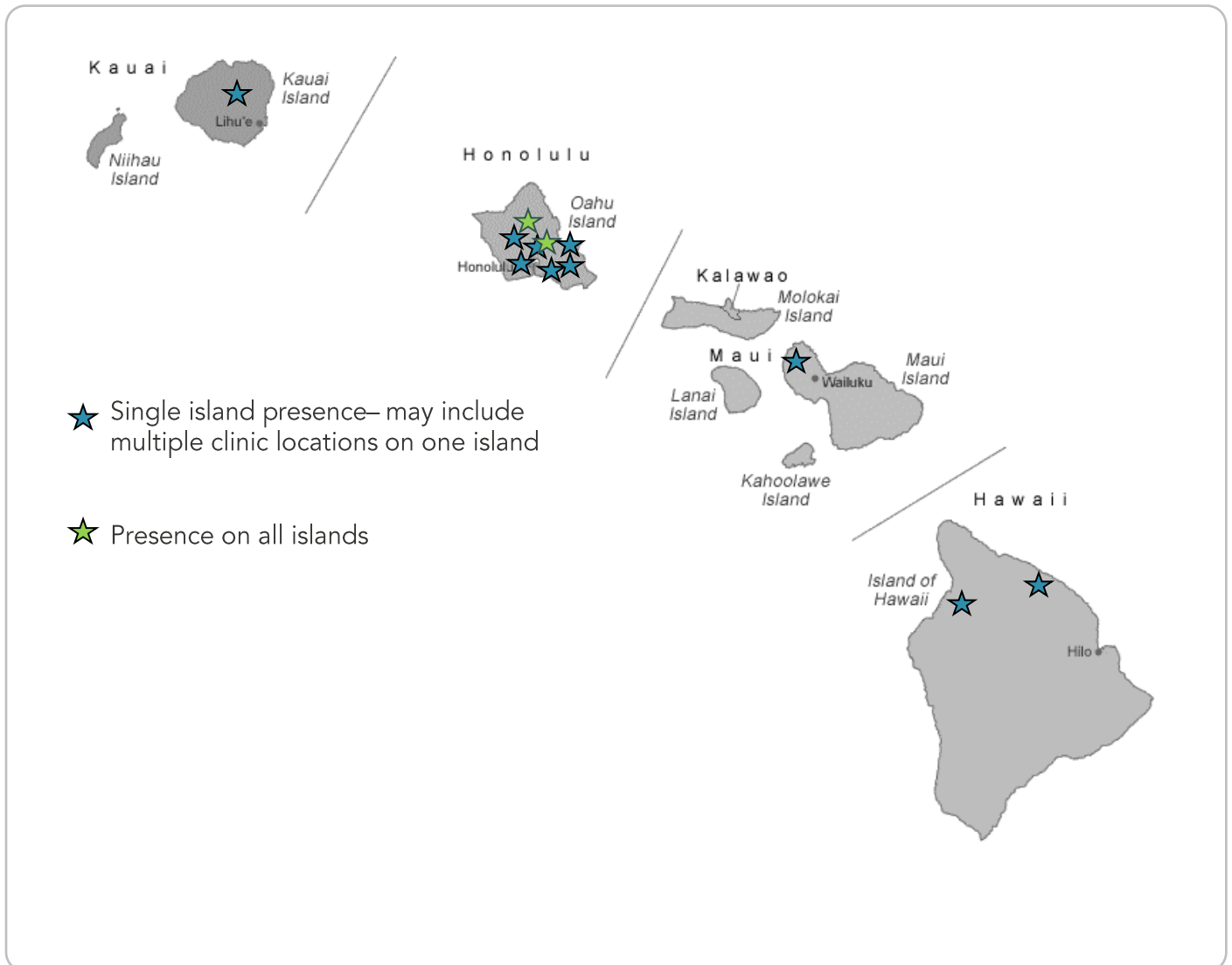
Women receiving current crisis stabilization or inpatient services were not eligible to participate due to the sensitive and potentially triggering nature of our discussions.

Hawaii Med-QUEST provided an initial round of introductions to 21 local clinical providers and community-based organizations for interviews. Of those 21 organizations, 12 agreed to have staff participate in informational interviews. Of those 12 organizations, five agreed to distribute materials to women able to safely participate. Women who participated in these interviews received a \$50 Visa gift card as compensation for their time and effort. The Stakeholder Outreach, Engagement & Outcomes chart depicts outreach efforts and outcomes. The Community-based Organization Geographic Coverage Area map shows the geographic coverage areas of participating CBOs.

Stakeholder Outreach, Engagement & Outcomes



Community-based Organization Geographic Coverage Area



Project Partners

This research would not be possible without the support of our state Medicaid partner. A special thank you to:



Through the generous support of our funders, the Medicaid Innovation Collaborative is able to deliver this primary research and programming at no-cost to states and managed care plans.



Bibliography

1. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2021, July 2). *Selected 2016 through 2019 Maternal and Child Health (MCH) Indicators*. Retrieved from Centers for Disease Control and Prevention: <https://www.cdc.gov/prams/prams-data/2019-selected-mch-indicators.html>
2. HRSA. (2022, February 18). *HRSA Data Warehouse*. Retrieved from Health Resources & Services Administration: <https://data.hrsa.gov/tools/shortage-area/hpsa-find>
3. Milton Cortez, T. C. (2016). *Community Health Needs Assessment*. Honokaa, HI: Hamakua-Kohala Health Center, Inc.
4. Reinert, M. F. (October 2021). *The State of Mental Health in America 2022*. Alexandria VA: Mental Health America.
5. SAMHSA. (2019). *National Survey on Drug Use and Health (NSDUH)*. Retrieved from Substance Use and Mental Health Data Archive: <https://www.datafiles.samhsa.gov/dataset/national-survey-drug-use-and-health-2019-nsduh-2019-ds0001>
6. SAMHSA. (2020, September 11). *NSDUH Detailed Tables*. Retrieved from National Survey on Drug Use and Health: <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>
7. Office of Hawaiian Affairs, Research, Demography. (March 2021). *Native Hawaiian Health Fact Sheet 2021. Volume IV: Native Hawaiian Health Status*. Honolulu, HI. Retrieved from: <https://ohadatabook.com/Volume%20IV-Health%20Status.pdf>