



INDIAN HEALTH SERVICE

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American Indian and Alaska Native Youth

# RESIDENTIAL TREATMENT AFTERCARE



# Evaluation of the Youth Regional Treatment Center Aftercare Pilot Project

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## EXECUTIVE SUMMARY

From 2017 to 2022, the Indian Health Service (IHS) evaluated a federally-funded, post-inpatient aftercare pilot project among two Youth Regional Treatment Centers (YRTC) that provide residential substance use and mental health treatment services to American Indian and Alaska Native youth. The purpose of the project was to determine program design and delivery capacities for reducing recidivism and sustaining sobriety among youth as they returned to their home communities. One center was operated by a Tribal organization in eastern Washington and the other center was operated by IHS in southern California. The pilot occurred during the COVID-19 pandemic, which affected staffing, programming, and participation objectives. IHS conducted an internal process evaluation based on the guiding principles outlined in the Foundations for Evidence-Based Policymaking Act of 2018 (Evidence Act)<sup>1</sup>, to understand the barriers and facilitators in the implementation of the YRTC Aftercare Pilot Project, and ways to improve an YRTC Aftercare program, starting in 2022. The process evaluation revealed valuable insights in service capacity, challenges, and opportunities to prototype and test the impact of various tools and technologies in improving local continuums of care and the pursuit of system-wide precision behavioral health care in youth. Based on the findings, IHS is able to revise its behavioral health programs and inter-agency goals for youth and adult American Indians and Alaska Natives.

*Authors:* Paschane DM, James TD, Kinlacheeny JB

*Year:* 2022

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

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<sup>1</sup> <https://www.congress.gov/115/plaws/publ435/PLAW-115publ435.pdf>

## INTRODUCTION

The Indian Health Service (IHS) Youth Regional Treatment Centers (YRTC) provide residential substance use and mental health treatment services to American Indian and Alaska Native (AI/AN) youth. Congress authorized the establishment of YRTCs<sup>2</sup>, and based on Tribal consultations, there are 13 YRTCs among nine of the twelve IHS Areas, with Alaska, California, Phoenix, and Portland Service Areas operating two YRTCs each.

In Fiscal Year (FY) 2017, IHS utilized \$1.8 million to organize a pilot project to address the gap in services that occurs when youth are discharged upon successful completion of a YRTC treatment program and return to their home community. In October 2017, the IHS Division of Behavioral Health (DBH) published the Youth Regional Treatment Center Aftercare Pilot Project (hereafter referred to as the YRTC Aftercare) notice of funding opportunity on the Federal Register<sup>3</sup>.

The YRTC Aftercare notice of funding opportunity, specified six project objectives for the pilot project:

1. Provide aftercare and case management services.
2. Create and train community support systems in evidence-based care.
3. Identify and implement best practices for increasing access to transitional services.
4. Incorporate social media into aftercare practices.
5. Increase data collection for post residential discharged youth.
6. Evaluate and disseminate information among all YRTC facilities.

The focus for the YRTC Aftercare pilot was to develop methods that assess clients' therapeutic progress upon completion and extend it through the critical period that follows separation from inpatient services and reintegration with the larger family, community, and Tribal context<sup>4</sup>. The primary goal is to prevent alcohol and substance use relapse among youth after they left the inpatient YRTC services.

Two YRTCs, one operated by IHS and another operated by a Tribal entity, were funded to develop approaches to aftercare, recovery, and other support services for AI/AN youth that can be used across other IHS and Tribal YRTCs. The two sites were Desert Sage in Hemet, California, and the Healing Lodge of the Seven Nations in Spokane, Washington. Both sites designed and tested methods of continuing their respective therapeutic services through coordination of remote and in-person treatment engagements as the youth returned to their home communities, geographically dispersed across the nation.

DBH scheduled the pilot aftercare project for three years (December 15, 2017 to December 14, 2020), approved for \$810,000 per year, per site. Due to the COVID-19 pandemic, DBH approved

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<sup>2</sup> The YRTC program is authorized under the Snyder Act, 25 U.S.C. 13; the Transfer Act, 42 U.S.C. 2001(a); and the Indian Health Care Improvement Act, 25 U.S.C. 1665a and 1665g.

<sup>3</sup> <https://www.federalregister.gov/documents/2017/10/11/2017-21786/division-of-behavioral-health-youth-regional-treatment-center-aftercare-pilot-project>

<sup>4</sup> Future analyses will examine the progress of entering and completing inpatient care at YRTCs.

an extension for a fourth year (up to December 14, 2021) with Desert Sage, who received \$810,000, and Healing Lodge of Seven Nations, who received none due to a large carryover balance. Before the end of the fourth year, the Healing Lodge of Seven Nations requested and received a no-cost one-year extension (ending December 14, 2022) to complete an innovation project, and Desert Sage closed out the project. The total cost of the pilot project was \$5,670,000.

The IHS Evaluation Policy requires IHS programs to provide “evaluative information in the ongoing management of Federal programs<sup>5</sup>.” Thus, DBH developed a process evaluation based on the guiding principles outlined in the Foundations for Evidence-Based Policymaking Act of 2018, to understand the barriers and facilitators in the implementation of the YRTC Aftercare pilot project, and ways to improve an aftercare program by conducting “an assessment, through objective measurement and systematic analysis, of the manner and extent to which Federal programs achieve intended objectives.”<sup>6</sup>

This evaluation report details relevant YRTC context and background for the development of the YRTC Aftercare program, the evaluation methodology, and the evaluation findings. The conclusion summarizes the report followed by appendices with documents referenced in the report.

## **BACKGROUND**

### Behavioral Health Risk among American Indian and Alaska Native Youth

Across the United States, AI/AN youth have significant potential as leaders in all sectors of life, as they represent a unique development of cultural determination and personal resiliency. Nevertheless, many AI/AN youth carry an overwhelming developmental burden due to complex histories of governmental and economic strife that has resulted in risk exposures and an increased likelihood of behavioral disorders. Increasingly, the Federal government is evaluating behavioral and mental health risks among AI/AN youth, including the Alyce Spotted Bear and Walter Soboleff Commission<sup>7</sup> on Native Children Act of 2016 (P.L. 114-244)<sup>8</sup>, which will report recommendations by July 2023 to improve relevant health, education, juvenile justice, and social service programs.

As a whole, the AI/AN population is notably young, as 20.3% are youth, compared to the 16.6% of the non-AI/AN population.<sup>9</sup> Currently, the estimated AI/AN youth population, ages 12 to 24<sup>10</sup>,

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<sup>5</sup> <https://www.ihs.gov/ihm/pc/part-4/chapter-8-program-evaluation/>

<sup>6</sup> <https://www.congress.gov/115/plaws/publ435/PLAW-115publ435.pdf>

<sup>7</sup> <https://commissiononnativechildren.org/>

<sup>8</sup> <https://www.govinfo.gov/app/details/PLAW-114publ244>

<sup>9</sup> US Department of Commerce, US Census Bureau. 2019 Monthly National Population Estimates by Age, Sex, Race, Hispanic Origin, and Population Universe for the United States: April 1, 2010 to December 1, 2020 (NC-EST2019-ALLDATA), Monthly Postcensal Resident Population plus Armed Forces Overseas, file "7/1/2020 to 12/1/2020." Washington, DC: US Census Bureau, 2021. <https://www2.census.gov/programs-surveys/popest/datasets/2010-2019/national/asrh/nc-est2019-alldata-p-file22.csv>

<sup>10</sup> 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

is 2.3 million, with an estimated 1.1 million AI/AN youth who are 12 to 17 years of age. Throughout the 574 tribes in the U.S.<sup>11</sup>, AI/AN youth reside in complex geographic settings, with various degrees of community-based and trauma-affected risks.

While there are no regular or geographically-specific measures of national AI/AN behavioral health risks or treatment requirements, it is possible, based on national surveys, to estimate the burden of risk-related distress among AI/AN youth, where those measures represent a range from low to high behavioral health treatment requirements.

For purposes of estimation, the low estimate is the prevalence of major depressive episodes, and the high estimate is the prevalence of early-age exposure to alcohol use. Based on the 2019 National Survey on Drug Use and Health, an estimated 298,000 AI/AN youth (13.0% of the AI/AN youth 12-24 years old) experienced a major depressive episode in the past year (measured in 2016, 2018, and 2019) and will likely require robust behavioral health services to mitigate the long-term effects of the episode<sup>12</sup>, especially if the mental health distress is co-occurring with substance use. Based on the 2019 Youth Risk Behavior Surveillance System, an estimated 429,000 AI/AN youth (18.7% of the AI/AN youth 12-24 years old) require some form of behavioral health services because of their experiences with early age alcohol use<sup>13</sup>, which is a notably high rate of exposure.

At this time, without any other evidence to the contrary, we can assume that the estimated range of AI/AN youth (12 to 24 years) who are at risk and will require behavioral health services and treatment on an annual basis is 298,000 to 429,000. The range for AI/AN adolescents (12 to 17 years), is 140,000 to 200,000. The 2018 IHS estimate of the active registrants for IHS services includes 172,497 AI/AN adolescents<sup>14</sup>. Applying the same risk parameters above, the range of AI/AN youth registrants who are at risk is from 22,425 to 32,257.

In the context of AI/AN communities, the risk of lasting behavioral health problems may be mitigated by local experiences and interventions, including those services offered by Tribes,

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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>).

<sup>11</sup> US Department of Interior, US Bureau of Indian Affairs. Indian Entities Recognized by and Eligible to Receive Services from the United States Bureau of Indian Affairs. Washington, DC: FR Doc. 2021-01606, 2021; 2021-06723, 2021 (name corrections). <https://www.federalregister.gov/documents/2021/01/29/2021-01606/indian-entities-recognized-by-and-eligible-to-receive-services-from-the-united-states-bureau-of>

<sup>12</sup> 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.

<sup>13</sup> 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.

<sup>14</sup> 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.

Tribal organizations, local communities, and families. Each AI/AN youth has a unique cultural, geographic, and economic past that has shaped personal development and subsequent exposure and response to mental health and behavioral health risks. The degrees to which local communities help mitigate personal levels of risk are unknown, but is an area of emerging research in the scientific literature<sup>15</sup>.

Youth Regional Treatment Centers and Their Capacities to Meet Treatment Requirements

IHS provides recurring funding to 13 YRTC to address substance use and co-occurring disorders among AI/AN youth.<sup>16</sup> Some AI/AN families and Tribes elect to use other youth treatment systems, such as Tribal services and referrals to private providers. IHS directly operates seven of the YRTCs, contracts services from one Urban Indian Organization (UIO), and funds five YRTCs operated by Tribal entities.

Currently, to access YRTC inpatient care, AI/AN youth must have at least two diagnoses, a substance use disorder and a mental health disorder. The substance use disorders include those for alcohol, cannabis, opioids, and stimulants. According to YRTC directors, the more common mental health diagnoses include conduct disorder, generalized anxiety disorder, major depressive disorder, oppositional defiant disorder, and post-traumatic stress disorder. Given the high prevalence of violence and trauma among AI/AN communities<sup>17</sup>, it is also possible that some of these AI/AN youth have been exposed to trauma, either as victims or as witnesses of traumatic events.

Table 1 summarizes the YRTC capacity by operator and IHS Service Area. In total, the YRTCs have 307 beds, and based on an average twelve-week course of treatment<sup>18</sup>, they can serve up to 1,228 AI/AN youth per year. Families are encouraged to admit their youth to a facility that is close to their home and community; however, due to the limited capacity, Tribes do send youth to YRTCs that are far from the youth’s home.

*Table 1: Youth Regional Treatment Centers and Bed Capacity*

<b>Name</b>	<b>Facility Operator</b>	<b>IHS Service Area</b>	<b>State</b>	<b>Bed Capacity</b>
Graf Rheeneerhaanjii	Tribal	Alaska	AK	12
Yéil Jeeyáx – Raven’s Way	Tribal	Alaska	AK	12
New Sunrise	IHS	Albuquerque	NM	24
Desert Sage	IHS	California	CA	32

<sup>15</sup> See the example: Rasmus et al. (2016). Native transformations in the Pacific Northwest: A strength-based model of protection against substance use disorder. American Indian Alaska Native Mental Health Research.

<sup>16</sup> See authority in P.L. 99-570, 102-573.

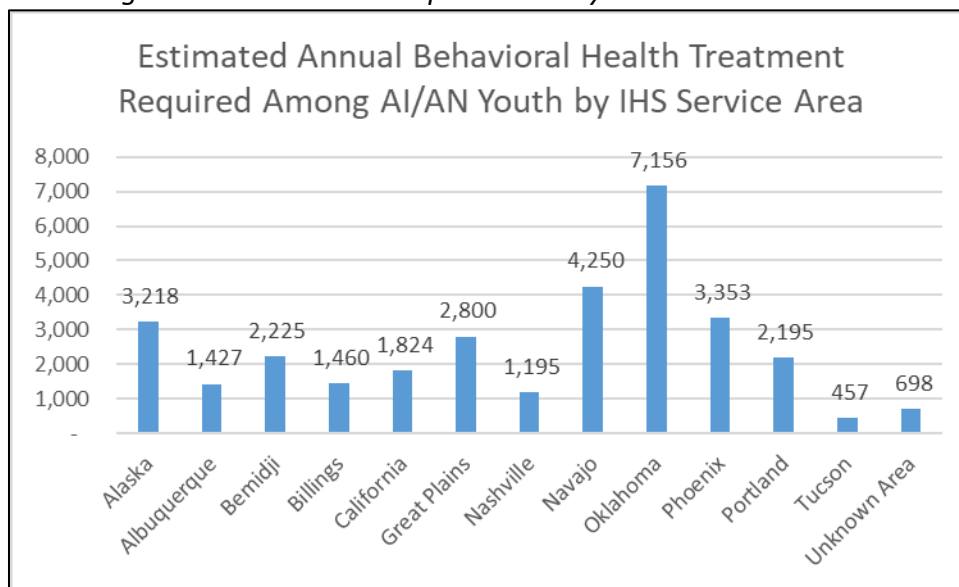
<sup>17</sup> Rosay AB (2016). Violence against American Indian and Alaska Native Women and Men: 2010 Findings from the National Intimate Partner and Sexual Violence Survey. National Institute of Justice Research Report. NCJ 249736. Washington, DC: U.S. Department of Justice, National Institute of Justice.

<sup>18</sup> 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.

Name	Facility Operator	IHS Service Area	State	Bed Capacity
Sacred Oaks (new)	IHS	California	CA	32
Great Plains	IHS	Great Plains	SD	18
Unity Healing Center	IHS	Nashville	NC	16
Navajo Regional	Tribal	Navajo	NM	16
Jack Brown Center	Tribal	Oklahoma	OK	36
Desert Visions	IHS	Phoenix	AZ	24
Nevada Skies	IHS	Phoenix	NV	16
Healing Lodge of Seven Nations	Tribal	Portland	WA	45
Native American Rehab. Assoc.	UIO	Portland	WA	24
	<b>Total</b>			<b>307</b>

Based on age and required diagnosis (corresponding to early age alcohol exposure rate of 18.7%), the nationally estimated treatment requirements among AI/AN youth who are IHS registrants is 32,257. Figure 1 illustrates the estimated treatment requirements, by patient count, among IHS youth who are IHS registrants, between the ages of 12 and 17, per IHS service area. IHS registrants include 698 youth who were not assigned to a service area, labeled as unknown. The service area containing the largest count of AI/AN youth registrants requiring treatment is Oklahoma, representing 22.2% of the total, followed by Navajo (13.2%), Phoenix (10.4%) and Alaska (10.0%).

*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).

The annual national IHS-funded YRTC capacity of 1,228 beds can meet 3.8% of the national estimated treatment requirements among IHS registrants. The estimated required annual bed capacity for all IHS youth who are IHS registrants, between the ages of 12 and 17, is 8,064 inpatient beds. In addition to other youth treatment systems, such as Tribal services and referrals



to private providers, a more thorough geographic analysis, based on the youth population, their verified treatment requirements, and travel distances may reveal a more accurate comparison between Tribal locations and YRTC bed locations and service capacities<sup>19</sup>.

The combination of the high prevalence of substance use, the rising prevalence of major depression episodes, and the low capacity of YRTC beds, suggests that AI/AN youth and their Tribes will require a notable change in how behavioral health services are coordinated and delivered. An underdeveloped capacity to address co-occurring substance use and mental health distress within the broader scope of behavioral health problems among AI/AN youth presents significant challenges in addressing the necessary structure and support of AI/AN youth and adolescent health services.

## **EVALUATION METHODOLOGY**

This evaluation of the YRTC Aftercare pilot project sought to determine the extent to which the two funded YRTCs achieved the six objectives detailed in the FY 2017 YRTC Aftercare notice of funding opportunity. To examine the evaluation questions, DBH conducted an analysis focused on grantees' ability to achieve project goals based on standards identified through a literature review, key informant interviews, and a review and analysis of grantees' quantitative data submitted through annual progress reports. During the pilot project, the data collected from the annual progress reports were insufficient for detailed evaluations of project performance.

### Review and Analysis of the YRTC Aftercare Annual Progress Reports

This evaluation report takes advantage of the Department of Health and Human Services (HHS) grant administration policies<sup>20</sup> and regulations<sup>21</sup> which applies to cooperative agreements awarded by IHS. These administrative activities outlined in the Notice of Award Terms and Conditions include requirements for financial and progress reporting. As stated in the YRTC NOFO, "Progress Reports" section, awarded YRTC Aftercare grantees were required to report annually, within 30 days after the budget period ended. These "Reports," referred to as Annual Progress Reports (APRs), must include a brief comparison of actual accomplishments to the NOFO goals established for the period, a summary of progress, if applicable, justification for the lack of progress, and other pertinent information as required. A final APR submission was required within 90 days of expiration of the budget period. In total, grantees submitted 5 APRs between October 2017 and December 2021. APRs were not required during COVID-19 because of YRTC and Tribal shutdowns; and, one site is completing a no-cost extension based on the opportunity to complete their innovation subproject. All data elements within the APRs were based on the YRTC Aftercare objectives listed in the NOFO. Measures of fidelity to proposed interventions and

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<sup>19</sup> IHS is increasing its use of geographic analyses to better plan services, including identifying (a) multi-entity, multi-resource efficiencies; (b) multi-sourced treatment requirements data; (c) multi-sourced services or interventions; (d) places of under-supported capabilities or infrastructure; (e) local barriers to service access and utilization; and, (f) emerging patterns of risks or opportunities.

<sup>20</sup> HHS Grants Policy Statement, Revised 01/07

<sup>21</sup> Uniform Administrative Requirements for HHS Awards, located at [45 CFR part 75](#).

adherence to site-specific work plans was not addressed in the respective YRTC data collection methods. The financial portion of the “YRTC Aftercare APR” is included as Appendix A.

For purposes of this evaluation, DBH reviewed and analyzed the YRTC Aftercare APRs. These questions help program staff understand how the YRTC Aftercare funding supported grantees efforts to expand YRTC services beyond the residential treatment center.

### Literature Review

The American Society of Addiction Medicine (ASAM) references five main levels (.5, 1-4) for the treatment of substance use disorders, with consideration of the local continuum of care (e.g., assets, resources, and support structure) and the individual’s whole-person wellness and intervention requirements<sup>22</sup>. To identify minimum standards for licensure and regulation for aftercare services for substance use disorders, IHS completed a literature review of documents relevant to the ASAM Level 3. Level 3 treatment provides residential substance use disorder treatment and is described as appropriate for patients who have functional deficits or require a stable living space to help with their recovery<sup>23</sup>. An analysis of peer-reviewed literature was conducted by DBH to develop a comprehensive summary of materials, which included gray literature and internal IHS documents, relevant to the overall YRTC program. The first conclusion from the review is that the possible scope, methods, and tools that would enable effective aftercare for AI/AN youth are not readily defined for how they may correspond to the ASAM levels of care, within divergent continuums of care in Indian Country. The second conclusion is that the complex risk found among AI/AN youth requires a design of services that can reinforce the benefits and effects of the Level 3 treatment in order to prevent relapse, and offer appropriate and timely risk mitigation as needed by the youth in their respective communities.

### Key Informant Interviews

The broad categories captured in the Annual Progress Reports centered on client services, participant demographics, staffing, trainings and accomplishments. Based on discussions between IHS, DBH Leadership, the DBH Alcohol and Substance Abuse Branch Program Officials, the DBH Data Coordinator and YRTC Directors, a set of supplemental questions was prepared and presented to the Project Directors representing the two funded YRTCs. These supplemental questions addressed data gaps that were informed by the literature review, and emerged in the project data collection process. For the list of “YRTC Aftercare Supplemental Questions” see Appendix B.

Due to COVID-19 travel restrictions, all key informant interview sessions were conducted via teleconferences and emails with interviews led by the IHS DBH National Data Coordinator. The questions centered on the overall experience, challenges and successes in achieving the YRTC Aftercare goals, and how to measure the impact of the YRTC Aftercare pilot program. Each YRTC respondent provided information from October 2021 to February 2022 for their respective YRTC

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<sup>22</sup> <https://www.asam.org/asam-criteria/about-the-asam-criteria>

<sup>23</sup> <https://www.drugrehab.com/treatment/levels-of-care/>

Aftercare program. This report presents a summary of the findings from key informant interviews conducted with the YRTC Directors funded through the DBH YRTC Aftercare pilot project.

## **EVALUATION KEY FINDINGS**

The framework for this evaluation was to ask if the funded YRTCs achieved project objectives outlined in the YRTC Aftercare NOFO. This evaluation took into account that the two sites represent different operational and management designs. With one as a Federal site and the other as a Tribal site. The Federal site relies on hierarchies of Federal employees, drawn from IHS and the U.S. Public Health Service, who have reporting and compliance obligations to leaders in the regional Tribes, Intra-Tribal organizations, IHS Service Area, California, and multiple Federal oversight agencies. While the Tribal site has Federal compliance obligations due to grants and funding reimbursements, they have greater autonomy, as they report to a board of directors and hire staff based on Tribal membership in neighboring Tribes, and as a board they respond to Washington state and Federal interests. Both sites struggle with legal and funding agreements that involve inter-state placements of youth. The notable differences in scope, geography, and stability of Tribal relationships affected policies, travel, and youth enrollments throughout the period of the project. Over the course of the four-year project, Desert Sage enrolled 39 AI/AN youth in their aftercare program, representing 49% of the youth who completed their inpatient treatment. Healing Lodge was able to enroll 326 AI/AN youth in their aftercare programs, representing 54% of the total youth who completed their inpatient treatment program. These differences in enrollments are due to youth dropping out of inpatient treatment or choosing not to use aftercare services, and it affected their respective implementations of the programs against the six pilot project objectives.

Therefore, the naturally occurring complexity in the program monitoring creates challenges in the overall process evaluation. The descriptive analysis addressing each question was derived from current, “in-the moment” data provided through the project progress reports, and timely key informant interviews conducted while project was in progress with reference to both historical and current trends in the field of substance use disorder treatment for youth, the AI/AN population, and residential and aftercare treatment.

## **PROVIDE AFTERCARE AND CASE MANAGEMENT SERVICES**

DBH evaluated the YRTC Aftercare pilot program with consideration to the expansion of aftercare and case management services. The resulting client capacity includes the personal efficacy for developing and sustaining their own safety, sobriety, and employability, utilizing feasible coaching, counseling, and community resources.

Desert Sage offered youth a 15-week curriculum, designed by a commercial youth development company. The curriculum combines a motivation-to-change style of cognitive-behavioral therapy with patients writing assignments, including journaling and expressing thoughts on self-awareness and other specific topics. The efficacy of the program is unclear, given that it assumes a proficiency in writing that is sufficient for self-exploration and explanation in the context of

therapy, and after returning to their home community. The program was administered to youth with various clinical diagnoses that are associated with diminished cognitive and learning states, which may affect their ability to participate in cognitive-demanding methods of writing. Likewise, the psychological and emotional changes through the continuum of care may put youth in possible communication debility phases associated to each clients' unique development, recovery, and accumulative experiences. The estimated average hours of training for youth by Desert Sage was 22 hours per client.

Healing Lodge provided services based on an *Adolescent Community Reinforcement Approach*, which pursues either changing the settings in which youth conduct everyday activities or changing the way the youth responds to influences from particular settings. Within this approach to change, youth pursued the completion of their General Educational Development tests (high school equivalency diploma), Food Handlers Permit, and a variety of communication, problem solving, and job preparedness skills. Youth in the Healing Lodge averaged 13 hours of training through the aftercare program, per client.

#### Staffing Case Managers or Aftercare Coordinators

Where appropriate and possible, YRTC hire care coordinators from within the Tribes. Both of the YRTC sites planned to hire additional staff, specifically a full-time case manager, to improve aftercare coordination and case management services. The reasoning for the additional staff is that the YRTCs recognized that existing staff were neither available nor prepared for the scope of aftercare case management. The case management scope alone included complex information and communication requirements, among clients, clients' families, Tribal officials, including Tribal care providers and coordinators, and officials of other relevant organizations, such as schools, housing authorities, and parole officers.

Using funds from the pilot project, Desert Sage hired one person as a full-time Federal employee, and Healing Lodge hired four persons from the Tribes they served. Desert Sage's effort at hiring an employee reportedly took much longer than expected because of Federal hiring practices and security clearances, but the aftercare coordinator stayed with the YRTC as a permanent employee. Healing Lodge had much more flexibility in hiring, but faced difficulty finding qualified persons and keeping them on staff. Healing Lodge experienced and reported staff turnover, due to staff career preferences and the job risks associated with COVID-19.

#### Developing Post Treatment Plans

The case managers were responsible for most of the new coordination requirements associated with aftercare. Both sites were able to provide the care coordination and case management that they defined as necessary to meet the needs of the youth who were in the aftercare program. Unfortunately, neither YRTC tracked staff time against the specific care coordination and case management tasks. Task-based accounting is a helpful method for administratively evaluating the time-cost of specific tasks, as well as who is able to provide those tasks, and how task priorities affect various service requirements. Likewise, time-cost task analysis allows for better planning of how a program may have emerging opportunities to enhance services through additional or reassigned funds.

Throughout the period of performance, the YRTC's held workgroup meetings, comprised of collaborative outside partners and internal staff, as allowed within COVID-19 restrictions. In total, the Desert Sage site conducted 10 workgroup meetings with those they held agreements, and Healing Lodge conducted 60 workgroup meetings. The NOFO did not require detailed data collection regarding the categorical records of the workgroups, such as the goals, content, cost, number of persons attending, action items, or other outcomes of the meetings. However, both sites reported that the workgroups were necessary and helpful for organizing aftercare programs.

#### Establishing Partnerships with Tribal Communities

A major challenge in providing aftercare and case management services is having sufficient memorandums of agreement (MOAs) in place to cover the variety of communication, contact, and data sharing elements required throughout the aftercare program. Unless formal MOAs were already in place and sufficient for the scope of the aftercare project, the YRTC's were required to facilitate processes of updating those agreements, which included an increase of time-cost on the YRTC executive team and their legal counsel. The matter of MOAs was especially complex during the COVID-19 pandemic, as governments, Tribes, and families were confused about risks, restrictions, and emerging plans of actions due to disruption of services. As such, both sites found it necessary to commit project resources for augmenting MOAs to accommodate the effects of the pandemic.

#### Engaging Families of AI/AN Youth Program Participants

Both YRTC's experienced challenges in keeping communications and coordination with the youth and their families throughout the period of performance. The YRTC's ensured that the youth had at least one family member involved in the youth's inpatient treatment and aftercare service plans. However, once the youth returned to the community and were out of sight of the YRTC staff, they were difficult to reach by the case coordinators. The lack of reliable and effective communication capabilities may have undermined the levels of engagement by family and Tribal members. Despite the limitations on keeping contact, the YRTC's planned and executed as many one-on-one counseling sessions between the youth and their care coordinators as they found possible. Desert Sage reported completing 147 counseling sessions during aftercare, with an average of 3.7 per youth. Healing Lodge reported completing 44 sessions, with an average of 0.1 per youth.

A challenge in comparing the work of the two sites is that they used different definitions for the roles of their staff, and corresponding actions by those staff. Desert Sage relied on a single care coordinator at the YRTC to integrate counseling with contact engagements, thus they counted each engagement as counseling. In contrast, Healing Lodge relied on a mix of case coordination and counseling from within Tribes, where counseling and engagement are separate sets of actions. In general, the less than expected number of remote counseling sessions are due to multiple challenges, including geographic distances, pandemic lockdowns, inadequate communication infrastructure, and inconsistent Tribal and community MOAs.

### Peer Recovery Support Specialist

Peer recovery support specialists (PRSS) are people who have been successful in the recovery process who help others experiencing similar situations. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process<sup>24</sup>. The 2017 YRTC Notice of Funding Opportunity included PRSS as an optional sub objective. Neither of the funded YRTCs proposed, developed or implemented PRSS activities.

Overall, the two YRTCs achieved the objective of providing aftercare and case management services to the degree that both programs organized and operated within the limitations of the COVID-19 pandemic, with limited pre-existing MOAs for support, and no technology or communication tools designed for the scope of their operations.

While this evaluation does not include an explanation for the differences in the delivery of one-on-one counseling, as this matter was not well tracked by the YRTCs, both YRTCs provided a framework to explain and address their respective aftercare goals. The frameworks did not detail how they managed the coordination between the training designs, direct delivery of coaching and counseling to youth, and the managing of access and completion of community referral and opportunities.

Having participated in the pilot, both programs are in a better position to redesign their respective programs and achieve better case management and treatment engagement among the AI/AN youth that they serve.

### Recommendations

- Future aftercare programming will require more effective data tracking, in order to differentiate counseling provisions from case coordination contacts.
- Implement time-cost task accounting to document project planning, services and modifications in workload details, such as the coordination between the training designs, direct delivery of coaching and counseling to youth, and the managing of access and completion of community referral and engagement opportunities.
- As soon as possible, MOAs will need to be complete for required partnerships, and to address the possibility of disasters and pandemics affecting the continuum of care and the processes for resolving differences in responses.
- Ensure that the aftercare is culturally appropriate, whole-person effective, within the scope of treatment and personal efficacy development, and safe for the youth.
- Reevaluate the role of Peer Recovery Support Specialist activities in the YRTC Aftercare programming.

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<sup>24</sup> <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>

## **CREATE AND TRAIN COMMUNITY SUPPORT SYSTEMS IN EVIDENCE-BASED CARE**

Both YRTC sites were encouraged to offer training to their respective community-based contacts who support the youth that they are serving. These contacts should increase opportunities to influence how communities develop and expand their service capacity, their coordination with the YRTC, and relevant cultural support of youth to sustain safety, sobriety and employability. The training can address many possible topics in a variety of formats, so it is best to ensure that the match between the mission of the YRTC and the audiences is established and updated to reflect the changing needs of both.

### Provide Behavioral Health and SUD–Related Trainings to Establish Community Support

Throughout the course of the project and across various topics, Desert Sage and Healing Lodge report that they trained 290 and 14 community-based contacts, respectively. According to their second year annual report, Desert Sage trained 230 staff, of their 290 total, on a variety of therapeutic topics, and the trainings included an unspecified number of community members. Desert Sage developed three marketing-style information brochures that primarily described the scope of the YRTC inpatient treatment program. Because Healing Lodge is a Tribal entity, they focused training on specific community-based contacts within the Tribes they serve; however, the count of trainings was lower than projected. All the same, it is unclear what Healing Lodge offered in terms of scope and purpose of the training. Finally, neither YRTC site provided training specific to the family members of the youth in their respective aftercare programs. It is unclear by their reports how the training reinforced support systems in evidence-based care.

Neither program identified the evidence in support of the efficacy of their respective training, treatment, or aftercare designs. IHS recognizes that there were notable limitations on training, such as difficulties with keeping contact with the family members and the restrictions imposed on all parties by COVID-19, as well as the lack of MOAs to address access and contact complexities.

### Recommendations

- Track the total cost and specific expenditures by the YRTCs on specific training through project period.
- Track trainings that reinforce support systems in evidence-based care, with curriculums that create alignment between entities in the local continuum of care.
- Develop and provide specific trainings and establish training plans for family members upon admission of the youth in their respective aftercare programs, including follow-up contact information.
- Establish early, comprehensive MOAs to address access and contact post treatment.
- MOAs will need to address the possibility of disasters and pandemics affecting the continuum of care and the processes for resolving differences in responses.

## **IDENTIFY AND IMPLEMENT BEST PRACTICES FOR INCREASING ACCESS TO TRANSITIONAL SERVICES**

The purpose of this objective is to improve methods of identifying and arranging transitional services for effective reintegration processes, including referral actions that lead to the youth's safety, opportunity to complete their education, and become employed. Ideally, the referral process, within the total therapeutic plan, is a precise match to the client, given their progress and personal efficacy requirements.

### Creating a Referral System that Increases Access to Transitional Services

The referral system can provide a point of reference for determining gaps in transitional and reintegration services, including those that address whole-health, education, employment, housing, and compliance with any juvenile justice requirements.

During the project, Desert Sage made 45 referrals, with an average of one per youth. Healing Lodge made 1,630 referrals, with an average of five per youth. How the sites defined and measured referrals was inconsistent and not comparable. The count of the referrals is not as important as the effectiveness of the referrals. Due to delays in acquiring supportive software, neither site tracked the progress and outcome of referrals in a format that allowed for detailed analysis.

Data-driven problems in referrals are closely associated with problems in care coordination (objective 1) as a whole. Both are processes that require an accurate, precise, individual-level record of relevant contacts, dynamic actions, and checks on quality control, including methods and reminders for follow-up and confirmation of completed actions.

### Recommendations

- Leverage existing networks of therapists and volunteers to create a coordinated means of streamlining the delivery of precise behavioral health services as therapeutic integrations of safety, sobriety, and employability.
- Create an effective referral system with updated point of contacts, service scope, and access requirements among all available sources.
- Identify methods of simplifying and connecting data communications through intake and handoff process, such as the use of digital templates.
- Establish referrals and protocols that include opportunities to have seamless transitions into employability, such as detailed assessments for optimizing training and employment resources and networks.
- Investigate technologies that permit YRTC's to use comprehensive communication protocols throughout the scope of care coordination and referrals management.



## **INCORPORATE SOCIAL MEDIA INTO AFTERCARE PRACTICES**

The social media objective is part of a larger technology goal, where future YRTC are able to effectively and efficiently meet the significant unmet treatment needs among AI/AN youth, as well as coordinate the use of AI/AN staff and volunteers who are not necessarily able to work on-site with the YRTC. Both sites explored how they could increase their use of technology-enabled social media and related tools as forms of improving aspects of personal efficacy in self-care, treatment engagement, and care coordination, with consideration of the challenges in remote locations, cross-jurisdictional management, and the lock-downs that Tribal and government entities enforced because of the COVID-19 pandemic.

### Effectively Using Social Media for YRTC Aftercare Practices

Both sites attempted to form a limited scope of tele-video counseling between the YRTC care coordinator and the respective youth. In the total scope of the aftercare program, Desert Sage provided 210 tele-video counseling sessions to youth. Healing Lodge provided no tele-video sessions, but they are in the process of developing a mobile phone application that will extend tele-video capabilities through a center-issued phone and an incentive-based, client-vetted system of rewards for participation in counseling and data collection. The differences in the use of social media and relevant helping technology reflects notable differences in the respective sites' actions to date regarding MOAs for shared services, governing policy, and resources directed to organizational capacity development.

Neither of the YRTCs have in-depth experience with contemporary technologies, so their scope of experimentation was limited. Nevertheless, they sampled methods of using communication devices, technology applications, and media sites in the scope of managing safe care and coordination among youth.

### Recommendations

- Include in future Cooperative Agreements *Substantial Involvement* to collaboratively explore technology and tool options that offer an opportunity for IHS to provide technical assistance on the integration of program designs and tool innovation management.
- Optimize the value of social media, but with a focus on stand-alone, safe, and applicable content management.
- Network the availability of therapists and volunteers, managed through central locations, and consider the use of network data sources that other federal agencies have developed.
- Combine social media content and networked therapists to create a coordinated means of streamlining the delivery of precise behavioral health services as therapeutic integrations of safety, sobriety, and employability, reinforced with tailored social media.

## **IMPROVE DATA COLLECTION FOR POST RESIDENTIAL DISCHARGED YOUTH**

Data collection is one of the most challenging aspects of any behavioral health intervention or therapy. Typically, the driving focus of the therapeutic team is responding to the immediate

psychological and behavioral needs of the client, not the administrative data that is required for coordinating and analyzing the quality of services. However, effective data collection is essential for aftercare because an effective program relies on continuous analysis of staff decisions and actions that are documented as timely and precise service adjustments for meeting the changing needs of AI/AN youth, their families, and their Tribes.

Developing Data Collections Plans for Post Residential Discharged Youth

Table 3 summarizes the data that the YRTC provided regarding their program design, and Table 4 summarizes their services to the clients. It is important to note that Desert Sage was able to provide data on 90% of their youth (n=35), but the data were not client-level records; rather, they were engagement-level data. In addition, Healing Lodge could only provide 15% of their data (n=48) because they relied on hand-written forms from their Tribal coordinators, but the data are client-level records.

*Table 3: Reported Aftercare Pilot Project – Program Design Data*

<b>Reported Data Measures</b>	<b>Desert Sage</b>	<b>Healing Lodge</b>
Staff Added	1	4
Workgroup Meetings	10	60
Youth Training Average Hours	22	13
Community Contacts Trained	290	14
Community Service Referrals	45	1,630
Average Youth Service Referrals	1.2	5.0

*Table 4: Reported Aftercare Pilot Project – Client Data*

<b>Reported Data Measures</b>	<b>Desert Sage</b>	<b>Healing Lodge</b>
Youth Participating Over Four Years	39	326
Youth Case Data Provided for Analysis	35 (90%)	48 (15%)
<i>One-to-One Sessions</i>	<i>147</i>	<i>44</i>
<i>Sobriety At Last Observation</i>	<i>11 (31%)</i>	<i>19 (40%)</i>
<i>Average Observations of Sobriety</i>	<i>2.5</i>	<i>3.5</i>

Healing Lodge was able to acquire four staff within the Tribal communities, primarily through long-standing negotiations with the local seven Tribes. The staff provided 44 one-on-one counseling sessions to the youth who returned to the Tribes after inpatient treatment. Compared to Desert Sage, Healing Lodge managed 6 times as many workgroup meetings among partners, and provided services to nearly 10 times as many youth. In contrast, Desert Sage provided 210 tele-video counseling sessions, averaged 3.8 one-on-one counseling sessions per youth, and conducted over 20 times more training to community contacts than did Healing Lodge. Healing Lodge provided nearly 37 times more service referrals to youth than did Desert Sage, resulting in an average of 5 times as many referrals per youth, though the impact of the referrals is unknown because of a lack of data collection.

Neither site in the project collected sufficient administrative data for explaining the cost-effectiveness of their service designs or the causal pathways to their respective patient outcomes.

Well-planned data collection commitments and communication tools can lead to many sustainable benefits for the youth, and support the success of service providers. Accurate data enables timely decisions within the continuum of care, and responses to early signs of risk.

### Recommendations

- Appropriately communicate data for clients, including their diagnoses, consequential experiences, and engagement status within their family, education, employment, and community.
- Develop effective informed consents and memorandums of data sharing agreement between parties of interest.
- Data collection efforts should support a complete exploration of the likelihood of recidivism or sobriety among youth in the aftercare program.
- Create improved data collection plans and data documentation of direct services and costs, including YRTC aftercare, which will address key elements, as much as the technological capacity allows:
  - Collect client-level data to include dynamic elements of direct services and referred actions and responses by the client and those providing services.
  - Automate data collection and integration of key service parameters, decisions, and events, in order to develop precise and timely services.
  - Integrate and communicate client assessment results<sup>25</sup> with references to feasible opportunities within clients' home communities or through other networks.

### **CONDUCT EVALUATIONS AND DISSEMINATE INFORMATION AMONG YRTC AND OTHER AI/AN YOUTH FACILITIES**

For this pilot, IHS was only able to fund two of the twelve YRTCs, at the time. As such, it is critical to the remaining YRTCs and IHS that those facilities that participated in the pilot are able to evaluate and disseminate information about their respective programs to the other YRTCs and their Tribal partnerships. Generally, the objective is to provide insights that will inform (a) designs and technologies for increasing the capacity for services to meet the estimated national treatment requirements and those verified by Tribes, (b) methods for completing effective incorporation of community-based resources, and (c) current evidence of efficacious methods for reducing alcohol and substance use relapse, leading to personal resiliency and employability.

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<sup>25</sup> A total client assessment platform would include valid formats based on clinical standards, such as screenings, and those that support a variety of treatment engagements (e.g., Global Appraisal of Individual Needs).

### Develop and Disseminate Comprehensive Information on AI/AN Youth Aftercare Practices

Both YRTC facilities provided insights through regular discussions on the challenges they faced and the solutions they developed to address service designs, care coordination, staff recruitment and training, referrals management, data collection, and social media. As a result, this report will contribute to the dissemination of valuable insights among the leaders of the YRTC facilities, as well as Tribes, other Federal agencies, and potential community partners.

Unfortunately, due to the inadequacy of the data collection at both sites, this report is unable to provide evidence to explain how the respective YRTC facilities' program designs, content, and delivery of services effected the youth in their care.

As expected, the COVID-19 pandemic restricted the expected scope and quality of engagement between DBH and the YRTC facilities, and the prolonged restriction on travel has limited how participants can exchange information and build collaborative analyses of their respective experiences. In response, throughout the aftercare pilot, both YRTC facilities participated in monthly, one-hour YRTC director calls facilitated by the IHS program official. This report by DBH and follow-on in-person discussions between YRTC directors will enable reporting and planning that supports the future effectiveness of YRTC program designs.

### Recommendations

- Determine a plan to disseminate the YRTC Aftercare pilot project results to contribute to the dissemination of valuable insights among the leaders of the YRTC facilities, as well as Tribes, other Federal agencies<sup>26</sup>, and potential community partners.
- Partner with the U.S. Department of Justice to perform a study of the potential fit of YRTC inpatient treatment for AI/AN youth who have lower levels of criminal offenses.
- Continue efforts to identify promising and best practices, service delivery, and quality improvement strategies to be used among all YRTC facilities.
- Facilitate opportunities for YRTC facilities to learn from this pilot project.

### **LIMITATIONS**

The naturally occurring complexity in the program monitoring of two YRTC facilities with different operational and management designs created challenges in the overall process evaluation. In addition, the impact of COVID-19 on YRTC Aftercare was significant. At best, the two sites had two years to organize their respective program content and data collection methods, hire new personnel, train community-based partners, establish Tribal agreements, and start working with the AI/AN youth before the pandemic affected their Tribal relationships, leading to a total

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<sup>26</sup> A review of 2019 data suggests that only 14% of the AI/AN youth who are arrested for juvenile crimes receive inpatient treatment through YRTC facilities, and as much as 61% would be eligible based on their offense. See U.S. Office of Juvenile Justice and Delinquency Prevention (2021). Easy Access to the Census of Juveniles in Residential Placement. <https://www.ojjdp.gov/ojstatbb/ezacirp/>

geographic shutdown. The one-year extension, which ended in December 2021, allowed the sites to bring more youth into their aftercare programs and test their respective interventions.

## **CONCLUSION**

A central goal of DBH is to help YRTC resolve the many factors that affect relapse in AI/AN youth. Through years of experience working with all the YRTCs (one is newly opened), DBH recognizes that many of the necessary support systems for youth may not exist in their respective communities, and that a benefit of this pilot project was facilitating the YRTC as an emerging leader in service designs, as such designs may fit the local continuums of behavioral health care.

Recognizing that there are significant unaddressed treatment requirements among AI/AN youth, and that the current service capacity among YRTCs is limited, DBH is motivated to address the longstanding barriers to optimal treatment options for AI/AN youth, and the cost-effectiveness of alternative service models. At the same time, it is important that these options be considered in the context of the local continuums of care and the total system of services, with emerging research evidence and technology prototyping that is specific to clinical goals, informing IHS programs and policies and all stakeholders who have the missions of addressing issues of Tribal affairs, AI/AN youth outcomes, equitable Federal services, and health services and healthcare quality in general.

### **Reexamining Youth Treatment Strategies within Local Continuums of Care**

A longstanding barrier to achieving whole-person wellbeing among AI/AN youth is the inadequate or incomplete local continuum of care, which can force the family or Tribe to choose between accessing locally-provided versus sufficiently-provided behavioral health services.

Locally-provided services, if they are available, offer notable treatment benefits. Through the local community, the AI/AN youth may have the opportunity to heal and recover within cultural, familial, and spiritual attachments, reinforced by community coaches and counselors who the youth is actively engaging while going through treatment transitions<sup>27</sup>.

A sufficiently-provided behavioral health service is one that is precise to the unique, emerging requirements of the AI/AN youth, fitted to the treatment and personal transitions that affect recovery and whole-person wellbeing<sup>28</sup>. Sufficiently-provided services are those that can effectively adapt to the youth's unique development of personal efficacy, reinforcing strengths in interpersonal safety, sobriety, and employability.

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<sup>27</sup> The evidence is notable for the effects of attachment on recovery (e.g., Johnson et al., 2016, Positive criminology and rethinking the response to adolescent addiction: evidence on the role of social support, religiosity, and service to others and long-term outcomes) and long-term health (e.g., Steiner et al., 2019, Adolescent connectedness and adult health outcomes).

<sup>28</sup> National Institutes of Health leaders have argued for increasing precision in health services to respond to the richness and complexity of individual variability, and better responding to diseases and disabilities through heightened attention on the specificity in patient behavior, patient-provider communications, and development of personal efficacy (see Collins FS, Varmus H, 2015; Hekler E, Tiro JA, Hunter CM, Nebeker C, 2020).

In an ideal continuum of care, the AI/AN youth has access to both locally-provided and sufficiently-provided behavioral health services. Few communities can sustain an ideal continuum of care because of dynamic cultural, geographic, and economic conditions that affect the formation of service organizations and institutional partnerships. Nevertheless, through robust analyses, communities can identify gaps in sufficiency and plan agreements among local and nearby entities to satisfy precise service requirements under varying circumstances.

IHS is pursuing methods by which it can understand the local continuums of care and their development, and organize grant programs to respond to the barriers that prevent youth from accessing locally-provided and sufficiently-provided behavioral health services.

As a method of analysis, IHS is reexamining youth treatment strategies in a new framework that starts with the assumption that local communities have a goal to achieve sustainable, cost-effective, and efficacious sets of services that are local and sufficient, and highly responsive to the needs of their service population as they pursue whole-person wellbeing. From there, the framework is applied to the whole, emerging market of service capabilities, tools, technologies, and protocols to determine what combinations of innovative approaches can enhance, supplement, or augment the unique local community so that it achieves its continuum of care goal.

This framework will inform the YRTC Aftercare evaluation and evaluations of other IHS grant programs by identifying potential gaps among continuums of care, for youth and adults. One potential solution to addressing these gaps might be through applied research and tool prototyping to help communities validate the suitability of innovations, given their unique experiences. Examples include the role of technology-enabled solutions, and in particular, specialized interoperable communications that will facilitate timely assessments, service provisions, care coordination, referral management, and ideal data collection within the local continuum of care for AI/AN youth.

### **Increasing Access to Transitional Services through Referral Management**

Increasing access to transitional services through optimal referral management is a process where an effective, ongoing assessment of the youth generates a clear array of personal needs, which are then matched to various resources that are in the community, provided by the YRTC, or available through an online or local resource. Referrals are not passive actions, as they include a process of facilitating the contact to the referral source and tracking the follow-through use of the referral by the youth. With full support in place, referrals are a time-consuming, data-intensive operation, and one that the YRTCs can manage best with the use of supporting technology tools for documenting, tracking, and organizing decisions and outcomes. Because youth often have to rely on multiple adults to facilitate their access to services, referrals should be clear and dynamic plans led by the YRTCs to achieve coordination, verification, and other means of ensuring youth safety. Likewise, advanced referral tools can demonstrate patterns of actions and decisions that affect patient outcomes.

### **Incorporating Telebehavioral Health Services and Social Media Platforms in Aftercare Practices**

The ability to network therapeutic services from central hubs is a major achievement and critical capability in IHS. For example, the IHS Telebehavioral Health Center of Excellence (TBCHE) provides point-to-point, confidential behavioral health services through secure tele-video communications to 25 U.S. sites. In a 2017 review of its services, the TBCHE provided more than 6,000 hours of behavioral health services, including more than 1,000 hours of youth-focused care. The integration of telebehavioral as a post-inpatient treatment option could increase the access and attractiveness of precision behavioral health services to AI/AN youth, especially as a coordinated capacity with YRTCs.

In addition, incorporating social media services into aftercare practices will enable IHS and Tribes to combine social media content and networked therapists to create a coordinated means of streamlining the delivery of precise behavioral health services as therapeutic integrations of safety, sobriety, and employability, reinforced with tailored social media. Social media tools, among other advantages, can also support a larger technology goal, where future YRTCs are able to effectively and efficiently meet the significant unmet treatment needs among AI/AN youth, as well as coordinate the use of AI/AN staff and volunteers who are not necessarily able to work on-site with the YRTC.

### **Use of Data to Improve Communication, Programming, and Services**

Well-planned data collection commitments and communication tools can lead to many sustainable benefits for the youth, and support the success of service providers. DBH will explore efforts by Tribes to advance their communication infrastructures as a means of supporting the communication of data and information exchanges by multiple response entities, such as emergencies. The goal is to make sure that appropriate and necessary information is readily transmitted in emergency and intervention scenarios, especially among socially-isolated and trauma-affected persons<sup>29</sup>.

Because most of the YRTC Aftercare pilot project occurred during the COVID-19 pandemic, when AI/AN youth likely faced exacerbated behavioral health risks, DBH is investigating how the local continuum of care can be better sustained when major events, such as pandemics interrupt services, funding, and staffing.

### **Revision of the 2022 YRTC Aftercare Programming**

The primary aim of this process evaluation was to determine through progress assessment whether funded projects implemented activities as intended in the program design, and how they addressed service challenges. Overall, the quality of implementation based on the standards outlined, rather than a focus on positive or negative outcomes, can indicate whether the program design or logic model is an appropriate match for program goals. Through this review, it is clear the YRTC Aftercare will benefit from a more clearly defined set of objectives, which focus on

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<sup>29</sup> Executive Order 14053: <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/11/15/executive-order-on-improving-public-safety-and-criminal-justice-for-native-americans-and-addressing-the-crisis-of-missing-or-murdered-indigenous-people/>

testing the effects of improved tools, technology, data, and their integration with pre-treatment and post-treatment protocols.

**Future Recommendations of the 2022 YRTC Aftercare**

Given the demonstrated need for improved treatment methods among AI/AN youth experiencing mental health and substance use disorders, the findings of this report will inform future IHS objectives for any initiatives among YRTCs and all DBH programs that rely on complex, local continuums of care. As the report suggests, there are many opportunities to improve services, including standardization of care agreements, care transactions, and patient assessments; testing of case management tools and analyses, alternative communication platforms, and tools that enable patient self-care. As a result, DBH is pursuing opportunities to cooperatively design and verify innovative approaches to the full scope of behavioral health services provided to AI/AN persons and communities, especially youth, addressing longstanding continuum of care deficiencies in local communities.



# Appendix A: YRTC Aftercare APR

<a href="#">View Burden Statement</a>	<b>Federal Financial Report</b> (Follow form Instructions)	OMB Number: 4040-0014 Expiration Date: 02/28/2025
1. Federal Agency and Organizational Element to Which Report is Submitted [Redacted]		2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment) [Redacted]
3. Recipient Organization (Name and complete address including Zip code) Recipient Organization Name: [Redacted] Street1: [Redacted] Street2: [Redacted] City: [Redacted] County: [Redacted] State: [Redacted] Province: [Redacted] Country: USA: UNITED STATES ZIP / Postal Code: [Redacted]		
4a. UEI [Redacted]	4b. EIN [Redacted]	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment) [Redacted]
6. Report Type <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Final	7. Basis of Accounting <input type="checkbox"/> Cash <input type="checkbox"/> Accrual	8. Project/Grant Period From: [Redacted] To: [Redacted]
		9. Reporting Period End Date [Redacted]
10. Transactions		Cumulative
(Use lines a-c for single or multiple grant reporting)		
<b>Federal Cash (To report multiple grants, also use FFR attachment):</b>		
a. Cash Receipts		0.00
b. Cash Disbursements		0.00
c. Cash on Hand (line a minus b)		0.00
(Use lines d-o for single grant reporting)		
<b>Federal Expenditures and Unobligated Balance:</b>		
d. Total Federal funds authorized		0.00
e. Federal share of expenditures		0.00
f. Federal share of unliquidated obligations		0.00
g. Total Federal share (sum of lines e and f)		0.00
h. Unobligated balance of Federal Funds (line d minus g)		0.00
<b>Recipient Share:</b>		
i. Total recipient share required		0.00
j. Recipient share of expenditures		0.00
k. Remaining recipient share to be provided (line i minus j)		0.00
<b>Program Income:</b>		
l. Total Federal program income earned		0.00
m. Program Income expended in accordance with the deduction alternative		0.00
n. Program Income expended in accordance with the addition alternative		0.00
o. Unexpended program income (line l minus line m and line n)		0.00

## Appendix B: YRTC Aftercare Supplemental Questions

YRTC questions for explaining service designs, practices, and experiences with aftercare:

1. What services did patients receive from your aftercare program?
2. What items or personnel did you procure to support your program?
3. What did you design new to deliver through your program?
4. What did you coordinate to deliver to the patient that is from outside your program?
5. What measurable impacts did your program have on patients?
6. What is your expected frequency and scope of counseling sessions for sustaining sobriety in patients?
7. What is your expected frequency and scope of coaching sessions for sustaining personal efficacy (e.g., self-care, referral follow-up, and training or education) in patients?
8. What is your expected frequency and scope of coaching sessions for developing attributes of employability (e.g., knowledge, skills, interpersonal communication, and self-management) in patients?
9. What is your expected frequency and scope of coaching sessions for developing affinity with and growth through cultural and spiritual connections with patients' communities?
10. What factors affect your frequency and scope of aftercare services?
11. How do you assess and address communication debility phases in patients (and family members), such as those associated with infrastructure, devices, referral processes, and personal factors (e.g., confidence, practice, education, recovery, and development)?
12. How do you assess and address patient safety?
13. What are your primary methods for coordinating, managing, and delivering services (e.g., case management) to patients once they leave inpatient care?
14. How do you record and use data (e.g., time-based accounting, pattern-based decisions, referral steps, and timed-out actions) regarding your coordination, management, and delivery of services?
15. What methods does your program use to ensure quality control in data collection, case management, referral completion, counseling and coaching, and training?
16. What tools or media does your program use, promote, or test to increase patient self-care, co-management of care, patient development, or community and program engagement?
17. What are the performance challenges to your staffing and what causes those challenges?
18. What are barriers (e.g., MOA development, geographic distances/jurisdictions, and continuum of care) to achieving your goals for coordinating and delivering services?
19. What methods were used to overcome barriers in your program?
20. How does your local community or outside entities help overcome barriers or complicate barriers in your program and its scope of work?
21. What are other organizations that assist you in designing your program or overcoming barriers?
22. Given the developing continuums of care in your service areas, what are the gaps that your program is addressing?
23. How do you best facilitate strengths in your continuum of care (e.g., training partners, showcasing program, and advising Tribes)?



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