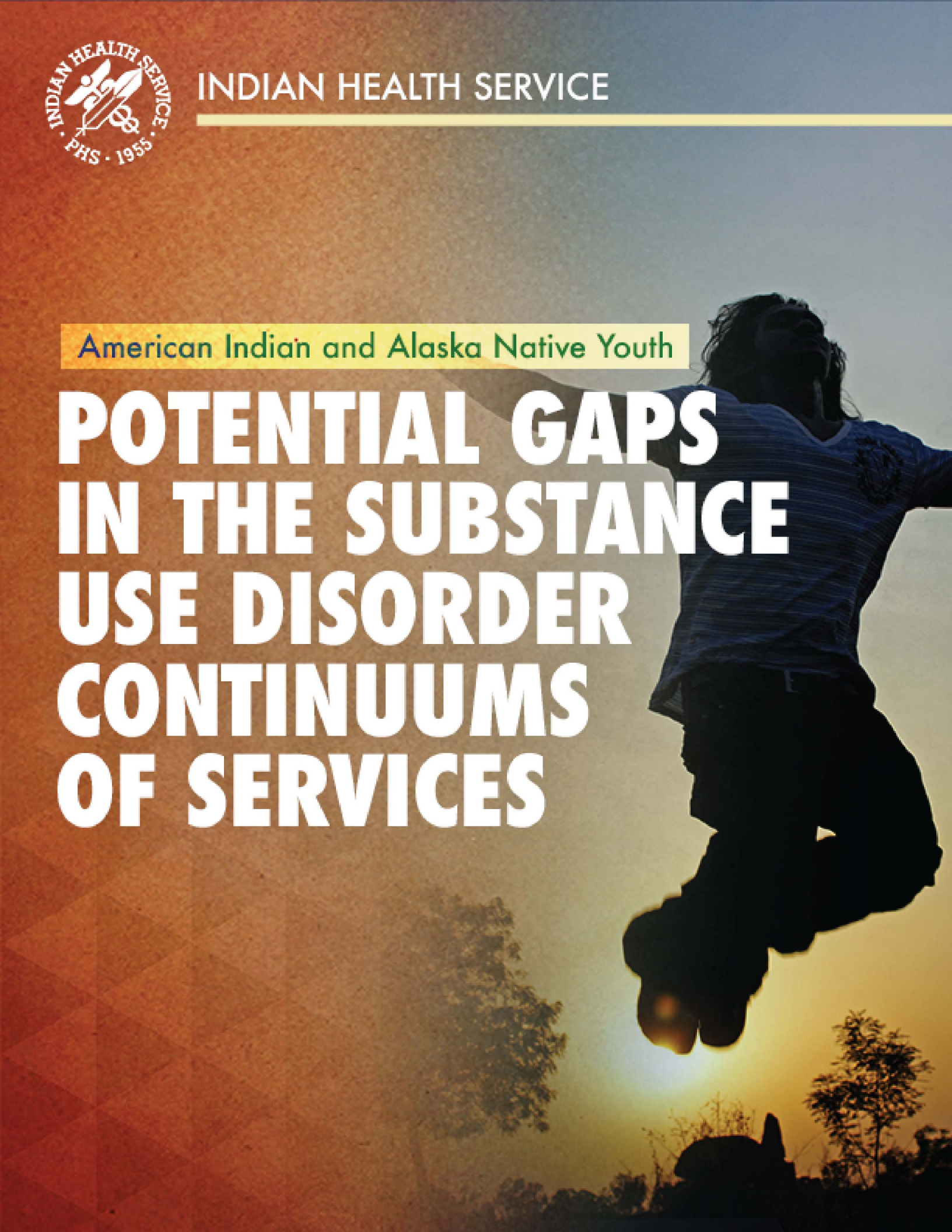
INDIAN HEALTH SERVICE

American Indian and Alaska Native Youth

POTENTIAL GAPS IN THE SUBSTANCE USE DISORDER CONTINUUMS OF SERVICES



2023

American Indian and Alaska Native Youth: Potential Gaps in the Substance Use Disorder Continuums of Services

INDIAN HEALTH SERVICE

OFFICE OF CLINCIAL AND PREVENTIVE SERVICES, DIVISION OF BEHAVIORAL HEALTH

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Executive Summary

In August 2020, the U.S. Comptroller General reported to the U.S. Congress the status of federal programs that are meant to reduce behavioral health risk among American Indian and Alaska Native (AI/AN) youth. The U.S. Government Accountability Office report (GAO-20-600) reviewed 38 grant programs among four federal departments, totaling nearly 1.9 billion dollars in fiscal years 2015 to 2018. The key GAO recommendation was a call for assessing the reliability of performance data contained within the annual performance reports of grant-funded Tribal partners. Following the GAO report, the Indian Health Service (IHS) Division of Behavioral Health (DBH) made major revisions to its methods of analyzing previous and new AI/AN youth programs, and performed a focused analysis on the DBH-funded inpatient AI/AN youth programming, resulting in the *Evaluation of the Youth Regional Treatment Center Aftercare Pilot Project*, available on the division's report webpage (www.ihs.gov/dbh/reports). In August 2022, DBH launched a one-year contracted field analysis to independently examine the policies and programs that may affect the capacity for IHS to provide or facilitate continuums of services to AI/AN youth. Although behavioral risk factors and conditions are complex and can manifest in various forms, the analysis focused on those AI/AN youth who suffered from substance use disorders. The timing of the analysis and this report is critical, as there are other related Federal priorities that affect AI/AN youth, including the interagency law enforcement work on Missing and Murdered Indigenous People, the listening sessions of the Alyce Spotted Bear and Walter Soboleff Commission on Native Children (P.L. 114-244), the Health and Human Services (HHS) Roadmap for Behavioral Health Integration, and the National Tribal Behavioral Health Agenda update, led by the Office of Tribal Affairs and Policy, Substance Abuse and Mental Health Services Administration, HHS. Herein, DBH responds to the field analysis and outlines a plans of action. These actions are limited to current authorizations and appropriations set forth by the U.S. Congress.

Authors: Paschane DM, Larson J, Fletcher-Sahmaunt K

Year: 2024

Source: Indian Health Service, U.S. Department of Health and Human Services

Introduction

The Indian Health Service (IHS) Division of Behavioral Health (DBH) is obligated by statute to provide comprehensive behavioral health services to American Indian and Alaska Native (AI/AN) persons, including AI/AN youth. The capacity for IHS to provide or facilitate continuums of services for AI/AN youth who suffer from substance use disorders (SUDs) has been under examined. In August 2022, DBH contracted a field analysis of policies and programs that may affect the capacity for IHS to address AI/AN youth SUD burdens. The goal of the analysis was to find possible gaps in how DBH understood the current scope, access, and quality of services, given the highly variable mix of federal and Tribal services across the U.S.
Integrated continuums of services include prevention, screening, intervention, treatment, aftercare, family engagement, peer support, and community services, all in service of whole person wellness[i]. For AI/AN youth, the spectrum and quality of SUD treatment available to them varies by both the continuum of services they access, but also the context of existing community support services. Some AI/AN youth may be exposed to substance use prevention campaigns and initiatives through locally-sponsored projects, or receive general risk mitigation through cultural and educational activities. AI/AN youth may also access services through referrals to SUD counseling by a primary care or emergency care provider inside or outside of the Indian Health System.

In some communities, IHS grant-funded programs support Tribes, Tribal organizations, and Urban Indian Organizations in developing SUD treatment services, which are encouraged to serve AI/AN youth. The goal of the grant programs is to develop the strategy and capacity to operate robust and effective assessments of behavioral health risk, and for those who are at risk, manage their access and effective use of services, including relevant exams, treatments, recovery or safety supports, and any relevant legal supports[ii]. Especially in youth, a cornerstone function of the risk mitigation is the client therapeutic engagement[iii], where there is a need to ensure that clients and staff can overcome the barriers, distractions, and mishandling of processes that potentially undermine services over time.

Another resource for AI/AN youth is the Tele-Behavioral Health Center of Excellence, which provides limited hours for counseling and addition psychiatry to 22 sites. The Center reports that the demand for youth and young adult services often exceeds capacity.

Demand for Services

Based on self-reporting through the U.S. Census, the estimated AI/AN youth and young adult population, ages 12 to 24[iv], is 2.3 million. Of these, an estimated 1.1 million AI/AN youth are adolescent (12 to 17 years of age). The 2018 IHS estimate of the active registrants for IHS services includes 172,497 AI/AN youth[v], or approximately 16% of the total AI/AN youth

population. The majority of AI/AN youth receive health care from outside of IHS; thus, the total AI/AN continuum of services is broad and complex.

One method of estimating the risk for SUDs among AI/AN youth is to examine the combination of reported early-age exposure to alcohol use and the prevalence of major depressive episodes reported through national surveys. The 2019 Youth Risk Behavior Surveillance System reported an estimated 429,000 AI/AN youth and young adults experienced early age alcohol use[vi], which is a comparatively high rate of exposure. The 2019 National Survey on Drug Use and Health reported an estimated 298,000 AI/AN youth and young adults experienced a major depressive episode in the past year (measured in 2016, 2018, and 2019). This indicates that a significant portion of the AI/AN youth population are at an elevated risk for SUD compared to other groups. If mental health distress is co-occurring with substance use, these youth will likely require robust behavioral health services to mitigate the long-term effects of these issues.[vii]

The 2018 IHS estimate of the active registrants for IHS services includes 172,497 AI/AN youth.[viii] Applying the same risk parameters outlined above, the range of AI/AN youth registrants who likely require treatment services is 22,425 to 32,257. Assuming this population is located proportionally, the largest requirement is in the Oklahoma City service area (22.2%), followed by service areas of Navajo (13.2%), Phoenix (10.4%) and Alaska (10.0%).

Between 2015 and 2020, IHS funded 107 community-specific projects that utilized Generation Indigenous funds, a category defined by Congress, and served over 43,000 youth. The latest cohort of community-specific projects has included 63 tribal partners (72 projects) and over 14,000 AI/AN youth. The specifics of the services, including SUD treatment, will be reported over the next four years as these communities build their service capacities. The degrees to which local communities help mitigate personal levels of risk, such as recovery from SUDs among AI/AN youth are unknown, but is an area of emerging research in the scientific literature.[ix]

IHS-Funded Inpatient Service Youth Capacity

In addition to direct care provided through federally operated facilities, within the potential continuums of services to address SUDs, the IHS funds a set of inpatient SUD treatment beds for AI/AN youth. The total national set of facilities is 13 youth regional treatment centers (YRTCs)[x], which includes seven operated as direct services by IHS[xi], five that are operated by Tribal organizations[xii], and one IHS-contracted Urban Indian Organization[xiii]. IHS recently funded two pilot projects specializing in aftercare, exploring innovative means of serving AI/AN youth after release from inpatient services. As of 2023, aftercare services vary by YRTC site.[xiv] Most YRTCs accept youth aged 12-18, though some set age limits at 13 or 17. However, AI/AN youth

are generally recognized by Tribes as up to and including age 24.[xv] IHS may be able to increase the maximum age to 24, for at least one YRTC.

Table 1: Youth Regional Treatment Centers and Bed Capacity by IHS Service Area

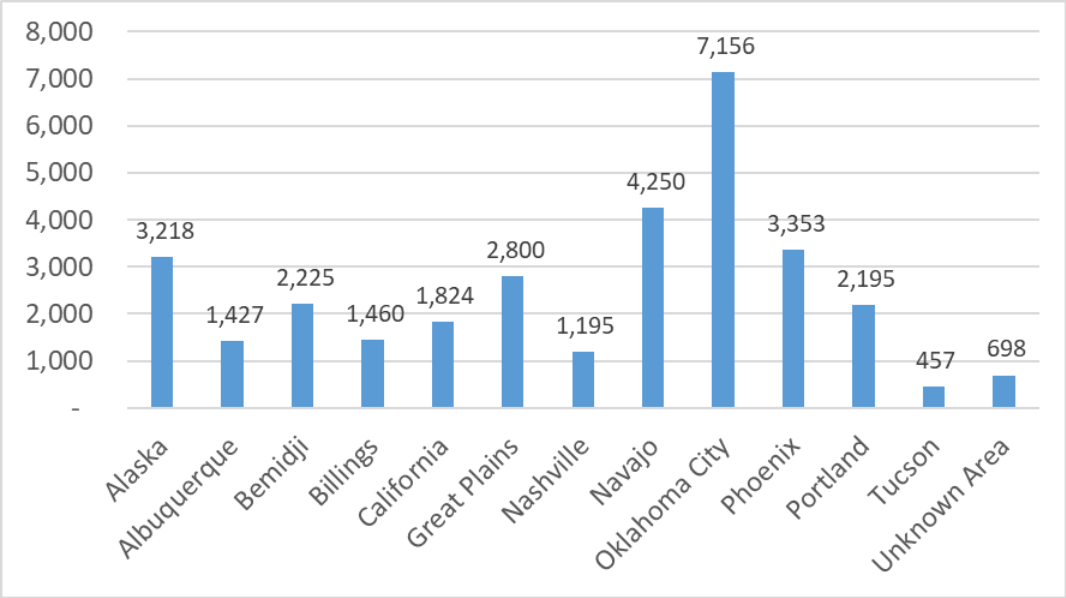
IHS Service Area	YRTC	Operator	State	Bed Capacity
Alaska	Graf Rheeneerhaanjii	Tribal	AK	12
Alaska	Yéil Jeeyáx – Raven's Way	Tribal	AK	12
Albuquerque	New Sunrise	IHS	NM	24
California	Desert Sage	IHS	CA	32
California	Sacred Oaks (new)	IHS	CA	32
Great Plains	Great Plains	IHS	SD	18
Nashville	Unity Healing Center	IHS	NC	16
Navajo	Navajo Regional	Tribal	NM	16
Oklahoma City	Jack Brown Center	Tribal	OK	36
Phoenix	Desert Visions	IHS	AZ	24
Phoenix	Nevada Skies	IHS	NV	16
Portland	Healing Lodge of Seven Nations	Tribal	WA	45
Portland	Native American Rehab. Assoc.	UIO (contract)	WA	24

In total, the YRTCs have 307 beds (see Table 1). Based on an average twelve-week course of treatment[xvi], they can serve up to 1,228 AI/AN youth per year, though there are often some site-specific limitations that affect bed uses, such as (a) the count of youth by sex and age, (b) the need to quarantine youth due to possible communicable diseases, and (c) the local availability of staff with the required professional qualifications and background clearances for working with youth.

Based on the estimates outline above, the annual national IHS-funded YRTC capacity of 1,228 beds can meet 3.8% of the national estimated treatment requirements among IHS registrants. In order to meet the estimated required annual bed capacity within IHS-funded YRTCs for all IHS youth who are IHS registrants, IHS would have to increase the total to 8,064 inpatient beds (see Figure 1).

Given the high estimated demand for services and the rather small supply of annual beds, it is surprising that most YRTCs experience vacancies. Historical vacancies and facility closures have been attributed to facility decay. Issues that may further affect vacancies are explored herein. At this time, there is no national management of YRTC data, regarding intake evaluations, referrals, inpatient treatment progress, release status, or long-term post-treatment outcomes.[xvii]

Figure 1: Estimated Youth Registrants Treatment Requirements by IHS Service Areas



U.S. Indian Health Service, Office of Public Health Support Division of Program Statistics. Supplement to the July 1, 2022 Chief Medical Officer Memo on User Population Estimates — Fiscal Year 2018 Final. The estimate uses the 18.7% of the AI/AN youth who report early age alcohol use (before 13 years old), from the U.S. Centers for Disease Control and Prevention 2019 Youth Risk Behavior Surveillance System (YRBSS).

All YRTCs offer their inpatient services free to the patient and family, and include intensive individual and group therapy, for approximately 90 days. Other mental health disorders and physical illnesses may be identified and addressed through the YRTCs and the broader AI/AN continuums of services. As much as possible, YRTCs help youth develop independent living skills and provide educational opportunities to pursue school continuity and the development of employability attributes. Before leaving the YRTCs, youth collaborate with the staff to create an aftercare plan to support their ongoing sobriety.

IHS recommends that youth are admitted to the facility that is closest to their home and community. However, due to the limited and dynamic bed availability, youth may be sent to YRTCs that are far from the youth's home. For some Tribal communities, other SUD treatment capacities may exist and may be available to AI/AN youth, provided by the Tribe or by private sources. Access to and availability of services is dependent on each facilities' contacts and resources, resulting in inconsistent care across Indian Country.

Summaries from the Field Analysis

The contracted field analysis of policies and programs that may affect AI/AN youth and SUD treatment was reported to DBH as the *Youth Precision Behavioral Health Systems Analysis Project*[xviii]. The analysis included reviews of government reports, court cases, and public laws

from 1986 to 2023; media reports; peer-reviewed scientific journal articles, relevant books, and other academic papers. The field analysis included in-person interviews with IHS staff and the staff of YRTCs, as well as staff at non-Native treatment centers, as a means of considering alternative SUD treatment in the local continuums of services.

The in-person interviews with YRTC staff included four sites among the seven IHS-operated sites, two among the five tribally-operated sites, and the one IHS-contracted Urban Indian Organization. The interviews focused on those SUD policies and programs that pertain to AI/AN youth and their development of resiliency and safe recovery.

Please note that the following summaries from the field analysis may require further legal and budgetary reviews before any changes are implemented by DBH or the YRTCs. For purposes of review, the text is bold when the summaries note a key observation that may affect future IHS policies.

Federal Laws and Policies

On October 27, 1986, Congress enacted Public Law 99-570, the “Anti-Drug Abuse Act of 1986” Sec. 4201, the “Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986.” This Act authorized funds for Indian Health Service for **alcohol and substance abuse services for Indian youth**. The centers were to **integrate with "the intake and rehabilitation programs" of the referring Indian community**. According to this law, the IHS was authorized to develop a Youth Regional Treatment Center (YRTC) program under the authority of an IHS area office, where Tucson Area and Phoenix Area were considered one area office. IHS was to identify physical structures (or build them) and **establish program guidelines**. In 1988, Public Law 100-690, also known as the "Anti-Drug Abuse Act of 1988," was enacted. The law mandated YRTCs for "each area under the jurisdiction” of an IHS area office.

At the time that YRTCs were established in 1986 a key component of the continuum of services was **community-based rehabilitation and follow-up services** for Indian youth, which **integrated long-term treatment, monitoring, and support after their return to their home community**. Under the Anti-Drug Abuse Act of 1988, the YRTC program further authorized the **inclusion of "family members** of such youth in the treatment programs or other services as may be appropriate." Funds were also set aside for a Demonstration Project between the Anti-Drug Abuse Acts of 1986 and 1988.

In 2010, the Patient Protection and Affordable Care Act (ACA; PL 111-148) reenacted, amended, and permanently reauthorized the Indian Health Care Improvement Act (IHCIA). Section 708 of the IHCIA required the Secretary of Health and Human Services to “develop

and implement a **program for acute detoxification and treatment for Indian youths**, including behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act (25 USC 450 et seq.). Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community."[xix]

The most extensive programming for SUDs is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). In the fiscal year 2017, their block grants alone totaled $1.8B, with **only one federally recognized Tribe receiving funds**. As GAO noted recently, "the amount of awards that states receive is based on a formula that takes into account a grantee's: population at risk of substance abuse; relative costs of providing prevention and treatment services; and relative ability to pay for prevention and treatment services."[xx] Interestingly, Tribes and Tribal organizations receive their related funding from their state's SAMHSA Substance Abuse Prevention and Treatment Block Grant "based on the ratio of the state's allotment provided to the tribal entity in the fiscal year 1991. 42 USC § 300x-33(d)."[xxi] **This poses a potential problem for Tribes, as their burden of disease is often much higher per capita**, while their service capacity is comparatively much lower. However, important to note, as of FY 2018, SAMHSA administers SUD-related grant initiatives specifically prioritizing efforts within tribal communities to address the opioid crisis through prevention, treatment, and/or recovery support.[xxii]

In 2018, GAO also reported gaps in services for adolescents and young adults, including research that noted there is, "insufficient access to recovery services and a shortage of treatment providers," and **too few treatment studies with adolescent participants** and federal grants focused on adolescent research.[xxiii] Even so, in the fiscal year 2016, the federal government spent $11.3B on substance use prevention, treatment, and recovery services and research. Still, the funding was deficient because it was not identified for youth or, more specifically, for AI/AN youth. The fiscal year 2023 budget requested $5.8B for "drug control funding that includes Substance use prevention, Treatment and Recovery Block Grants, State Opioid Response Grants, Programs of National and Regional Significance, and Health Surveillance and Program Support," none of which is AI/AN youth specific.[xxiv]

Cultural Considerations

For more than two decades, cultural psychologists have argued that "cultural traditions and social practices influence behavior substantially." Evidence demonstrates how culture impacts substance abuse, health consequences, spirituality, attitudes, treatment

responses, engagement, and outcomes. Additionally, "culturally competent social work practice is well established in the profession."[xxv] And while culturally adapted interventions have proven successful, many **YRTC interviewees indicated they are not reimbursable under Medicaid**.[xxvi]

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the U.S. Department of Health and Human Services Secretary, and the states on various issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).[xxvii] In their issue brief dated February 2021, MACPAC published, "Traditional healing services are not a Medicaid-covered service."[xxviii] **Over the years, several states, including Arizona, California, and others, have sought permission to reimburse the cost of Culturally Based Interventions** (CBI), such as sweats, smudges, and other ceremonies (collectively known as traditional healing services). States suggest that the federal government has promoted the use of CBIs in the Indian Health Care Improvement Act for over 45 years.

Public Law 94-437 (1976), also known as the **Indian Health Care Improvement Act, supports the "training of traditional Indian practitioners in mental health"** and utilization for treatment (section 201 (c E), reimbursable under Medicaid (section 402). Relatedly, Title 25 stipulates that **traditional healing training and utilization are encouraged and potentially open to Medicaid reimbursement**. More directly, the Centers for Medicare and Medicaid Services (CMS) published guidance on February 26, 2016, in State Health Official (SHO)#16-002, explaining that **"culturally appropriate health services" are "reimbursable at a rate of 100 percent."**[xxix] There has been no definitive negation of such authorization.

Congress created the Federally Qualified Health Centers (FQHCs) prospective payment System (PPS) in 2001. However, section 223 of the Protecting Access to Medicare Act (PL113-93) may only allow reimbursement under a demonstration project. **The PPS program provides a bundled rate for each qualifying patient visit and, if applied to YRTCs in its existing form, would significantly impact the ability of YRTCs to be reimbursed for their services.** Also, under PPS, licensed clinical social workers, psychologists, and psychiatrists are identified as billable PPS providers under federal law, but **other health professionals may not be billable**. Relatedly, FQHC PPS might be considered for alternative payment methods, allowing states to implement flexible strategies for adequate and efficient reimbursement for comprehensive, high-quality patient care.[xxx] IHS could also consider including other health service personnel such as community and behavioral health aides, traditional healing providers, licensed professional counselors, and those providing cultural and spiritual services, such as non-denominational chaplains employed by the VA as necessary for healthcare.

Operational Challenges

Legal and jurisdictional issues further reveal problems in juvenile drug treatment courts. In 2016, DOJ published evidence-based guidelines for effective juvenile drug treatment courts, but problems persisted for AI/ANs due to a failure to identify youth as AI/AN at the outset in the justice system. **By processing AI/AN youth outside of the tribal jurisdiction, they may be prevented from receiving timely care from systems that are available to them such as YRTCs.** According to The Sentencing Project, "tribal youth [are] more than three times as likely to be incarcerated as their white peers."[xxxi] GAO reported that more than half of the tribal officials they interviewed acknowledged jurisdictional problems with state and local justice systems.[xxxii] This means AI/AN youth are not receiving immediate attention for issues connected to substance abuse, truancy, violence, and more.

All IHS employees working with youth must receive a favorable Child Care National Agency Check and Inquiries (CNACI), as federal law requires.[xxxiii] While the process can be slow, further clearance processing delays occur because of lengthy processing, misplaced documents or fingerprints, or clerical interruptions. The wait can be as long as two years. **Where there is a limited supply of potential employees in the local workforce, CNACI delays can have significant negative effects on operations.** In some cases, YRTCs must have cleared employees chaperone not-yet-cleared employees, thus limiting staff time for youth. YRTC staff repeatedly noted the need for more group therapy training and better training through in-person and improved digital resources. Similarly, staff indicated the need for close-knit violent behavioral teams who can quickly respond to escalating situations.

According to GAO and our own data, **AI/AN communities do not have enough substance use prevention services for young adults** even though that population is at an elevated risk for substance use compared to non-native populations.[xxxiv] In part, the lack of services is tied to a lack of providers. To compound the deficiency, services generally available to the broader American population lack cultural competence or knowledge of risk factors that are relevant to SUDs among AI/AN persons.

While YRTCs provide residential rehabilitation services, they do not offer medically-managed detoxification services. SAMHSA outlines the spectrum of detoxification services for adults, from level 1, which doesn't require onsite monitoring, to level IV-D, which is both inpatient and intensive. [xxxv] **Although section 708 of the IHCIA requires the Secretary of HHS to develop and implement a program for acute detoxification for all eligible individuals on a referral basis, there is no evidence that such facilities exist for AI/AN**

youth. It is unclear if or how access to care has been impacted by the state of detoxification services.

Some YRTCs have expressed that AI/AN young adults, between the ages of 18-24, experience the same challenges with SUD as seen in AI/AN youth. As noted above, the AI/AN young adult population is 1.2 million. As such, **the broader youth age range is likely to include young military veterans**. IHS may need to work with other government programs, such as the Department of Veterans Affairs, where the number of AI/AN Veterans with service-connected healthcare needs is nearly two times higher than non-AI/AN Veterans.[xxxvi] Recent studies show that anxiety and depression were higher in AI/AN soldiers, compared to their peers, and suicidal ideation for the same population was higher across all ancestry categories.[xxxvii]

Many YRTCs explained that even if individual treatment is perfect, that person often returns to the environment that fostered the original problem. This cycle often results in a return to use, and potentially a return to the YRTC. While a return should not be considered failed treatment, **a continuum of services that includes cultural connection, community resilience, aftercare, whole-person wellness, anti-gang programs, sobriety houses, employment training, education, and life skills is needed to counter a potential return to use.**

Aftercare is a necessary component of the continuum of services for youth substance use, and it must include engaging family members who may not speak English on the need for continued treatment. Native Language and English booklets should be a standard provision in YRTC aftercare programs. Moreover, some **family members may need help understanding the complexities of aftercare to assist their family members better as they continue to heal**. Relatedly, families often lack the resources to visit youth undergoing treatment, and youth often lack the resources to access aftercare programs.

During interviews, the staff at the YRTCs explained they do not always follow a patient's individualized education program due to complexities with behavior or treatment, especially regarding students with a learning or communication disability. **A creative and flexible structure is needed to support the staff, allowing students to continue their education while undergoing treatment and aftercare.** Some YRTCs hire teachers with special qualifications that work well within the treatment cycle, such as special education teachers or continuing education programs. Similarly, alternative learning platforms that provide an enticing experience, including culturally relevant material, traditional ecological knowledge, and experiential learning, would likely improve student engagement and minimize time spent in front of a computer. Especially if young adults are incorporated into the YRTC service age, patients would benefit greatly from education-related programs,

including tribal college certifications and degrees to assist them with employment opportunities and in-demand technical and life skills. Online and in-person programs might enable students to continue their education while undergoing treatment at a YRTC.

The continuum of services should further provide advanced educational opportunities, spiritual and cultural programs, elder mentorships, life skills, and more. Such programs have significant healing value.

The length of time an individual remains in recovery housing is also critical to the success of their treatment. Research indicates **residents who "stay six months or more are less likely to return to substance use** than those who remain a shorter period."[xxxviii] For some AI/AN youth returning to an unhealthy home environment, a transitional living (sobriety house) and learning environment may be necessary. While some initiatives exist to link AI/AN youth to BH services, and there is room for partnership with the Collegiate Recovery Programs, the continuum of care does not adequately support long-term or transitional treatment. Relatedly, tribal colleges identified as "1994 Institutions" could provide invaluable opportunities by offering educational programs in sustainable agriculture and cultural programs, conceivably leading to a cultural reconnection for many tribes and potential employment in areas more attuned to tribal interests.

A multilayered program is more likely to succeed where tribes have appropriate resources for culturally relevant solutions. **Entrepreneurship education and development have been shown to "promote self-efficacy and positive relationships with caring adults and role models; social support; positive attachment to school; cultural connectedness; and hope and optimism."**[xxxix]

One important issue YRTC staff noted was **a lack of integrated health records (IHS, tribal, urban) and fragmented aftercare programs across multiple entities.** Transparency and collaboration in the continuum of services are critical for program success. If healthcare providers cannot see what others are doing, they may inadvertently create obstacles to care. A recent GAO report noted similar problems at HHS regarding state agencies as one of many facets of an integrated health record.[xl]

Operational Strengths

All of the seven YRTCs visited for this analysis offered participation in cultural practices, such as smudging and sweating. There were no discussions regarding organized religion, although many locations provided space for ceremony, meditation, personal reflection, or the practice of any faith.

The YRTCs offer a wide variety of modalities of treatment. **All facilities offer cultural art projects as part of therapy.** Art therapy is well-established as an important modality for self-expression, raising self-esteem, improving depression and anxiety symptoms, and more. But for AI/AN youth, art may take on a spiritual resonance, from whom they might gain courage and strength. Some YRTCs encourage AI/AN youth to write a research paper on their tribal history and culture, which may add value to treatment as youth better understand circumstances that contribute to their situation, "reduce barriers to care [and] promote" health.[xli]

An interest among YRTCs is the ability to provide horticulture therapy through gardens where youth can learn to grow culturally relevant produce, such as the three sisters (corn, beans, and squash). Where such therapy exists, they also harvest and cook their produce as permitted, which helps them connect to cultural values, learn self-sufficiency, self-reliance, and improve eating habits.

Desert Visions, located on the Gila River Reservation in Arizona, is the **only facility that accepts pregnant AI/AN youth**. Such a service requires remarkable coordination with nearby IHS medical facilities, and youth can continue treatment after delivering a child.

In order to address shortages of personnel and long delays in advertising available job openings and processing clearances to work with youth, the Great Plains YRTC **medications are prescribed through the IHS Tele-Behavioral Health Center of Excellence**. As a related operational factor, the state of South Dakota views this YRTC as an outpatient facility, which can impact their state funding and CMS reimbursements.

In order to address the widespread problem of finding qualified individuals with expertise in working with adolescents, Desert Visions accepts and trains university interns to learn its distinctive approach to Dialectical Behavior Therapy for Adolescents (DBT-A), adapted to incorporate cultural and spiritual practices. However, Desert Visions cannot actively engage with universities and establish relationships to promote their internship opportunities due to their staffing limitations. In this way, **current staffing limitations impacts the future availability of care.**

To operate effectively, YRTCs need to be located near hospitals, law enforcement agencies, and airports. This is necessary in order to promote seamless collaboration, ensure immediate medical care, provide a safe environment, facilitate legal interventions, and improve accessibility for individuals seeking treatment or support. Additionally, **establishing partnerships with local organizations, schools, and community groups** would allow the facility to host educational workshops, skill-building sessions, and support groups, benefiting residents and the broader community. Likewise, field trips, camping

trips, and similar outdoor recreational outings are well-established therapeutic endeavors to improve mood, reduce anxiety, and counter depression.[xlii]

Potential Gaps in Services

Overall the summaries of the field analysis raise questions about potential gaps in the SUD continuums of services for AI/AN youth. Each of these potential gaps may require follow-on investigations in cooperation with the YRTCs, federal agencies, and Tribal leaders. DBH will need to confirm the scope of the potential gaps, their possible effects on treatment outcomes, and any policy or operational barriers that may affect resolving the gaps.

The following are the potential gaps that DBH is prioritizing for further investigations:

1. AI/AN youth may not have access to an effective continuum of services for SUD treatment.
2. YRTCs seem to lack the capacity to monitor AI/AN SUD service plans at the national level.
3. IHS may lack the capacity to monitor the quality of AI/AN youth SUD treatment protocols.
4. YRTCs may lack the authority to operate promising services and means of staffing.
5. HHS guidance on cost reimbursements for AI/AN youth SUD treatments may be incomplete.
6. IHS may not have access to effective means of recruiting, hiring, and clearing YRTC staff.
7. HHS guidance on medically-managed detoxification services for AI/AN youth may be incomplete.
8. IHS may lack the authority to test digital continuums of services with AI/AN youth SUD services.
9. IHS may lack the legal structure to manage SUD treatment data exchanges between service entities.

Proposed Action Plan

IHS analysts will continue to investigate the potential gaps in the AI/AN youth SUD continuum of services, and determine where federal leadership can support resolving such gaps. Furthermore, IHS will continue to examine how federal and Tribal policies, programs, and protocols affect SUD treatment outcomes and other risk mitigation among AI/AN youth. The goal is to produce a standard for successful actions, building on verified evidence of what is efficacious and acceptable, and suitable among divergent service entities.

The following is a proposed action plan for DBH, as it continues to work with YRTCs, among IHS entities, other federal agencies, and Tribes and other Tribal organizations:

1. Develop a multi-year AI/AN youth SUD treatment and risk mitigation strategy that includes opportunities to test, verify, and modify whole-person oriented programming and partnerships, including alternative and traditional treatment methods, and diverse service entities within the scope of SUD recovery, preventing recidivism, and gaining employability attributes.
2. Work with appropriate federal and state government sources to develop a Medicaid single-rate or simplified pass-through budget for the treatment of AI/AN youth at YRTC facilities.
3. Based on the authority of federal laws and interagency agreements, form an operational agreement with federal partners to be highly responsive to local continuums of services, especially as these require resolving emerging and active cases that have both SUD treatment and legal requirements (e.g., Pathways to Wellness led by the Office of Justice Services, Bureau of Indian Affairs).
4. Build the capacity to perform national analyses that support AI/AN youth SUD treatment, including observations of disease burdens, scope of treatment services within continuums of services, records of treatment services and their total patient effects (intake evaluations, referrals, inpatient treatment progress, release status, long-term post-treatment outcomes), relevant workforce trends, effects of relocation,[xliii] and the costs of developing service capacities, including digital innovations.
5. Establish a dedicated national system for managing key operational YRTC data, including vacancies, aftercare reporting, and staff openings; and, use the data to coordinate networked services through the telehealth resources operated by IHS.
6. Establish an online national analysis engagement network to ensure federal and Tribal leaders have access to a highly-responsive digital environment for promoting and discovering analyses and reports that affect the broad scope of issues in AI/AN youth treatment and risk mitigation, as these are from disparate sources.
7. Pursue a high-speed YRTC staff processing protocol, including outsourcing background checks and staff monitoring to ensure rapid, high-quality verifications of safe staff.
8. Move all YRTCs to a single accreditation process in order to analyze key quality standards through national digital tracers of high-priority service protocols.
9. Perform a geographical survey of the potential detoxification options, facilities, and potential facilities, given local operational and governance capacity to support risk reduction processes among AI/AN youth, who may or may not utilize YRTCs for inpatient SUD treatment.
10. Prepare a notice of award for grant funding to Tribes and Tribal organizations, where the cooperative agreement enables a focus on testing and verifying the efficacy and appropriateness of local-to-regional youth program capacity development within a

digital continuum of services framework, including the continuum of housing and education with cross-sector domains.

Conclusions

Based on the field analysis, there are several potential gaps in the AI/AN youth SUD continuum of services, and these are challenging policy and program matters that require additional investigation. Meanwhile, DBH is proposing a plan with key actions, informed by the analysis by IHS, GAO, and other federal and Tribal sources. Of note is the effort by DBH to advocate for the ability to manage key data at a national level, and test and verify future digital continuums of services, where protocols and tools are highly responsive to AI/AN persons, including youth. National coordination of service analyses and management actions can lead to interagency resolutions among unclear national policies, responsiveness to Tribal interests in regional program designs, efficiencies in acquiring personnel and tool services, quality improvements in facility operations and conditions, and rapid responses to unexpected risks, such as the recent pandemic and its disproportionate effects on AI/AN youth.[xliv] Each Tribe and AI/AN community offers a unique set of resources for mitigated risk in youth, including the prevention, treatment, and aftercare regarding SUDs and their lifetime effects. Each AI/AN youth has a unique cultural, geographic, and economic past that has shaped personal development and subsequent exposure and response to psychological and behavioral risk. Increasingly, AI/AN leaders and researchers are investigating how local communities can better serve AI/AN youth with respectful, efficacious, and cost-effective methods. As such, IHS will continue to plan strategies to improve the youth service capabilities among Tribes and AI/AN communities, including partnerships that are responsive to local and regional requirements.

[i] U.S. Centers for Disease Control and Prevention. Whole School Whole Community, Whole Child (WSCC) model https://www.cdc.gov/healthyschools/wscc/index.htm

[ii] U.S. Indian Health Service, Substance Abuse and Suicide Prevention Program: Substance Abuse Prevention, Treatment, and Aftercare, Funding Announcement Number: HHS–2022–IHS–SAPTA–0001, November 4, 2021. https://www.federalregister.gov/documents/2021/11/04/2021-24020/substance-abuse-and-suicide-prevention-program-substance-abuse-prevention-treatment-and-aftercare

[iii] Tetley A, Jinks M, Huband N, Howells K. (2011). A systematic review of measures of therapeutic engagement in psychosocial and psychological treatment. Journal of Clinical Psychology, 67, 1-15. https://pubmed.ncbi.nlm.nih.gov/21633956/

[iv] The boundaries for defining youth by age are complicated by youth as a social and personal transitional experience; however, various service entities, Tribal organizations, and international organizers include youth to the age of 24 years; see examples of the United Nations (https://www.un.org/en/global-issues/youth) and Journal of Youth and Society (https://journals.sagepub.com/home/yas).

[v] U.S. Indian Health Service, Office of Public Health Support Division of Program Statistics. Supplement to the July 1, 2022 Chief Medical Officer Memo on User Population Estimates — Fiscal Year 2018 Final.

[vi] The estimate uses the 18.7% of the AI/AN youth who report early age alcohol use (before 13 years old), from the U.S. Centers for Disease Control and Prevention 2019 Youth Risk Behavior Surveillance System (YRBSS), and applies it to the estimated 2,294,102 AI/AN youth reported by the current U.S. Census Bureau supplements to the 10-year census.

[vii] The estimate uses the calculated 13.0%, based on the average rates of major depressive episodes for available data for 2016 (11.5%), 2018 (15.2%), and 2019 (12.2%), from the U.S. Substance Abuse and Mental Health Services Administration 2019 National Survey on Drug Use and Health (NSDUH), applied to the estimated 2,294,102 AI/AN youth reported by the current U.S. Census Bureau supplements to the 10-year census.

[viii] U.S. Indian Health Service, Office of Public Health Support Division of Program Statistics. Supplement to the July 1, 2022 Chief Medical Officer Memo on User Population Estimates — Fiscal Year 2018 Final.

[ix] See the example: Rasmus S, Allen J, Connor W, Freeman W. (2016). Native Transformations in the Pacific Northwest: A strength-based model of protection against substance use disorder. American Indian Alaska Native Mental Health Research, 23(3), 158-86. https://pubmed.ncbi.nlm.nih.gov/27383091/

[x] See authority in P.L. 99-570, 102-573.

[xi] HS-operated YRTCs include Sacred Oaks Healing Center (Davis, California), Desert Sage Youth Wellness Center (Hemet, California), Desert Visions Youth Wellness Center (Sacaton, Arizona), Great Plains Area Youth Regional Treatment Center (Mobridge, South Dakota), Nevada Skies Youth Wellness Center (Wadsworth, Nevada), New Sunrise Regional Treatment Center (San Fidel, New Mexico), and Unity Healing Center (Cherokee, North Carolina).

[xii] Tribally operated YRTCs include Graf Rheeneerhaanjii (Fairbanks, Alaska), The Healing Lodge of Seven Nations (Spokane, Washington), Jack Brown Youth Regional Treatment Center (Tahlequah, Oklahoma), Navajo Regional Behavioral Health Center (Shiprock, New Mexico), and Yéil Jeeyáx- Raven's Way (Sitka, Alaska).

[xiii] One of the 41 Urban Indian Organizations is contracted by IHS to operate a YRTC, namely the Native American Rehabilitation Association of the Northwest (Portland, Oregon).

[xiv] https://www.ihs.gov/sites/dbh/themes/responsive2017/display_objects/documents/yrtcaftercareeval.pdf

[xv] The Center for AI/AN Youth, the National Congress of American Indians, and many other organizations identify youth up to age 24.

[xvi] Some YRTCs plan to offer more than twelve weeks of inpatient treatment, and some youth may complete their treatment plans before twelve weeks are over. The twelve-week plan is a maximum use of beds available, assuming they are ready for use.

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[xx] "Adolescent and Young Adult Substance Use: Federal Grants for Prevention, Treatment, and Recovery Series and for Research," GAO-18-606, Government Accountability Office. September 2018. 16. https://www.gao.gov/assets/gao-18-606.pdf https://www.gao.gov/products/gao-18-606

[xxi] ibid

[xxii] U.S. Substance Abuse and Mental Health Services Administration. Tribal Opioid Response Grants. https://www.samhsa.gov/tribal-affairs/tribal-opioid-response-grants

[xxiii] ibid

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